ACT INTEGRITY COMMISSION

Investigation Report – Operation Falcon

An investigation into the allegations of the omission of required medical observations and falsification of observation records at the Alexander Maconochie Centre.

January 2025

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Acknowledgement of Country
The ACT Integrity Commission acknowledges the Ngunnawal people as the traditional owners and custodians of the Canberra region. We pay our respects to Elders past, present, and emerging and extend our respects to all Aboriginal and Torres Strait Islander people.

Contents

ACT INTEGRITY COMMISSION

FROM THE OFFICE OF THE COMMISSIONER

Our Ref: R20/0111

Mr Mark Parton MLA
Speaker
Legislative Assembly for the ACT
CANBERRA ACT 2601

Dear Mr Speaker

INVESTIGATION REPORT – OPERATION FALCON

On 30 November 2020 the Commission received a corruption report alleging that on 16 October 2020 corrections officers at the Alexander Maconochie Centre (AMC) failed to conduct certain detainee observations. The Commission decided to investigate the matter under s 100 of the *Integrity Commission Act 2018* (the Act).

Enclosed is the Commission's Investigation Report prepared pursuant to s 182 of the Act and provided to you in accordance with s 189 (Presentation to the Legislative Assembly).

In the Report, the Commission considers several discrete matters that arise as part of Operation Falcon. The investigation focused on the General Manager of the AMC and a corrections officer. While adverse findings were made, I have concluded that there was no corrupt conduct.

Yours sincerely

The Hon Michael F Adams KC
Commissioner

17 January 2025

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Introduction

Investigation Report

1. This Investigation Report is provided in accordance with s 182 of the *Integrity Commission Act 2018* (**IC Act**) in connection with matters arising from non-compliance with mandatory observation policy at the Alexander Maconochie Centre (**AMC**).

2. In accordance with s.188 of the IC Act the Commission previously provided its Proposed Investigation Report (PIR) to certain persons to whom it relates or who have a direct interest in its findings to afford natural justice to those persons by giving them the opportunity to comment on its content. One of the persons (identified as Person 2) having such an interest, as their conduct was considered in the investigation and a proposed adverse finding was indicated, was given the opportunity to receive a copy of the Report but declined to accept it for welfare reasons and, accordingly, has not commented in its content. The Commission has now considered such comments as were received and has made some amendments to the report as a result. In the main, the report expressly indicates where those amendments have occurred.

3. The two persons whose conduct was under consideration, namely the General Manager of the Alexander Maconochie Centre (the **General Manager**) and a corrections officer (Person 2) have been the subject of some adverse findings but, for various reasons explained in this report, no finding that they were guilty of corrupt conduct has been made.

Role of the Commission

4. The Commission is established under the IC Act with the function, amongst other things, of investigating conduct that is alleged to be corrupt conduct and referring suspected instances of criminality or wrongdoing to the appropriate authority for further investigation and action. In order to make a finding that corrupt conduct occurred, the Commission must be satisfied to the necessary degree (see below) that it falls within at least one of the elements specified in each of ss 9(1)(a) and 9(1)(b). So far as this investigation is concerned, the potentially relevant elements are –

   - *First limb*: the conduct could constitute
     - a criminal offence,
     - a serious disciplinary offence, or
     - reasonable grounds for dismissing a public official or dispensing with or terminating their services.

   - *Second limb*: the conduct contravenes one of several standards, that include:
     - exercise of the public official's functions in a way that is not honest; or
     - conduct by the public official that constitutes a breach of public trust.

5. "Serious corrupt conduct" is that which "*is likely to threaten public confidence in the integrity of government or public administration*" and "systemic corrupt conduct" means "*instances of corrupt conduct that reveal a pattern of corrupt conduct in 1 or more public sector entities*".

6. For the purposes of the IC Act, a "public official" means a person who has "public official functions" for the Territory or is "acting in a public official capacity" for the Territory, and relevantly includes (but is not necessarily limited to) a person who is an employee of a public sector entity or a contractor or volunteer exercising a function of a public sector entity.5 A "public sector entity" is defined in the Act to include an "entity of a public nature"6, a term further defined to mean an entity whose functions are, or include, functions of a public nature when the entity is performing those functions for the Territory.7 It is uncontroversial that both the General Manager and corrections officers are public officials within the meaning of the IC Act. (The General Manager signed his emails at the time covered by the Commission's investigation as "General Manager, Alexander Maconochie Centre", but stated in his private

examination that he was “Deputy General Manager” in 2020. For simplicity, this Report refers to him as the General Manager.)

Pseudonyms and position titles

7. The Commission has determined pursuant to s 187 of the IC Act that it would be contrary to the public interest to include names of certain individuals in this Investigation Report on the basis that to do so would unreasonably infringe their right not to have their privacy and correspondence arbitrarily interfered with. Pseudonyms are used instead.

8. The pseudonyms are as follows:

Person 1	Detainee, AMC
Person 2	Corrections Officer, AMC
Person 3	Official Enquiries Co-Ordinator, AMC
Person 4	Another member of the Executive Support Team at the AMC
Person 5	Person 3’s supervisor, AMC

9. Where position titles are used in this Investigation Report, the reference is to the person who occupied that position at the time of the conduct being investigated. The incumbent may since have changed.

Investigation background

10. The Commission commenced an investigation pursuant to s 100 of the IC Act following a report made by Person 1 concerning the omission of required medical observations and the falsification of a Detainee Observation Form (**Observation Form**).
The allegations investigated by the Commission were that on 16 October 2020 corrections officers did not conduct a welfare check on Person 1, a detainee at the AMC, who was required to be the subject of hourly observations during a 24-hour period and that false entries had been made in a Detainee Observation Form indicating that they had taken place. Issues with undertaking and adequacy of required observations and making an appropriate record were also raised in different ways in the Inquests into the deaths in custody at AMC of Steven Freeman, who died on 27 May 2016, and Luke Rich, who died on 1 February 2022. In the former Inquest, the issue of observations arose in the context of the morning muster at the AMC.
The Coroner's report (dated 11 April 2018) recorded as a key finding of fact that a corrections officer "observed Steven's foot twitch and he took that as sufficient for the purposes of the morning prisoner welfare check and headcount." The Coroner's relevant recommendation, with which the ACT Government agreed, was focused closely on procedures requiring eye contact and facial recognition for ensuring prisoner safety and welfare checks through musters and headcounts. In the latter case, subject of a report on 22 August 2024 (discussed in greater detail at [97] ff), required observations were not carried out.

11. Person 1 had originally reported the alleged omission of hourly observations to the Indigenous Official Visitor Corrections (**the Official Visitor**). In an email dated 18 October 2020, Person 1 stated "I want to talk ASAP. It is to lodge a complaint regarding hourly observations, or lack of to be precise". As this was a Sunday, the Official Visitor responded the following morning, stating, "No problems. I'm hoping to be in later today". The Official Visitor's personal diary entry for Monday 19 October 2020 confirms that she attended the AMC and spoke with Person 1; it further records the allegation that hourly observations did not occur, and Person 1 felt unwell at the time. Following inquiries made by the Official Visitor (set out in detail below), the Official Visitor advised her, "I have had a response around your observations, they have acknowledged there was some observations missed and have put this down to operational needs". As the investigation unfolded, the adequacy both

of the management response to the Official Visitor and to the issues that had been raised also became an issue.

12. In substance, the investigation concerned the conduct of Person 2 and the General Manager.

13. Between June and November 2023, the Commission held private examinations of the Official Visitor, the General Manager and Person 3. It was initially proposed that Person 2, the Corrections Officer who failed to carry out the required observations and apparently falsified the Observation Form would be called before the Commission for examination. However, the Commission was informed of significant welfare issues with Person 2, which were likely to be exacerbated by an appearance before the Commission. Since the information otherwise available to the Commission was sufficiently cogent to inform the issues being considered in the investigation, it was decided that any additional information that might be obtained by examining them was unlikely to be significant enough to warrant placing their welfare at risk. Accordingly, the officer was not examined.

Findings of fact

14. In a conventional trial, conclusions are drawn by applying the rules concerning the onus (or burden) and standard of proof. An investigation under the Act is not a trial: there are no parties; and no legal or evidentiary burden is placed on anyone to prove or disprove any fact. There is an applicable standard of proof in the sense that the process of investigation and the ability to make any findings must be based on a rational assessment of the relevant and available evidence to an appropriate level of confidence. In respect of findings of corrupt conduct, this is accepted to be the civil, as distinct from the criminal, standard of proof. The civil standard is conventionally stated to be reasonable satisfaction on the balance of probabilities, whilst the criminal standard is satisfaction beyond reasonable doubt.

15. When considering the balance of probabilities, the Commissioner must be persuaded by the evidence that the existence of a fact is more likely than not.

16. The difference between the criminal and civil standards of proof is of crucial significance and is not mere semantics. Even in respect of very serious misconduct capable of amounting to a crime, it is only necessary that the Commissioner be reasonably satisfied on the balance of probabilities; it is not required that the Commissioner reach the degree of certainty essential to ground a conviction. An adverse finding of serious corruption is not mere conjecture or surmise even if it falls short of certainty.

17. Findings of corrupt conduct are serious conclusions that may well have grave repercussions and affect a person's reputation, professional standing and employment. It is conventionally perceived that it is inherently unlikely that persons of good character will knowingly act corruptly and this, in addition to the gravity of the consequences that flow from a particular finding, are considerations that must affect the answer to the question of whether the issue has been established on the balance of probabilities, to the reasonable satisfaction of the Commissioner.

18. The rule is conventionally stated: 'In such matters "reasonable satisfaction" should not be produced by indefinite testimony, inexact proofs or indirect inferences'. This should not, however, be understood as being directed to the standard of proof. Rather, in the context of the Commission, those words should be understood as simply reflecting the conventional perception that people act rightly and, in light of the potential consequences of adverse findings, a finding should not lightly be made, even on the balance of probabilities, that a person has been guilty of corrupt conduct. Generally put, the more grave the proposed findings, the better the quality of the evidence needs to be.

19. In this investigation, documentary evidence and CCTV footage objectively and clearly establish various central facts. There has been no requirement for the Commission to prefer one version of events over another according to various recollections and to work through the human foibles which typically accompany them.

20. When considering the importance or significance of facts, matters or issues that affect the propriety of impugned conduct, it will almost always be necessary to consider the potential outcomes of the conduct as known or as they ought reasonably to have been known to the public official at the time at which the conduct was engaged in. In the circumstances here, the fact that, as it happened, the risk to the detainee's health arising from the failure to make the required observations did not eventuate does not mitigate the seriousness of the omission. Further, the fact that there may have been an available alternative to one means of risk management does not mitigate a failure to engage in another, where that failure is in clear violation of a requirement to do so.

