CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jordan Wayne Cruickshank
Hearing dates:	3 and 4 September 2019
Date of findings:	10 October 2019
Place of findings:	NSW Coroners Court - Milton
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in the course of a police operation – police communications with family – question of recommendations.
File number:	2018/142510
Representation:	Counsel Assisting the Inquest: J Hopper of Counsel i/b Crown Solicitors Office. The NSW Commissioner of Police, and officers of the NSW Police Force: J Edwards of Counsel i/b Office of the General Counsel, NSW Police Force. Ms Debbie Walker: S Crellin, Aboriginal Legal Service.

Findings:	**Identity** The person who died is Jordan Cruickshank. **Date of death**: Jordan Cruickshank died on 6 May 2018. **Place of death**: Jordan Cruickshank died at Shoalhaven District Hospital, Nowra NSW 2541 **Cause of death:** The cause of Jordan Cruickshank's death is methamphetamine toxicity in the background of atrioventricular node artery dysplasia. **Manner of death:** Jordan Cruickshank died in the course of a police operation.

Recommendations pursuant to section 82 of the Act.

1. The **Commissioner of Police** consider adding an item to the Senior Critical Incident Checklist, of advising the next of kin of their right to view the body of the deceased.

2. The **Commissioner of Police** consider introducing a mandatory training course and/or disseminating training material on the obligations of senior police under the equivalent section to the current Part 4.2.3 of the Critical Incident Guidelines, which includes:

- that specific notifications need to be made if the deceased person is from the Aboriginal or Torres Strait Island community; and
- emphasis on the need for officers to familiarise themselves with the appropriate local contacts for those notifications, including Aboriginal Community Liaison Officers

Non-publication Orders

There shall be no publication of the material listed in Annexure 1 to these Findings.

Section 81(1) of the Coroners Act 2009 (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to the date and place of the death, and its cause and manner.

These are the findings of an inquest into the death of Jordan Cruickshank.

Introduction

1. Jordan Cruickshank was 24 years old when he died in Shoalhaven District Hospital in the early hours of 6 May 2018. He had been taken there by ambulance after he was found unconscious in the backyard of a house in Bomaderry, the town where he lived in NSW's south coastal region.

2. On the night of Jordan's death a police operation was underway to arrest him for outstanding driving charges. He was the subject of an arrest warrant and two police officers had been pursuing him on foot before they lost sight of him. It was very shortly after this that he was found unresponsive and taken to hospital.

3. This is a mandatory inquest pursuant to sections 23(1)(c) and 27(1)(b) of the *Coroners Act* 2009 *(NSW)* [the Act]. An inquest is mandated when a person dies '*as the result of police operations*'. The purpose is to ensure there is an independent and transparent investigation of the circumstances of the death, and the conduct of any involved police officers.

Jordan Cruickshank's life

4. Jordan is an Indigenous man who was born on 29 January 1994. He and his five siblings grew up in the town of Bomaderry in southern NSW. He was particularly close to his brothers Edward and Cody, and three years ago he became a father with the birth of his little daughter.

5. Jordan struggled with problems of drug addiction and he also had diabetes. Friends and family reported that around the time of his death he was using crystal methamphetamine heavily.

6. Jordan's mother Debbie Walker attended the inquest, together with her partner Tim Foster and Nakita Pender who is the mother of Jordan's child. They were supported by Aboriginal Community Liaison Officer Arthur Wellington.

7. At the close of the evidence Ms Crellin read to the court Ms Walker's loving tribute to her son. She spoke of his love of playing cricket and football and his many friendships. She spoke too of her deep sadness that she had not been able to see his body after he died and say her last goodbyes, a source of enduring grief for her.

8. Ms Crellin also read to the court the words of Ms Pender, who is the mother of Jordan's child and had been his friend from their earliest years. She spoke of

a man who was loyal and kind, and who had dreams of living a life different to the one he was living at the time of his death.

9. It was clear that despite his struggles Jordan was much loved by his family, and they grieve his loss deeply.

The attempt to arrest Jordan

10. On 25 April 2018 Court Attendance Notices were issued for driving offences allegedly committed by Jordan. Earlier that day police officers had seen Jordan driving a car in Nowra. Aware that he did not hold a current driver's license they followed him in two police cars with lights and sirens activated. Allegedly, Jordan did not respond to their indications that he pull over, instead driving away at speed.

11. Police unsuccessfully attempted to serve Jordan with Court Attendance Notices containing the above charges, before obtaining an arrest warrant on 30 April to bring him before a court. He was also the subject of an arrest warrant for previous driving charges.

12. On 5 May 2018 police officers became aware of information that Jordan had been at a house in Samuel Street in Bomaderry earlier that day. This was the home of Ms Casey Ardler. There was also information that he had been inside a red Hyundai vehicle that had been reported stolen. It was not alleged that Jordan had been involved in the theft of the car.

13. Shortly before midnight on 5 May Sergeant Mark Watson and Senior Constable Jessica Thomas, both attached to Nowra Police Station, drove to an intersection near the house in Samuel Street. They observed a male person looking out from behind a curtain in the house, and decided to knock at the door to see if Jordan was there. If he was they intended to arrest him.

14. Behind the front fence of the house the two officers saw the stolen red car. Ms Ardler allowed the two officers to enter the house. Once inside they saw Jordan's two brothers Edward and Cody, whom they recognised. The officers then heard a loud noise and realised Jordan had jumped out of a bedroom window and was running from the house. They gave chase on foot. SC Thomas saw Jordan run into a reserve before she lost sight of him in the darkness.

15. In the meantime Sgt Watson had called for police assistance. One of those who drove to the area was Inspector David Cockram. In nearby Katela Street he encountered Ms Lorraine Trindall, who lived in the street. She was shaken and told him that she had just found Jordan in her backyard, '*sitting partially upright*'. He had not responded when she called out to him. Just prior to that, while inside her house she had heard a sound outside like '*a grunting noise'* and '*a kind of groan'*, followed by a louder noise as though someone had fallen over.

16. Police went immediately to Ms Trindall's backyard where they found Jordan slumped over and unresponsive. They called an ambulance and commenced CPR, which was maintained until the arrival of ambulance officers about ten minutes later. Inspector Cockram and SC Justin Kelly, both of whom were involved in the CPR, told the court that at no time could they detect a pulse and that as the minutes passed Jordan's body became colder.

17. Treatment continued in the ambulance on route to Shoalhaven District Hospital, but Jordan could not be revived and he was pronounced deceased at 1.02am.

The medical cause of Jordan's death

18. The cause of Jordan's death was clear on the evidence. The autopsy report of forensic pathologist Dr Elsie Burger found that Jordan had died of methamphetamine toxicity in the background