Corrections management policies and procedures

21. Operational policies and procedures of ACT Corrective Services (**ACTCS**) (but not operational forms) of the type referred to in this report are notifiable instruments. They are voluminous. Appropriately ACTCS provides access to these documents from its website via a link to the legislation register. Each instrument records on its face the history of any amendment to the instrument. In many instances it was past practice for the instruments to state that the material in the relevant procedure was excluded from notification on the grounds that the material would be likely to disclose information that may endanger public safety or undermine justice, security or good order at a correctional centre. This practice is now largely no longer followed, with the result that the community can have a high degree of insight into the way in which a correctional centre is managed. Of course, that insight would be undermined if the requirements of the legislated instruments were not actually adhered to.

22. One such policy of particular relevance is the *Corrections Management (Risk Alerts) Policy 2019*[1] (**Risk Policy**). The policy was first issued in May 2019 and remained effective until it was next amended and republished in October 2024. While it is conspicuous that there was no apparent change to the policy in the interim, it will be seen that the change is in line with the General Manager's indication in August 2024 (see below) that updated observation forms were being trialed in July 2024 and that an operating procedure was due to be finalised. The *Corrections Management (Detainee Observations) Operating Procedure 2024* was made on 25 October 2024 and became effective on 31 October 2024.

[1] Notifiable Instrument NI2019-658 dated 11 October 2019

The requirement for medical observations

23. The ACTCS intake form in respect of Person 1 states that her sentence commenced on 17 January 2019 and the dates of her earliest and latest release. She was in fact released on 1 February 2021. The form depicts a photograph of Person 1, her name, signature and date of birth. It is also signed by a Sentence Management Officer from the AMC. The form itself is not dated.

24. Another document headed, "ACT Health" indicates a physical and psychological assessment of Person 1 was conducted on 17 January 2019 as a "Screening induction". It is not necessary for present purposes to set out the particulars of that assessment, except to say that at the time of the screening she had been diagnosed some years prior as having a genetic heart condition "associated with cardiac arrest which is very life-threatening". Four days later, on 21 January 2019, a document headed, "ACT Health Primary Notification Form" states that Person 1 is "M3", and medical observations are to be made "60 x 24", meaning once per hour during each 24-hour period. The form clearly states, "What signs/symptoms ACTCS officers need to look for', being "Observe for dizziness, fainting, loss of consciousness, shortness of breath, chest pain". The form is signed by a person whose designation is "RN2". According to the Australian College of Nurse Practitioners, this is an enrolled nurse who is regulated through the Health Practitioner Regulation National Law. Enrolled nurses "must have a licence to practise, which assures they meet the mandatory requirements stipulated by the Nursing and Midwifery Board of Australia" and, accordingly, appropriately trained, qualified and licensed in health care and, more specifically, in a nursing role.

25. As a result of the requirement that Person 1 be observed once per hour every 24 hours, she was placed in the Special Care Centre area of the AMC, this being a distinct area within the AMC.

26. The Risk Policy applied at the time to “all correctional centres in the ACT”. It states that “ACT Corrective Services…is committed to ensuring the consistent categorisation, management and recording of risks related to the welfare, safety and security of detainees in a correctional centre”. The Risk Policy does so by developing “risk alerts”, which are “[r]atings applied to a detainee in order to inform decision-making on the management of the detainee”. It goes on to provide that “The safety of all persons, and

security and good order in a correctional centre are supported by the identification and appropriate management of a detainee's risk status".

27. The letter "M" is a risk alert, according to clause 5 of the Risk Policy: it stands for "medical" and associates a particular medical risk with a particular detainee. The Risk Policy further provides that "Justice Health Services will advise when 'M'…risk alerts are no longer required for a detainee". No- one else is authorised to determine when a medical risk alert is no longer required. Person 1 was categorised as "M3". The policy provides the following in relation to that particular risk alert:

M: Medical	Detainee has a health condition that requires treatment or diagnosis, including known or suspected conditions that have not been confirmed. To be assessed in accordance with Justice Health Services procedures, with an appropriate category selected from this table.			
	Responsible service:	Justice Health Services to advise ACTCS		
Alert level	**Risk**	**Observation regime**	**Category Assessment/ Approval**	**Entry to electronic record system**
M1	Serious requiring immediate treatment	Determined on a case by case basis by Justice Health Services	• Assessment and approval by Justice Health Services • Approved for entry by Area Supervisor or above	• HRAT Coordinator • Correctional Officer Grade 3 • Night Supervisor • Officer-in-Charge
M2	Regular or ongoing treatment required	Determined on a case by case basis by Justice Health Services		
M3	Known or suspected medical condition, or symptoms requiring assessment	Determined on a case by case basis by Justice Health Services		

28. The table states that the observation regime for "M3" is to be "Determined on a case by case basis by Justice Health Services". Person 1's observation regime was set out on the observation sheets relating specifically to her, and consisted of one observation every 60 minutes, every 24 hours. The required observations needed some form of personal communication with the detainee, with some adjustment to allow for sleep. By way of context, the General Manager confirmed that "*not every detainee in the Centre is on written observations*". Whilst risks for detainees are inherent in the prison environment, as the General Manager commented in his evidence, "from the day dot", the observation regime identifies particular additional risks for particular detainees and a necessary response to this situation.

29. It is clear that there had been no change to the risk assessment applicable to Person 1 and it was mandatory that Risk Policy current at the time of the omissions should have been complied with in the circumstances as they existed on 16 October 2020.

30. The General Manager agreed during his examination before the Commission that the medical risk alert ratings are set by "persons qualified to set them" and that "it's for the safety of the detainee", thus confirming that he understood key points of the Risk Policy. Nonetheless, when asked about the "M3" risk alert level attaching to Person 1, the General Manager responded, "…that, that's low end. Realistically M360 [meaning M3, observations every 60 minutes] it's, yeah, there's no incredible alert there". He then went on to indicate a relaxed approach to the requirement to check on the detainee every 60 minutes, stating "…hey, look, you know, there's times when things happen…Observations are missed". He further stated that there is always a risk in the prison environment, and that "[t]here's a risk on every detainee".

> COUNSEL ASSISTING: So when you say here today that it's not that serious and there's an M2 and M1, really you don't know for certain how serious that detainee's condition may or may not be? You simply don't have that information, do you? --- A. No…
>
> …
>
> THE COMMISSIONER: And there's a reason for [being required to conduct observations every 60 minutes], because they are M3, you don't have to know what the particular medical condition is, and even if you did, it wouldn't be useful information for you. What you know is…whatever this condition is (a) it's medical and (b) you've got to make sure they're okay every hour? --- A. Yes.

31. The General Manager was pressed on this, and conceded (as was obvious) that he did not have the information to make an assessment of how serious a person's condition may be, saying, "*No, it's not my job*". That, of course, is the point: the assessment had been made by a person with the relevant expertise and, in accordance with the mandatory policy, the resulting regime was obligatory. It is self-evident that the fact that the prison environment was risky for all detainees does not reduce the particular risk that followed from the incarceration of someone with Person 1's medical condition. The apparent – though perhaps in the moment – comment by the General Manager that appeared to minimise that risk was somewhat problematic.

The rules about medical observations

32. The Observation Form itself, which corrections officers fill out according to a detainee's particular observation regime, sets out "Instructions for use" as follows:

- Observations must be conducted in person, not by camera.
- The recording of observations must be made contemporaneously – at the time of observation.
- Observations must describe the detainee's behaviour as observed by the corrections officer (including any dialogue, requests and concerns such as refused to eat and appearance of the detainee).
- Where more than one officer conducts observation on a single detainee, the name of each officer is to be entered on the front of the sheet in the space provided.
- Where observations are completed on a detainee, and there is no further need to complete a sheet, all remaining blank lines are to be ruled through diagonally and initialled across the line by the last officer conducting the observation…

33. The General Manager confirmed that corrections officers are trained on how to conduct observations as recruits and set out his expectations of what should have been occurring in terms of making observations of detainees as follows –

> GENERAL MANAGER: They would walk to that door and look through the viewing hatch. We certainly don't promote it but there are times when staff may have to do something via CCTV, depending on whether there's CCTV in that cell, but ordinarily, the, well, ordinarily, the expectation is an individual on observations, a staff member would attend that cell and see that individual.
>
> COUNSEL ASSISTING: And do they need to get a response from that individual or is it enough to simply look at them or what does that interaction look like normally? --- A. Well, it depends on when and what time of day/night, this is. Obviously, at 2 o'clock in the morning, there's a level of respect and human rights that you try not to impinge on. So if someone's in bed, you're not going to ask for a response. It could be that you've looked in the door and the individual's sitting there watching TV, eating noodles. I don't need to talk to that individual. I don't need to disturb them. It's up to our staff to assess if there's a need to, you know, if, are they seeing something that doesn't feel right or it's appropriate.

34. When pressed for details, the General Manager elaborated as follows:

> Well, I mean, look, you, you're trying to look for any movement possible, so you can understand that, you know, the person is well. You're looking for other signs in the cell that maybe that something has occurred. You know, it's not unusual – I wouldn't say unusual but we've certainly had instances where observations have been completed and there's a syringe and there's a detainee. So obviously then that, that enacts a different action. But again you're trying to be as respectful as you can to the detainees and it really depends on what the nature of the observations are...

35. As to the timing of observations, the General manager said that, if required for "60 x 24", while it was not expected they would be done the moment the new hour ticked over, any latitude beyond ten minutes either side of the hour would be "starting to exceed what I'd consider to be safe and fair".

36. It will be seen that on 16 October 2021 (that is, the same 24-hour period) four observations of Person 1 were missed at or about 10:00, 12:00, 14:00 and 15:00 hours. This means that Person 1 was not checked between 09:00 and 11:00 hours, 11:00 and 13:00 hours and 13:00 hours and 16:00 hours, the last obviously being a continuous period of three hours. The risk associated with this timeframe in respect of a detainee with Person 1's heart condition is self-evident.

Observation Form for Person 1 on 16 October 2020

37. A copy of the Observation Form for Person 1 on 16 October 2020 is set out in paragraph 43. Every entry in this form is a departure from the "Instructions for Use". Where descriptions of "the detainee's behaviour as observed by the corrections officer (including any dialogue, requests and concerns such as refused to eat and appearance of the detainee)" are supposed to appear, they are absent: all entries, including in relation to those observations which CCTV establishes were not made, simply read "in cell" or "in bed" without any description of what the detainee was doing at the time – "the behaviour as observed".

38. An entry that Person 1 was in her cell at 0100 hours (as is the case on Person 1's Detainee Observation Form for 16 October 2020), provides no information other than that of physical location. The lack of value represented by such an entry on the Observation Form was pointed out to the General Manager:

> COMMISSIONER: It's perfectly obvious, isn't it, that you may reasonably think at night there's no people wandering around, all cells are locked up and therefore it's reasonable to infer that the prisoner's in the cell. The question is not whether he's in the cell. The question is whether you have made an observation. That's the crucial matter, isn't it?
>
> GENERAL MANAGER: Yeah, yeah, yeah."

39. The relevant Observation Form is set out below –

ACT Government
Justice and Community Safety

ACTCS
DETAINEE OBSERVATION FORM

NAME: [redacted]	AREA AND CELL #: [redacted]
Category: M3	PID: [redacted]
Date of Shift: 16/10/2020	Frequency of OBS: 60x 24
Reasons for Observations:	Mental Health At Risk Medical Management
DIAGNOSIS / SYMPTOMS / BEHAVIOUR TO BE OBSERVED *(Justice Health or Mental Health to advise)*	

Officer/s conducting observations:	
1. [redacted]	2. [redacted]
3.	4.
5.	6.
7.	8.

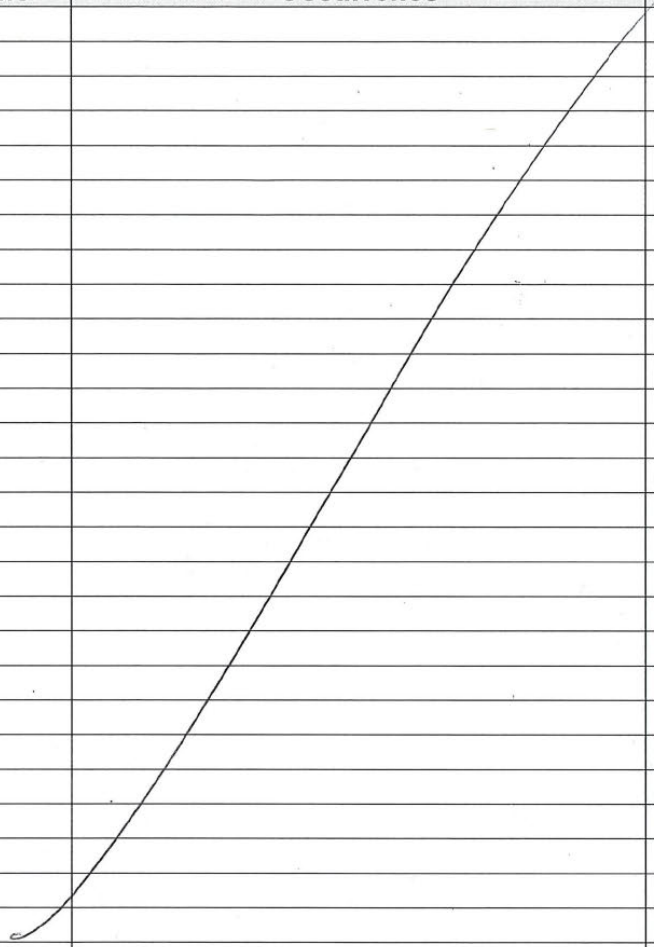
* Use this form for 24 hours of observations, commencing start of Day Shift and ending at the conclusion of Night Shift. See instructions on page 4 of this form.

Time	Occurrence	Signature
0000	in bed	[redacted]
01:00	in cell	
0200	In cell	
0300	In Cell	
0400	In cell	
0500	in cell	
0600	in cell	
0700	in cell	
0800	In cell	
0900	In cell	
1000	In cell	
1100	In common area	
1200	In cell	
1300	In cell	
1400	In cell	
1500	In cell	
1600	In common area	
1700	At visits	
1800	In yard	
1900	In cell	
2000	Shift in Cell	
2100	In bed	
2200	In bed	
2300	In bed.	

CONTINUED OVERLEAF

NAME:	PID:	CELL:	Obs:

Time	Occurrence	Signature



INSTRUCTIONS FOR USE:

- Observations must be conducted in person, not by camera.
- The recording of observations must be made contemporaneously – at the time of the observation.
- Observations must describe the detainee's behaviour as observed by the corrections officer (including any dialogue, requests and concerns such as refusal to eat and the appearance of the detainee.
- Where more than one officer conducts observation on a single detainee, the name of each officer is to be entered on the front of the sheet in the space provided.
- Where observations are completed on a detainee, and there is no further need to complete a sheet, all remaining blank lines are to be ruled through diagonally and initialled across the line by the last officer conducting the observation.
- **At the conclusion of night shift/end of observations, place a copy of the sheet into the Clinical Manager's pigeonhole.**
- **Load scanned completed signed copy to CIS.**
- **Place the completed original sheet in the dossier.**

Supervisor's/Manager's Comments (if any):

Nightshift Supervisor Name: [redacted]	Signature: [redacted]	Date: 16/10/20
Area Manager Name:	Signature:	Date:

40. The ACT Health Primary Notification Form required corrections officers to monitor her for "dizziness, fainting, loss of consciousness, shortness of breath, chest pain", so that mere observation of the detainee in her cell, without monitoring the particular identified issues in a reasonable way, departed from the required standard. None of the descriptions of the observations entered by all four corrections officers who completed the form on that day indicated the required information and, accepting that some kind of observations occurred, this suggests that they were inadequate. The inference reasonably follows that this was not an isolated event but common practice.

41. The General Manager conceded that "there could be a little more detail" in these entries. He elaborated: "…when we're talking, you know, in cell, as best as you can, what are they doing?... I mean again, as much detail as possible".

42. Once observations have been recorded and Observation Forms are signed by the night shift supervisor, they are to be provided to the Area Manager to check, as evidenced by a specific sign-off section for the Area Manager. The General Manager explained that an 'Area Manager' is a Corrections Officer Grade 3 (**CO3**) with responsibility for the day-to-day running of the AMC.

43. The Observation Form for Person 1 on 16 October 2020, while signed in the box indicated for the Nightshift Supervisor, was not signed by the Area Manager. It may therefore be inferred that the Area Manager did not check the form. This meant that the Area Manager did not identify and then rectify the omission in relation to the lack of adequate observation or detail on the form, being "what [the General Manager] would expect of [his] supervisors and managers". For example, the Area Manager did not say to the Nightshift Supervisor or the corrections officers conducting the observations, something like, "Hey mate, fill it in properly, will you" or "provide example, provide a little bit of leadership in that", which the General Manager accepted would suffice, with no requirement for disciplinary action; but ignoring the failure must be unacceptable. In his evidence, the General Manager confirmed that Area Managers should not only be checking Observation Forms but doing spot checks. The Observation Forms for the previous and subsequent days suffer from similar defects. On none of the three days spanning 15 and 17 October 2020 has the Area Manager box been signed. When the General Manager was asked why the signature box was blank, he simply responded, "*I can't explain it*". It is unlikely that this omission is limited to those three days and thus reasonable to infer that this level of supervision was not undertaken, not only on those

days, but as a continuing failure. It is a natural consequence of the lack of adequate oversight that defects in observations and recording their results would likely become widespread and entrenched. It is not clear why these shortcomings were not addressed and rectified, but the fact that they were not points to a systemic failure in administrative arrangements.

Review of CCTV footage

44. The *Corrections Management (CCTV) Policy 2019* provides that CCTV of correctional centres must be retained for up to three months unless particular circumstances exist, in which case the footage must be retained for seven years, meaning that footage from the AMC is not retained indefinitely. Circumstances in which the material must be kept for seven years includes "incidents where further action is taken within 12 months (*Incident Reporting, Notifications and Debriefs Policy*)".

45. The Commission was able to access the relevant footage from 16 October 2020 due to a separate download into a local folder made in order to enable review by Person 3 and her manager in 2020, following receipt of the Official Visitor's complaint made on behalf of Person 1. In addition to confirming that observations were not made at 10:00 hours, 12:00 hours, 14:00 hours and 15:00 hours as recorded on the observation form, the footage also provides context and insight into the operations of the relevant unit on this date.

46. At all relevant times, Person 1 was in cell number 4. The first clip of footage, which displays the timestamp from 09:50 hours to 10:10 hours on 16 October 2020 (there is no suggestion that the time stamps on the CCTV are not accurate), shows that no corrections officers were in the immediate vicinity of the cells throughout that entire period. Shortly after 10:09 hours, the clip shows the door of cell 9 opening, followed shortly by the doors of cells 8, 4, 2, 1 and 9 respectively also opening, but with no corrections officers in the vicinity of the doors when they open. Person 3 explained that these doors can be unlocked from the officers' station and that these open doors mean the lock-in has ended for this part of the AMC. Person 1 is seen exiting cell 4 at 10:09:40 hours and walking to the end of the corridor before the clip ends at 10:10 hours. No corrections officer conducts a deliberate observation of her between 09:50 and 10:10 hours.

47. The second clip of footage runs for ten minutes either side of midday. At 11.50:28 hours, Person 2 is seen opening the door of cell 3 which is directly adjacent to the cell of Person 1. Person 2 is then seen to escort the detainee from cell 3 to a door in front of the officers' station located at the end of the cell corridor. The detainee walks past the officers' station and Person 2 is seen going into the station which consists almost entirely of glass windows. At 11:52:02 hours, the same detainee is seen coming back into the corridor of the cells through the door directly in front of the officers' station and back into cell 3. Person 2 remains in the officers' station during that time and can be seen seated through the glass windows.

48. At 11:53:56 hours three corrections officers are seen leaving the officers' station, none of whom is Person 2. It appears that Person 2 remains in the station at that point. At 11:54:53 hours, a corrections officer and two trainees are seen entering the corridor of the cells, with the corrections officer moving from cell to cell appearing to check that all doors are locked, including cell 4 which housed Person 1. At no point did the corrections officer open the viewing window of Person 1's cell, nor of any other cells. The corrections officer and the two trainees are then seen to enter the officers' station a 11:55:44. At this stage Person 2 can be seen seated in the officers' station.

49. This footage shows that Person 2 remained in the officers' station from 11:50:55 hours until this clip ended at 12:10 hours. They were seated for much of this time, on occasion standing up and moving within the station for a matter of seconds. Throughout this period other corrections officers come and go to and from the station. No corrections officer conducted an observation on Person 1 between 11:50 and 12:10 hours.

50. The third clip of footage covers the period between 13:50 hours and 14:10 hours. From the commencement of the footage, an unknown detainee is seated on a couch at the end of the corridor closest to the officers' station. The doors to cells 3 and 1 are open, while all other cell doors, including that of Person 1 in cell 4, are closed. Person 2 can be seen seated within the officers' station where they remained for the duration of the clip. Throughout this period, there appears to be at least one other individual in the officers' station. At no point in this clip did any corrections officers enter the corridor of the cells in which Person 1 is housed and no corrections officer conducted an observation on Person 1.

51. The fourth and final clip of CCTV footage is from 14:50 hours through to 15:10 hours. The doors to cells 3 and 1 remained open, with all other cell doors closed, including that of Person 1. Person 2 can be seen initially moving around in the officers' station and then taking a seat around the same desk area at which they had previously been seated. At 15:04:50 hours, the detainee from cell 3 walked into the corridor, entering her cell while the door remained open. The same detainee then exited her cell at 15:04:55 hours, walked to the end of the corridor closest to the officers' station and out of the camera view to the right which appears to be a common area with couches. The same detainee came back into view at 15:05:35 hours and sat on the floor in front of the door to cell 2 which is still closed, where they remained until 15:09:21 hours. This detainee appeared be speaking to the detainee inside cell 2. Person 2 remained inside the officers' station throughout this period and no other corrections officer entered the corridor of the cells during this time: no corrections officer conducted an observation on Person 1 between 14:50 and 15:10 hours.

52. The CCTV footage from 16 October 2020, demonstrates that:

a. Person 2 was on duty in the wing and able to conduct the required observations but did not conduct any observations on Person 1 at 10:00, 12:00, 14:00 or 15:00 hours;

b. no other corrections officer conducted medical observations on Person 1 at those times;

c. Person 2 falsified the Observations Sheet for Person 1 on 16 October 2020 by recording and initialing that they had completed the medical observations and had done so at (or about) the indicated times;

d. it was readily apparent upon review of the same footage that the medical observations could have been but were not conducted on the four occasions set out above;

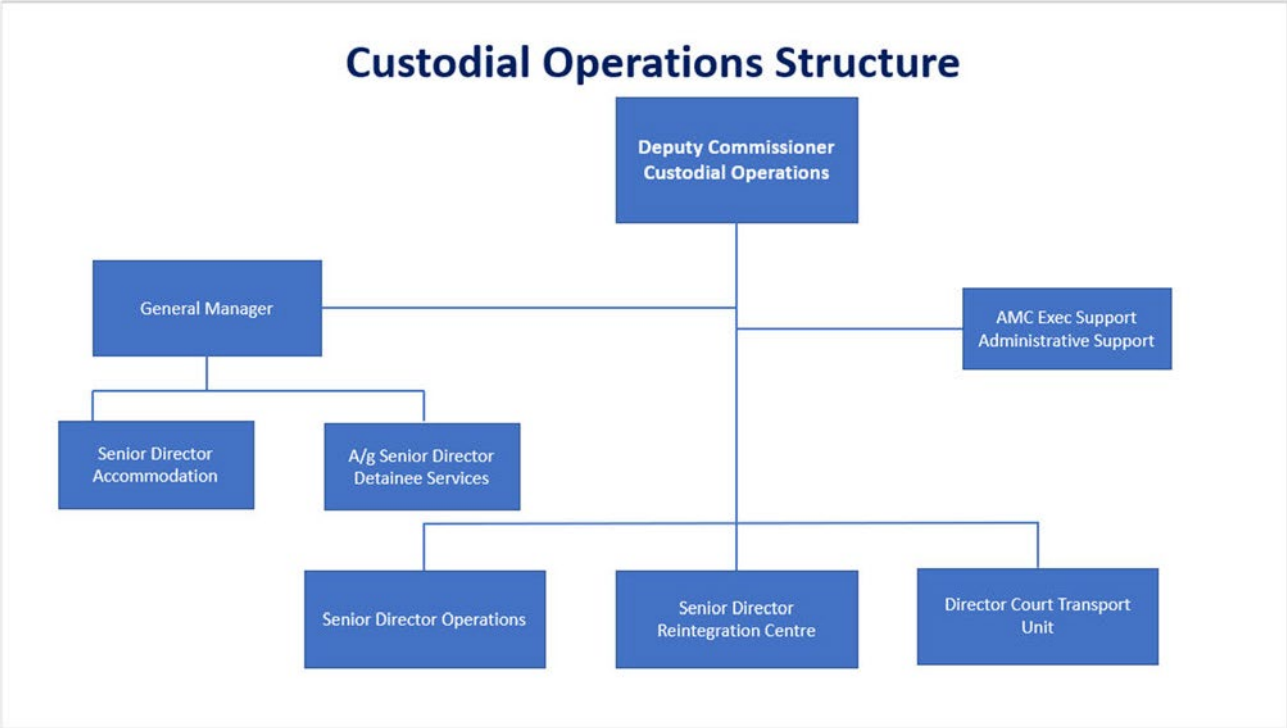
e. consequently, it was and would have been readily apparent to any responsible official who had watched the video or was aware of its content that Person 2 had falsified the Observations Sheet in respect of Person 1 on 16 October 2020; and

f. the suggestion that "operational reasons" accounted for the failures to conduct the medical observations in correspondence with the Official Visitor was demonstrably untrue, in respect of at least three of the four omissions. This is discussed further at paragraph 83ff.

Managerial responsibilities

General Manager

53. It is necessary to consider the General Manager's position in the Custodial Operations hierarchy in 2020 in the context of establishing his responsibility for handling the matter of missed observations and the falsified detainee observation form in respect of Person 1. The Operational Structure diagram is –



54. The JACS Annual Report for the period states that the General Manager is "responsible for the day-to-day operational regime of the AMC". Scheduled medical observations, together with the associated supervisory and record-keeping arrangements are necessarily part of that regime, as also, more generally, is responsibility for ensuring compliance by corrective officers with policy and ensuring appropriate disciplinary action is taken where necessary for misconduct.

55. The General Manager as at the time of the matter investigated by the Commission had been awarded the Australian Corrections Medal (ACM) for his "integrity, commitment to duty and ongoing devotion to continuous improvement and staff development" in the Queen's Birthday Honours List in 2022. The ACM "recognises distinguished service by an operational member of an Australian state or territory civilian corrections service for adults."

56. The citation for the award reads, in part, as follows:

> "[The General Manager] is a highly regarded Correctional Officer who displays integrity in his dealings with detainees and staff. He has provided distinguished service to ACT Corrective Services (ACTCS) and the community through an unwavering focus on service improvement.
>
> …
>
> As the General Manager of the AMC, he has responsibility for and oversight of the AMC's operations, which includes the safe care, custody and management of remand and sentenced detainees. His drive, integrity, and commitment to the people in his care has earned him the upmost (sic) respect from all that interact with him… "

57. Several more commendations of the General Manager were provided as part of his submission in response to the PIR.

Misconduct

58. The General Manager was asked about the medical observations not in fact having been conducted in respect of Person 1 but the Observation Form filled in as though they had been. He repeatedly stated in his evidence to the Commission that he considered it to be a serious matter if a corrections officer had lied in this way: "…if you're lying, yeah, if you haven't completed, if you're completing the sheet and you haven't done what you've said on this sheet that's serious… I take it very seriously". The General Manager agreed that "there would at the very least have to be some investigation and some explanation as to why you've said you did the observation and you actually did not", saying "That's correct" when this proposition was put to him. This approach was plainly correct. But it did not translate into action.

59. The General Manager explained that "disciplinary actions will either be made at the Commissioner level or at PWS [People and Workplace Strategy]", and went on to say that "If there's, if there's evidence that you've had, that this is ongoing and you have a real problem doing the right thing you may lose your job." The General Manager further explained that the process to get to sanctions was that, after confirming the facts – that is, having established that inspections had not been conducted by reviewing "CCTV that's certainly going to show whoever walked in that door" – he would refer the matter to the Integrity Unit who would either conduct any investigation or remit it to "an operations manager [to] conduct a preliminary assessment". Either way, the General Manager would be advised of how the Integrity Unit dealt with the matter.

60. The General Manager told the Commission that he could not remember how he had dealt with this particular matter. He was unable to provide any account of what steps were taken, in regard either to Person 2 or the relevant Area Managers. In relation to the latter, he explained that "[t]hese things would have been a conversation" and "it's not a disciplinary action against them. It would have been a conversation in that you guys need to be checking."

61. He stated that, if he had taken any disciplinary action against Person 2 in respect of their failure to conduct the medical observations, and in respect of falsifying the Observation Record, it would appear on a record which "they [HR] would have assisted…to keep…" The Commission obtained Person 2's personnel file and no record of any action in respect of this matter was recorded.

There is no documentary record that any investigation at all was undertaken, or any referral made. It may therefore reasonably be inferred that this did not occur.

62. The *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2020* (**Incident Reporting Policy**) states that:

> ACTCS expects all staff to uphold the highest standards of ethical and professional conduct. This requires all staff to report any incident relating to suspected or actual staff misconduct… to the Intelligence and Integrity Unit as soon as practicable after a staff member becomes aware of the incident.

Misconduct, as would be expected, expressly includes the falsification of records.

63. It is clear that the Observation Form for Person 1 on 16 October 2020 contains false entries. Person 2 made the entries in respect of 10:00, 12:00, 14:00 and 15:00 hours as though they had conducted the medical observations when they had not. The only reasonable available inference is that this was intended to deceive. This constituted serious misconduct well within the terms of the Incident Reporting Policy and should have been reported to the Intelligence and Integrity Unit by the General Manager as soon as practicable after he became aware of them from Person 3's email of 10 November 2020 (see [105.f]).

64. Failure to report an incident "relating to suspected or actual staff misconduct" to the Intelligence and Integrity Unit is itself misconduct and negligent performance of duty. Accordingly, the General Manager's failure to report Person 2's actions means that he himself has engaged in misconduct.

Complaint mechanism

65. The *Corrections Management (Detainee Requests and Complaints) Policy 2019* (**Complaints Policy**) establishes the complaints management in all correctional centres in the Territory, including the AMC. The Complaints Policy notes that a detainee can make a formal complaint via a complaint email address. Person 3 gave evidence that in her role as Official Inquiries Coordinator in November 2020 she regularly dealt with formal detainee complaints received thus:

> PERSON 3: So that role, in 2020 some time we brought in the detainees' complaints email address which detainees all had access to email. So then my job was, of course, monitoring the responses and handing it out to different director, senior directors, whether that senior director is operations. Like gathering all information pretty much. Handing it to my team leader which was the team leader of Compliance then to go to the General Manager at the time, like the, like it would go for clearance to the General Manager.
>
> THE COMMISSIONER: And then he would allocate people who were going to respond and what needed to - - - A. Exactly.
>
> THE COMMISSIONER: What the responses were. --- A. then I would gather those responses.

Complaint made by Official Visitor

66. Person 3 explained that an official inquiry email address was used for complaints and correspondence from Official Visitors, which was separate from complaints of friends or family of a detainee, the Ombudsman and the Humans Rights Commission. The latter were filtered down to her through ACTCS Ministerial Support.

67. Person 3 said she would always consult with her direct supervisor after receiving an email from an Official Visitor, either via email or by direct conversation depending on the urgency and the physical location of herself and her manager. She explained that, after the appropriate senior director was identified, they would gather any relevant information or documents and formulate a draft response to the complaint. This draft would be sent back to Person 3 who would then give the draft to her manager for approval. Her manager would then either send the draft directly to the General Manager or request Person 3 send it to the General Manager.

68. Once the response had been considered by the General Manager, Person 3's evidence was that sometimes the General Manager would reply directly to the Official Visitor and other times he would request that Person 3 respond. This process usually created a paper trail.

69. Only complaints which disclose critical incidents are reportable to the ACT Corrective Services Inspector (**Inspector**). Upon receipt of such a complaint, the Inspector would "deem whether or not they are going to investigate that". It is apparent that Person 1's complaint was reported to the Inspector but missed medical observations do not fall within a 'Notifiable Incident Category' as set out at Annex A of the Incident Reporting Policy.

70. The Official Visitor engaged the email complaint mechanism set out above, in accordance with policy. This occurred after Person 1 emailed the Official Visitor on Sunday 18 October 2020, two days after the missed observations, requesting that she come into the AMC to discuss missed observations, which she did the next day. The Official Visitor gave evidence that she understood Person 1 had been under observations due to a cardiac condition and thus had a "higher level of health needs".

Official Visitor's role

71. The *Official Visitor Act 2012* (ACT) (**Official Visitor Act**) requires the Minister to appoint at least two official visitors and defines an "official visitor" as a person authorised to visit a "visitable place" under s 9A. A "visitable place" is defined as having the meaning attributed under s 57 of the *Corrections Management Act 2007* (**CM Act**), being "a correctional centre".

72. The functions of an official visitor include the following:

    a. investigating and seeking to resolve complaints from, or on behalf of, entitled people at the place;

    b. identifying and reporting on systemic issues adversely affecting entitled people at the place;

    c. if appropriate, referring complaints or issues from, or on behalf of, entitled people at the place to relevant investigative entities; and

d. providing quarterly reports as to, amongst other things, complaints received, and the action taken in respect of them, the number of visits, the number and kinds of matters referred to an investigative entity and any systemic issues identified by the official visitor and making recommendations about "about any systemic issues identified by the official visitor".

73. "Entitled people" are defined at s 8 of the *Official Visitors Act* which incorporates the meaning attributed to that term at s.57 of the CM Act being "a detainee at a correctional centre".

74. Section 18(1) of the Official Visitor Act provides that "[a]n operating entity for a visitable place must give an official visitor for the place any reasonable assistance the official visitor asks for to exercise the official visitor's functions at the place." This includes providing access to documents and records and answering reasonable questions in relation to a complaint. Section 19(2) makes it an offence to "obstruct or hinder an official visitor in the exercise of the official visitor's functions" without reasonable excuse, carrying a maximum penalty of 50 penalty units and or imprisonment for six months.

75. The *Corrections Management (Official Visitor) Policy 2019* (**Official Visitor Policy**) states that ACTCS "is committed to working together with the Official Visitor to ensure independent oversight of conditions and detainee management in correctional centres". It defines the status and role of an Official Visitor as "an independent person appointed by the Minister for Corrections … to provide a monitoring and complaints system in a correctional centre".

76. The General Manager described the arrangement between the AMC and Official Visitors for complaints as a practical matter within the legislative and policy framework described above:

> GENERAL MANAGER: …So conversations with the OVs are that they completely understand what a serious allegation is versus what's something that we can manage appropriately within the facility or on the ground. So I've urged them and they agree that any issue that is deemed to be of a serious nature, of a serious allegation would go through the inbox.
>
> What's something that - - -
>
> THE COMMISSIONER: So the arrangement is that they decide whether it's serious enough for, as it were, instigating a formal process and when they've made that

> decision the response, the agreed response is that they send an email to the - - -? - --To the, to the specified … the complaint mailbox. Is that right? --- A. Yes, that's correct.
>
> Q. So you leave it up to them to decide the level of seriousness with which a complaint should be dealt with. --- A. Yeah, that's our agreement.

77. The Official Visitor outlined her functions as she understood them in evidence to the Commission:

> We have oversight of the functions of corrections… We have oversight of the functions within the gaol and the courts itself so we visit with regularity both the court and the gaol and speak to people to see whether they need any advice or assistance getting any of their complaints or things that they haven't managed to work with the officers to settle and so we will help them settle any of their complaints… It's not an advocacy position so it's a fine line.

She added that her role included acting as an intermediary with the officers in corrections in relation to complaints which often relate to health concerns. The Official Visitor explained that complaints are referred to the Ombudsman or the Human Rights Commission where they cannot be resolved "*at ground level*", and that she reports back to the Minister for Corrections if she feels that there are any matters requiring the Minister's intervention.

78. The General Manager explained that an Official Visitor attends correctional centres to discuss matters with detainees and staff "with the aim of resolution and improving our service", and noted that it is left up to the Official Visitor to determine the level of seriousness with which a complaint should be dealt: as a practical matter, this – at least initially – determines whether the Official Visitor will have a discussion with AMC staff or email the complaint as set out above. Emailing is generally agreed upon as being the appropriate mechanism by which to raise serious allegations.

79. The statutory role of Official Visitor is significantly greater than that of being a mere conduit for detainees' complaints. The role is an essential and substantial integral element of oversight in the management of detainees in the context of a significant commitment of the Territory to human rights. As will be seen, the General Manager's response to the issue raised by the Official Visitor in connection with Person 1's complaint was highly problematic.

Communications between AMC and the Official Visitor

80. The Official Visitor's email to the AMC complaints email address on behalf of Person 1 on 5 November 2020 read as follows:

> Good afternoon
>
> I have had a complaint from [Person 1] re her hourly observations.
>
> [Person 1] tells me on Friday 16th October there were rolling lock-ins. [Person 1] says she felt unwell but did not want to call up via the intercom as she did not want the detainees from the other wing
>
> who were not locked in to overhear her conversation. [Person 1] felt it would be best to wait for the CO to come round for the hourly observations and speak with the staff in person.
>
> [Person 1] tells me no hourly observations were attended throughout the day whilst she was locked in. I have checked the log for [Person 1] for that day, it has been signed off as observations being completed.
>
> I think on this occasion it may be worth viewing the video footage to confirm this accusation. Is this able to be done?

81. This query thus raised three issues: first, the detainee's complaint that required observations had not been made; second, that the detainee observation form stated they had; and, third, that the issue could be resolved by examining the CCTV footage and asking that this be done.

82. Internal AMC correspondence reveals the following chronology of events upon receipt of the Official Visitor's enquiry.

(i) 5 November 2020, 15:01 hours – Person 3 forwards the Official Visitor's complaint in respect of Person 1 to the General Manager, saying in a covering email:

> *Sorry another OV one – I've spoken to [Person 5] about this one, would you like us to review the CCTV footage?*

(ii) 5 November 2020, 15:28 hours – the General Manager replies to Person 3, stating:

> *I think we take a "quick" look. I'm concerned that a detainee can make a complaint, and we are then spending hours looking into it when she could have used the intercom for what it's designed.*
>
> *Maybe we look at the Ob sheet and then just a few times it states they were conducted.*

(iii) 5 November 2020, 15:42 hours – Person 3 forwards the email chain above to Person 5 (Person 3's manager), saying:

> *FYI. I'll order [Person 1's] dossier and look/request CCTV then.*

(iv) 5 November 2020, 15:48 hours – Person 5 responds to Person 3, copying in the General Manager stating:

> *Yep I'm happy with that as well. I had the same concerns.*

(v) 6 November 2020, 06:53 hours – the General Manager responds with the following to Person 3 and Person 5:

> *I think also we reply with:*
>
> *Thank you for your enquiry. As Observations are an operational matter we will look into this and take any actions as/if required. As there may be an outcome that is staff related, we will not be advising of this. [The General Manager explained in his evidence that this meant that the detainee would not be informed; it was not a reference to the Official Visitor.]*
>
> *[Person 1] should be advised and strongly urged to utilise the intercom as this is what it is for.*
>
> *Staff have many duties to fulfill through a day and operational circumstances can change rapidly – the intercom system should be used in all circumstances where a detainee is requiring staff assistance due to a medical situation.*
>
> *Your thoughts [Person 5]??*

(For reasons that will become clear, it should be noted that the reference in the first sentence of the proposed response to observations being "an operational matter" is by way of differentiating it from being a merely administrative issue. The indication that a staff related issue would not be advised was – as the General Manager explained in his evidence – concerned what the detainee would be told, not that the information would be kept from the Official Visitor. As it happened, this sentence was omitted from the email that was actually sent – see (vii)).

(vi) 10 November 2020, 14:36 hours – Person 3 sends an email to the General Manager:

> *…We have viewed [Person 1] Obs on three occasions on 14 October and unfortunately obs were not taken out as per [Person 1] obs sheet.*
>
> *These times were 10am, 2pm & 3pm…" [this omits the midday failure]*

(vii) 10 November 2020, 15:41 hours – Person 3 sends the response to the Official Visitor:

> *"As Observations are an operational matter we will look into this and take any actions as/if required.*
>
> *[Person 1] should be advised and strongly urged to utilise the intercom as this is what it is for.*
>
> *Staff have many duties to fulfill through a day and operational circumstances can change rapidly – the intercom system should be used in all circumstances where a detainee is requiring staff assistance due to a medical situation.*
>
> *If you have any further questions please let me know."*

(This reply did not say anything about the availability or content of CCTV footage. It effectively did no more than confirm receipt of the Official Visitor's complaint. However, it confirms that the "operational circumstances" are matters that might justify the omitted observations, as distinct from corrective officers' non-compliance with the requirement.)

(viii) 12 November 2020, 12:06 hours – the Official Visitor emails the AMC in reply, stating:

> *"Thank you, yes I agree all detainees should be utilising the intercoms system. Please let me know the outcome of this once the video footage has been reviewed."*

(ix) 26 November 2020, 09:07 hours – the Official Visitor follows up on her email dated 12 November 2020, saying,

> *I continue to await a response?*

(x) 26 November 2020, 10:10 hours – Person 4 (another member of the AMC Executive Support Team, manning the AMC Official Enquiries inbox) forwards the Official Visitor's email to the General Manager. Her covering email says:

> *[Person 5] and [Person 3] reviewed the footage and have said that the obs weren't done.*
>
> *The footage is here [provides network address]– What would you like me to respond with?*

(xi) 26 November 2020, 12:36 hours – the General Manager responds to the email above:

> *Thanks [Person 4],*
>
> *I think we respond with:*
>
> *Missed observations can occur for various operational reasons. On this occasion, some observations were missed.*
>
> *In any case, if there is a staff performance issue this will be dealt with by the GM as a staff matter.*
>
> *All staff are aware that observations are to be maintained where operationally possible.*
>
> *[The General Manager] has advised he is happy to meet and discuss the issue in person if that is suitable.*
>
> *Kind regards*
>
> *Does that work??*

(xii) 26 November 2020, 13:50 hours – [Person 4] emails the Official Visitor:

> *Good afternoon [Official Visitor's name],*
>
> *Missed observations can occur for various operational reasons. On this occasion, some observations were missed. In any case, if there is a staff performance issue this will be dealt with by the GM as a staff matter.*
>
> *All staff are aware that observations are to be maintained where operationally possible. [The General Manager] has advised he is happy to meet and discuss the issue in person if that is suitable."*

(xiii) 27 November 2020, 06:41 hours – the General Manager responds to the email at sub- paragraph (x) above again:

> *…I'm going to have to meet with [Official Visitor's name] anyway as I'm not going to have you guys checking CCTV all day because of reported missed obs – it's an operational matter that can be taken up with the CO3's anyway.*

83. The General Manager's first proposed response of 6 November to the Official Visitor (sent on 10 November with the indicated minor change) is to the effect that, on the assumption that the observations were not conducted, the explanation might be that the relevant staff member had failed to perform their duty or that operational exigencies had prevented them from being conducted.

84. It is no doubt the fact that, especially in a tightly controlled and sometimes volatile environment such as a correctional centre, circumstances can change rapidly and operational reasons mean some procedures do not occur as planned.

85. Person 1 told the Official Visitor that the AMC had 'rolling lock-ins' on 16 October 2020. A 'rolling lock- in' was described to the Commission by the General Manager as follows:

> So ordinarily we would instigate rolling lock-ins due to staffing issues, so therefore we're short staffed. So what we will do then is unlock a certain part of the prison and give those detainees time out. We'll move staff to that area. After a period of time we'll lock that area in and then we'll move to another area and unlock that and give them time out. That's to make phone calls, do et cetera, blah, blah, blah, like. So that's what we mean by rolling lock-ins. So area managers will say let's start in the remand area. We'll lock that in an hour later. We'll then move to [sentenced detainees]. We'll unlock them. We'll lock them in an hour and a half later, et cetera. So everybody within the facility gets time out.

86. The General Manager also explained that one person must be in the officers' station at all times. He stated that the reason for this is "…*because other doors cannot open manually. So that officer must be able to open doors for other staff, to move in and out*".

87. Whilst rolling lock-ins might entail that officers might not be available to conduct observations in the locked-in sections – in which event, as the General Manager explained in his evidence, the observation notes would say so – this was not an issue in the present case, the CCTV demonstrating that officers were available, which is confirmed by the notes. Nor is there any basis for supposing that the General Manager ever considered that operational reasons, in the sense of the unavailability of corrective officers or some unanticipated supervening requirement, might actually have explained the omission of the observations at issue here.

88. The General Manager made it clear in his examination that he had no recall of this incident or of his response to it, including whether or not he took any action so far as Person 2 was concerned.

89. In response to the PIR, it was submitted on behalf of the General Manager that the use of the phrase "operational reasons" was contextually accurate and that he had in mind a broad range of matters, including staff underperformance or misconduct and his references in the draft email and that of 27 November at 06:41 to staff management

and performance support this interpretation. It is certainly the case that the conduct of observations is an operational matter. However, the explanation that observations can be missed for "various operational reasons", clearly is meant in the sense that this can occur *because of* supervening operational requirements as distinct from amounting to a breach of those requirements. The discussion commenced by reference to operational reasons and is immediately linked to the fact that observations were omitted, with the possible added factor of staff performance to be dealt with.
The distinction is implicit also in the General Manager's immediate response of 6 November at 06:53 to the Official Visitor's complaint. Accordingly, the contention proposed on the General Manager's behalf is not tenable. This is important because, in fact, the observations were not missed for any operational reasons – as, indeed, the submissions acknowledge – and that the General Manager was aware of this when he drafted the email of 26 November. On the other hand, it is fair to observe that – as a hypothetical, as distinct from what occurred in the present case – observations might be missed for operational reasons, where for example, staff are called away from regular duty in a wing because of unforeseen eventualities requiring duty elsewhere (and, as explained by the General Manager this is not an uncommon occurrence).
The question is whether the General Manager intended to convey an explanation for this particular event and, hence, to mislead the Official Visitor.

90. In his comments on the PIR, the General Manager has brought to the Commission's attention a very serious situation that arose on 10 November 2020, when 28 detainees housed in Accommodation Unit North (AU North) refused to return to their cells for evening lock-in. The incident was protracted and degenerated into a riot, with detainees having armed themselves with weapons, causing significant damage to the accommodation unit and setting fires. Emergency services were called to attend.
The riot resulted in the complete loss of the unit, displacing all 28 detainees, and causing over $5.7 million in damage. It was an extremely serious incident, which necessarily consumed the time and attention of the General Manager of the facility, who bore primary responsibility for managing its aftermath and resulted in an extreme increase in his workload pressures, responsibilities and associated work stress for a number of months into 2021. These responsibilities included taking immediate control of incident response operations, coordinating emergency response teams, implementing contingency plans and ensuring communication across all operational units, implementing temporary rolling lockdowns, reallocating staff resources to critical

areas of need, engaging with internal and external stakeholders, overseeing intelligence gathering processes and investigations, managing the complex logistics of transferring detainees to New South Wales correctional facilities, and preparing for a formal debrief. Professional tensions also arose that added personal stress.

91. It is submitted on the General Manager's behalf that the cumulative effect of these events and the consequential stress directly impacted his ability to devote full attention and appropriately manage routine matters, including email correspondence with the Official Visitor and, to the extent this was insufficient or lacking detail, this was a reflection of the operational strain and mental fatigue he experienced during this period and cannot reasonably be considered to amount to dishonesty.

92. It is also necessary to take into account the fact that, in March 2021 the General Manager commenced extended leave as a result of injuries arising from a motor vehicle accident, which profoundly affected his physical capacity and ability to work. He was completely off work until late July 2021 when he commenced a gradual return to work before returning to full-time hours in January 2022. During this period, the General Manager role was undertaken by another officer. This adversely affected his capacity to follow-up on necessary management responses to the failed observations of October 2020, including taking disciplinary action against the corrections officer involved.

93. It must be accepted that the work burden carried by officials is usually heavy and that this is especially so in fraught environments such as the AMC. The position of General Manager of the AMC is senior and entails a very substantial workload. He receives, in his estimate, "200 emails a day, minimum…That, that's the life of looking after two operational facilities, with 350-odd staff". It is accepted that he may not have read the email sent at 14:36 on 10 November 2020 or had an opportunity to direct Person 3 either to delay a response to the Official Visitor or draft an alternative one before Person 3 sent the response at 15:41. As a result, his failure to intervene at this point may not be blameworthy. However, he neither corrected the response sent to the Official Visitor by Person 3 at 15:41 hours on 10 November 2020, nor followed up with the additional information of which he was by then certainly aware, despite the Official Visitor specifically asking about review of the CCTV footage just two days later. It can well be the case that email communications are often made as an immediate response to an issue that has suddenly arisen which will not be carefully crafted and

may not represent the actual or considered position of the sender or be strictly accurate. It is necessary to be cautious about making too much of such an email and to give full weight to the circumstances of the General Manager's very substantially increased workload and the accompanying stress arising from the riot of 10 November 2020 and the impact of the motor vehicle accident in the following March. It is noted that the Inspector's Report, completed 21 March 2021, made 13 recommendations, all of which would have entailed substantial work by the General Manager.

94. The events under consideration here occurred on 16 October 2020 and were raised with management of the AMC by the Official Visitor on 5 November, when it came to the General Manager's attention. His initial response was immediate. It minimized the significance of the possibility of missed observations, in light of the availability of the in-cell intercom and expressed impatience with the suggestion of examining the CCTV to ascertain the facts, though he plainly accepted this should be done. He drafted a proposed response on 6 November to the official Visitor which was, in substance a holding position. On 10 November 2020 the riot occurred. It is fair to accept that for the General Manager this could well have been a very significant distraction affecting his consideration of the email of that date that CCTV showed that the observations had not occurred, as had been claimed in the Observation Form. It was not until 26 November, however, that he drafted the proposed communication to the Official Visitor in which it was agreed that, indeed, as the detainee had complained, the observations had been missed.

95. The emails of 6 and 26 November were not in any sense informal communications. They were addressed to an independent external official charged with important supervisory functions directly relevant to the issue raised by the detainee's complaint about missed mandatory observations. Despite an apparent tendency to minimize the importance of compliance with the observation regime, the General Manager was well aware that it was a significant issue for the Official Visitor and that candid disclosure of information which was sought by the Official Visitor was an essential part of his responsibility as the General Manager. It is inevitable that, when he drafted the email proposing the response to the Official Visitor, he was well aware that operational reasons did not explain the missed observations, if only because of the terms of the report to him to the effect that CCTV showed the observations reported in the Observation Form had not in fact occurred. The outstanding question was what

needed to be done about the non-compliance with the operational requirements – and, from the standpoint of his managerial responsibilities whether this was a one-off situation or one that required addressing at a more general level. These issues were also of obvious significance from the point of reference of the functions of the Official Visitor, which were not, however, engaged if she accepted (as she plainly did) the implication in the communication from the AMC that the missed observations were a mere happenstance of the operational exigencies of the day in question. This was a significant failure of probity.

96. The implications of the circumstances for the effective management (or otherwise) of the observation regime required at least reference to the Integrity Unit and other supervisory officers, such as the Area Managers. The failure to take any action at all had the potential for catastrophic consequences. (Aside from any other issue, Person 1 was still in custody.)

Death of Luke Rich at AMC on 1 February 2022

97. The death of a detainee by suicide occurred on 1 February 2022 in a cell at the AMC, in relation to which the Office of the Inspector of Correctional Services (Inspector) conducted an inquiry and the Coroner, an inquest. The incumbent of the position of General Manager of the AMC on 1 February 2022 was the same person as at 16 October 2020.

Inquiry – Inspector of Correctional Services

98. The Inspector's 2022 Report notes the detainee "apparently died by suicide between 6:30pm and 7:00pm on 1 February 2022". Of direct relevance to the issues in the Commission's investigation, that report found that on the day of his death, observations conducted by corrections officers were deficient in that they either did not occur, or did occur (including by CCTV) but the detainee's behaviour was not adequately observed or recorded. In addition to making a finding that "No in-person observations of Detainee A occurred at 5:00pm on 1 February 2022 despite being signed off as occurring, contrary to operational guidelines", the report included the following:

> Although ACTCS records have an observation on Detainee A signed off as completed at 5:00pm, it appears that this was not in fact done. The dayroom CCTV camera shows that no one approached the door to Detainee A's cell between 4:15pm and 6:03pm. Interviews with COs [corrections officers] suggest observations of cell 3 were not done by CCTV either.

99. The Inspector's 2022 Report was also highly critical about the lack of detail recorded by corrections officers on the Detainee Observation Forms, noting the following:

> Observations of detainees are a key safeguard to protect detainee life, safety and wellbeing. The ACTCS detainee observation sheet clearly sets out acceptable standards for how it should be completed and has a straightforward table for recording observations. It is unacceptable for COs to be signing off on observations that did not occur or did not occur in the manner required. Furthermore, the descriptions accompanying the observations of Detainee A on 1 February represent extremely poor practice as the description 'in cell' is used for every observation prior to 6:00pm…

This observation applies equally to the "in cell" phrase that was consistently used in respect of Person 1 on 16 October 2020.

100. The Inspector's 2022 Report stated that "observations is a matter of vital importance which should be emphasised in recruit training and part of performance oversight by senior COs of more junior COs". That this obvious point still needed to be made despite the same issue having arisen (and been brought to management's attention by the Official Visitor) in Person 1's case some 16 months earlier strongly suggests that what had occurred was an entrenched practice and was a mark of serious managerial failure.

Inquest – Coroner

101. The Coroner handed down the Inquest report into Mr Rich's death on 22 August 2024. A useful timeline is as follows –

16 October 2020 – scheduled observations are not conducted on Person 1 and entries in detainee observation forms are falsified;

10 November 2020 – General Manager made aware by AMC staff of this but no action is taken;

1 February 2022 – Mr Rich found deceased at the AMC;

August 2022 – Inspector of Correctional Services releases report into the death;

22-26 May 2023 – Coroner holds hearings;

November 2023 – General Manager appears before the Commission in this investigation in respect of missed observations on 16 October 2020;

8 August 2024 – General Manager provides written statement to the Coroner after receiving notice that the Coroner was considering making adverse findings; and

22 August 2024 – Coroner hands down Inquest report.

102. Like the Inspector, the Coroner also found that an observation scheduled at 17:00 hours on the day of Mr Rich's death had not been conducted in person, but the relevant detainee observation form had been falsified to indicate that it had. The Coroner did not make a finding in relation to whether or not a CCTV check was made of Mr Rich on this occasion but, in stating that the omission of an in-person observation resulted in a lack of human contact, it is implicit that CCTV checks, which lacked any human interaction (so that the detainee would not even be aware a check had been conducted) – does not provide the essential element of conducting an (in person) observation constituted by enabling personal interaction.

103. The General Manager provided a written statement to the Coroner dated 8 August 2024. This statement was published as an annexure to the Coroner's report. The General Manager stated in his examination by the Commission that he could not recall what action he had taken in respect of the missed observations and subsequent falsification of entries on the detainee observation form on 16 October 2020, justifying the inference that no action had been taken. His (subsequent) statement to the Coroner stated –

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

This excerpt from the statement to the Coroner suggests that it was only the death on 1 February 2022 that highlighted the issue of an unsatisfactory practice in relation to observations and prompted "a need for change". Furthermore, in light of the fact that non-compliance with the observations regime had been known since at least November 2020 and had not instigated any action, the practice was effectively condoned by ACTCS Management. This conclusion is supported by the statement that –

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

The General Manager pointed in his statement to his message of 20 May 2023 (two days prior to the Inquest hearings) to all staff reminding corrections officers to comply with "this regime", presumably the then operating procedure that had been promulgated in 2019.

104. The Coroner noted that "No policy documents that were produced at the inquest described what, for custodial purposes, observations were intended to achieve, and how they were to be conducted and documented". There was some guidance in the forms themselves, which was covered by the Commission in counsel assisting's questioning of the General Manager. (The far more comprehensive *Corrections Management (Detainee Observations) Operating Procedure 2024* was made on 25 October 2024 and became effective on 31 October 2024.)

105. (It should be noted that the Coroner did not make a finding of causation between the missed observation at 17:00 on 1 February 2022 and Mr Rich's death, and the Commission, by setting out the sequence of events and the nature of the General Manager's evidence, does not intend to suggest otherwise.)

106. It appears that the General Manager was being significantly less than candid by implying in his statement to the Coroner that before the death of Mr Rich, there was no problem known to be present concerning observations of detainees. Nor is his evidence to the Commission that he could not recall what he had done about the missed observations credible, making every allowance for the distractions arising from the riot and its aftermath and the effects of his serious motor vehicle accident. He must have recollected that nothing was done until the impending Inquest into the death of Mr Rich. Had he taken disciplinary action in respect of Person 2 and managerial steps to ensure compliance with the observations regime, he must have recalled doing so.

107. These measures should have been undertaken as soon as reasonably practicable after coming to light in 2020, accepting the delays reasonably engendered by countervailing factors.

Ancillary issues

Availability of intercom system

108. As indicated above, the General Manager's initial response to the Official Visitor's report was to emphasise the importance of the availability of the in-cell intercom if they needed help. This also was put forward as mitigation of, if not an excuse for, failing to conduct medical observations as required by the Risk Policy by the General Manager during his examination by the Commission.

109. Use of the intercom system, which permits a two-way conversation between detainee and corrections officer, is not completely straightforward from a detainee's point of view. The Official Visitor told the Commission –

> OFFICIAL VISITOR: Now [Person 1] told me she, from memory, that she wanted to talk to the officers but she didn't want to buzz up because other people can hear and it's just a little intercom system that they can buzz up and she's correct, other people can hear, and the smallest thing within the prison population can make you a target, can make you stand out, so she didn't want that, and that's why she, I assume from what she was telling me, that's why she felt so affronted that the officer hadn't been to her cell door to check, you know the little slide door to check on her because she was going to have a private conversation with them.

The Official Visitor explained, "It's a very paranoid population within the AMC. Everyone's frightened of everyone telling on them for something". The reasons given by Person 1 for not initiating contact with a corrections officer over the intercom were not entirely unreasonable and certainly did not reduce the importance of ensuring that required observations are carried out. They were in substance conveyed by the Official Visitor in her initial report.

110. In his evidence to the Commission, the General Manager referred to the use of the intercom system as follows –

> COUNSEL ASSISTING: So what do you mean by "a quick look" [at the CCTV]? --- A. It's not hard. Take a quick look, look at CCTV, look at the obs sheet.
>
> Q. So you've also stated a concern here. You're concerned that "A detainee can make a complaint and we are then spending hours looking into it, when she could have used the intercom for what it's designed." Now, the complaint is about missed observations, as well. Would you agree? --- A. I - yes… I've made, I've taken the concern, take a quick look. What should I take, take a long look? I'm concerned that she made a complaint when she should have just buzzed up. If she's

concerned by what's going on, they're adults, as well. I've put it in there [referring to the internal AMC email chain]. Take a look.

111. In relation to the AMC suggestion that Person 1 use the intercom, contained in the first response to the Official Visitor's initial complaint, the Official Visitor said –

> COUNSEL ASSISTING: Now in the response from [Person 3] you'll see there as well that, "[Person 1] should be advised and strongly urged to use the intercom as this is what it's for. --- A. Yes.
>
> Q. Did that appear to be an adequate response to you in your capacity as Official Visitor? --- A. No, it actually bothered me. I felt that it was a brush-off. That first line was an absolute brush-off for me as the Official Visitor. And all detainees should be encouraged to use the intercom because it's a safety issue. They're locked in. There's, there's no cameras in the cells and so I think I responded with that and I'm certain I spoke with [Person 1] about that, and a generic-type thing I say to people is, "You don't have to say everything over the intercom. You just need to try and express, 'I've got a health concern can I speak with you in person,'" so that other people aren't hearing the specifics around it.
>
> Q. But overall you weren't satisfied with that response from them? --- A. No, I wasn't.

112. The availability of the intercom system in no way reduces the necessity of making the medical observations as stipulated. It should be obvious that a detainee may well not be in a position to use the intercom in the event of a serious problem arising.

Duty and standard of care

113. Deprivation of liberty is a significant matter for many reasons, which necessarily imposes significant duties on corrections authorities. It informs the duty of care owed to detainees. The standard of care owed by corrections authorities to detainees is largely reflected by the relevant legislative and policy framework. For example, the CM Act provides that functions under that Act in relation to a detainee must be exercised, amongst other things, to "respect and protect the detainee's human rights". Relevantly, ss 53(1)(b) and (c) of the Act require the Director-General (of the Justice and Community Safety Directorate) to ensure that "arrangements are made to ensure the provision of appropriate health services for detainees" and that "conditions in detention promote the health and wellbeing of detainees" respectively. Section 53(2)(b) goes on to state that the Director-General must also ensure that detainees have access to "timely treatment where necessary, particularly in urgent circumstances". The Risk Policy is an aspect of this requirement, pursuant to which

Person 1's medical situation was professionally assessed and she was categorized "M3" and scheduling medical observations in respect of a detainee who is known to have a medically diagnosed heart condition is designed to meet these obligations. It follows that conducting those medical observations and recording them accurately is an essential component of the standard of care owed to that detainee.

Findings

114. Person 2, a corrections officer, omitted to conduct mandatory medical observations and falsified four entries on the Observation Form in respect of Person 1 on 16 October 2020. In making the entries the officer represented that they had observed Person 1 at 10:00, 12:00, 14:00 and 15:00 hours when they had not.

115. The responses sent to the Official Visitor were misleading and intentionally omitted disclosing information about the non-compliance with the regime which was relevant to the Official Visitor's functions, thus hindering her in their performance.

116. The General Manager:

(i) failed to give adequate consideration to the significance of the original complaint made by Person 1 as to the omission of observations;

(ii) failed to follow up the AMC's initial response to the Official Visitor upon becoming aware that the observations were missed and the Detainee Observation Form entries had been false, to both of which reference had been made by the Official Visitor;

(iii) arranged for misleading information to be provided to the Official Visitor;

(iv) by omitting to report the corrections officer's failure to conduct mandatory medical observations or the falsified entries to the Integrity Unit, as required by the Incident Reporting Policy engaged in misconduct;

(v) took no action, either formal or otherwise, in respect of Person 2, or the Area Manager responsible for Person 1's area of the AMC, in relation to the missed observations or the false record; and

(vi) failed to take managerial action in respect of the level of compliance generally with the policy as to required observations.

117. The practice of falsifying or misleading or inadequate entries in Observation Forms observed in the instant case in 2020 was continuing in 2022.

118. No managerial action was taken arising from omitted observations of October 2020 and, until 2024, nothing further was done by the General Manager to take managerial action directed to correcting the problem.

Corrupt conduct

119. The task of the Commission is to consider whether the impugned conduct of Person 2 and the General Manager was corrupt within the meaning of the Act.

120. The starting point for interpreting the definition in s.9 of the IC Act of “corrupt conduct” is to identify the purpose and function of the Act, which is usefully summed up in s.6(a) as "providing for the identification, investigation and exposure of corrupt conduct." "Corrupt" is an ordinary English word which, when describing conduct, denotes behaviour that – to a significant (as distinct from inconsequential) extent – involves moral turpitude or a lack of probity. Mere ineptitude or carelessness, even negligence, would not suffice unless it reflected this element or, at least, amounted to recklessness (in the sense of indifference to known possible problematic outcomes). This reasoning is reflected in the definition in s.9 of "corrupt conduct", which essentially requires two elements to be present: the first (s.9(1)(a)), where the conduct must involve a possible criminal offence, serious disciplinary offence or reasonable grounds for dismissal or terminating the services of a public official; and, the second, (s.9(1)(b)) where the conduct falls into one or more of the stipulated categories.

121. This reasoning applies to the definition in s.10 of "serious corrupt conduct", which operates where the corrupt conduct (which necessarily has already been found) also has the likelihood of "threatening public confidence in the integrity of government or public administration" or, pursuant to s 11, where the corrupt conduct is “systemic”. By virtue of s 184 of the IC Act, an investigation report is not to include findings of corrupt conduct unless it is serious or systemic although it may include findings or opinions about the conduct of a stated person that may be corrupt conduct if the statement of the finding or opinion does not describe the conduct as such.

Person 2

122. The crux of the impugned conduct in respect of Person 2, so far as the Commission is concerned, is the intentional failure to conduct required observations and the falsification of four entries on Person 1's Observation Form on 16 October. For the purposes of s.9(1)(a) of the Act, this was conduct that could "constitute a serious disciplinary offence". Doing so, given that the correctional officer is a "public official" (as discussed at paragraphs 6 to 21), means the functions "as a public official [have been performed] in a way that is not honest" for the purpose of s.9(1)(b)(i).

123. It is necessary to consider whether the conduct would reasonably be seen as "threatening public confidence in the integrity of … public administration". This is not a single instance, but a failure on four occasions – though in the one shift – to make the required observations and it is probable to the required standard that this was intentional, as distinct from being attributable to mere carelessness or oversight. Certainly, the false entries must have been deliberate, each being a distinct instance of serious dishonesty. There is insufficient evidence for the Commission to be satisfied that this had occurred on other occasions.

124. However, as has been pointed out, the Commission has not examined Person 2 and has not served them with a copy of the PIR. The possibility that there might be some matter, personal to Person 2, that might afford some explanation for the objective facts and which might affect the likelihood of threatening public confidence in the integrity of public administration must be taken into account. Furthermore, the officer was very much in a subordinate role with others having responsibility – which appears to have failed – to supervise the performance of their duties. In the end, I have been unable to determine to the requisite standard that the conduct I have found to have occurred, even if it were considered to amount to corrupt conduct would amount to serious corrupt conduct. Accordingly, I make no finding that Person 2's conduct was corrupt within the meaning of the IC Act. I should add that this reluctance to conclude that they committed serious corrupt conduct is influenced somewhat by the fact that, though given natural justice by legal standards, their situation may also have meant that, realistically, they are not in a position to make a response that does them justice.

125. Despite this conclusion, it is important that it should be understood that a critical part of "public administration" is the delivery of services, particularly those that can only effectively be delivered by government. To a very significant extent, the ability of

detainees to manage their own health and safety is removed by virtue of their detention and entrusted to officials, which is markedly different to the situation in which people usually find themselves. This gives the human rights implications of detention particular poignancy, in addition to the ubiquitous common law duty of care. Corrections officers' work necessarily includes measures for managing known serious risks to health and welfare. Intentional disregard, without lawful excuse, of the responsibility to safeguard the health and welfare of detainees must inevitably threaten public confidence in the integrity of public administration in respect of corrective institutions, and amount to serious corrupt conduct for the purpose of s.10 of the IC Act. The intentional falsification of records designed to ensure the integrity of the applicable health and welfare regime would almost certainly also amount to serious corrupt conduct.

General Manager AMC

126. In respect of the findings set out at [116], the General Manager has made the following responses –

- He accepts the finding that he failed to give adequate consideration to the significance of the original complaint made by Person 1 regarding the omission of observations. He acknowledges that more thorough consideration of the complaint was warranted and regrets that this did not occur. He recognises that his focus on other matters was given priority. While understandable in the context of the significant pressures following the 10 November riot, he accepts that this does not excuse his oversight.

- He accepts the finding that he failed to follow up the AMC's initial response to the Official Visitor upon becoming aware of the missed observations and falsified entries in the Detainee Observation Form. He acknowledges that this follow-up was an essential part of his role and regrets not ensuring that appropriate steps were taken to support the Official Visitor's oversight process. He takes full responsibility for this lapse and understands the importance of such actions in maintaining accountability.

- He accepts the finding that he did not report the corrective officer's failure to conduct mandatory medical observations and their falsified entries to the Integrity Unit, as required by the Incident Reporting Policy. He acknowledges that this was a failure on his part and takes responsibility for not meeting the expectations set out in the policy. He regrets this omission and recognises the significance of adhering to reporting requirements to uphold integrity and transparency.

- He also accepts the finding that he did not take formal or informal disciplinary action in respect of Person 2 or the Area Manager responsible for Person 1's area of the AMC. He acknowledges that such actions were appropriate and regrets that he did not prioritise them during a period when his focus was drawn to other pressing challenges which he prioritised in the circumstances. He recognises the value of addressing performance issues promptly to ensure accountability and prevent systemic issues from arising.

- Finally, he accepts the finding that he did not take sufficient managerial action as would be expected of a General Manager to address compliance issues regarding mandatory observations. He acknowledges that as General Manager, he had a responsibility to ensure compliance with required standards and regrets not doing more to address systemic issues. [He] takes responsibility for this failure and is committed to ensuring a greater focus on compliance in the future.

- The General Manager accepts these findings without reservation and acknowledges the impact of his actions during this period. He regrets the shortcomings identified and is committed to learning from them to improve as a manager. At the same time, he maintains that dishonesty findings are not supported by the evidence, as outlined in his submission. He fully appreciates and regrets that his actions were lacking but were not a deliberate and calculated course to mislead the Official Visitor.

127. It is accepted that the General Manager's role necessitates prioritizing the various demands imposed on him by the heavy, various and difficult responsibilities his position entails and that it is no part of the Commission's role to second-guess those choices. On the other hand, the matters to which attention has been drawn did not merely involve issues of prioritization, but of omitting to take appropriate action at any

time. The question which the Commission needs to answer is whether those matters give rise to corrupt conduct as it is defined in the IC Act. As has been pointed out, the essential elements of that definition are described in both s 9(1)(a) and (b) of the Act.

128. The requirements of s 9(1)(a) bring into consideration whether the General Manager's conduct could constitute a serious disciplinary offence or a criminal offence. "Serious disciplinary offence" is defined in s 9(3) as including any "serious misconduct" or any other matter that may constitute grounds for termination action or a significant employment penalty. "Serious misconduct" is defined in terms of s 1.07 of the *Fair Work Regulations 2009* (Cwlth) as having the ordinary meaning of the words, the first example (in sub sec 2(a)) being "willful or deliberate behaviour that is inconsistent with the continuation of the contract of employment". It is at least arguable that the conduct enumerated in at [116], taken together, could fall within the example, thus conduct that could constitute a serious disciplinary offence. The potential criminal offence is that prescribed by s 19(2) of the Official Visitors Act of obstructing or hindering the exercise of the official visitor's functions without reasonable excuse. It is submitted on behalf of the General Manager in substance that the email to the Official Visitor was not intentionally misleading and the other omissions to take up the Official Visitor's complaint were explained, if not entirely excused, by the overwhelming workload arising from the riot of 10 November 2020 and the incapacity caused by his motor vehicle accident. It is submitted that this would not be willful or deliberate behaviour for the purpose of considering whether he had committed a serious disciplinary offence and would amount to a reasonable excuse within the meaning of s 19(2) of the Official Visitors Act.

129. However, having regard to the vital importance of safeguarding the health and welfare of detainees (and the potentially catastrophic consequences of ignoring known risks) and full cooperation with the independent supervisory role exercised by Official Visitors, the described conduct, even if not deliberate or willful, *could* (though not necessarily *would*) be grounds for a significant employment penalty, even making every allowance for the mitigatory matters relied on. So far as the offence under s 19(2) of the Official Visitors Act is concerned, it is contended that, if the email were misleading, this was not intentional, the Official Visitor was not actually hindered in the exercise of her functions in the sense that she was not prevented from conducting any investigation or making any inquiry she thought she should undertake and, at all events, the General Manager's actions occurred as a result of the supervening events

of the riot and its aftermath and his motor vehicle accident, these events providing a reasonable excuse for the conduct in question.

130. The question whether conduct hinders or obstructs the exercise of the Official Visitor's functions is an objective one and must be considered in light of the legislative purpose served by the Official Visitors Act. Section 19 of the Official Visitors Act makes it an offence without lawful excuse to "refuse or neglect to render assistance … or fail to answer any question if asked by an Official Visitor" or "obstruct or hinder an Official Visitor in the exercise of the Official Visitor's functions". The due performance of those functions in the particular circumstances in which they are called to be exercised necessarily entails the active cooperation of relevant corrections management: in short, the failure to actively cooperate or fully and candidly provide an answer to questions posed by the official Visitor could amount to hindering or obstructing the official Visitor in the exercise of their functions. The email of 26 August was in fact misleading in suggesting that the omitted observations had resulted from operational exigencies. Even if it were to be understood as suggesting only that this might have been the case, it would still have been objectively misleading. It is therefore arguable that the misleading information proposed in the General Manager's email could be found to constitute a breach of these requirements, for which the explanation submitted on the General Manager's behalf was not a physical or practical difficulty that might provide a reasonable excuse. Again, this would not amount to a finding that the conduct would amount to the offence under s 19 of the Official Visitors Act, but only that it *could* be so.

131. In the result, however, it is not necessary to come to a final conclusion about whether the elements of s 9(1)(a) are satisfied, since I have concluded that it is not possible to be satisfied to the requisite degree that the elements of s 9(1)(b) are present.

132. The only relevant elements of s 9(1)(b) of the IC Act are whether the General Manager exercised his functions in a way "that is not honest" (s 9(1)(b)(i)) or "constitute[d] a breach of public trust (s 9(1)(b)(ii)(A)). "Dishonest" is meant in its ordinary sense, as it would be understood by the ordinary decent member of the community, whether or not the person of interest knows or believes it to be dishonest. Although a protean term, the notion implies – so far as is presently relevant – some intentional attempt to deceive, either directly or indirectly by omitting some material

matter. Although I am satisfied to the requisite degree that the General Manager was well aware of his obligations to take action in respect of the non-compliance of Person 2 with their duty and dishonest entries in the Observation Form, I am not satisfied to the requisite degree that the failure to fulfill his obligations in this respect was dishonest.

133. As already explained, the email of 26 November 2020 was objectively misleading and intentionally so in the sense that the General Manager knew that the observations had not been missed for operational reasons. However, having regard especially to the difficult circumstances arising from the riot of just over two weeks previously, I am unable to be satisfied to the requisite degree of positive satisfaction that he intended to represent to the Official Visitor that operational reasons in fact explained the missed observations in question as distinct from intending only to make a general observation as to why observations might not take place, which logically left the question open in the context of an invitation to personally meet with the Official Visitor to discuss the matter. So far as breach of public trust is concerned, I cannot be positively satisfied that the email was intended to mislead the Official Visitor as distinct from being carelessly or ineptly drafted.

Conclusion

134. I am not satisfied that the conduct of the General Manager amounted to corrupt conduct within the meaning of the IC Act. Even where misjudgement occurs and mistakes are made, perhaps because of difficult operational workloads, it is always important for appropriate follow-up action to be taken and for erroneous or misleading information to be corrected as quickly as practicable. The failure to do so in some circumstances might well amount to corrupt conduct.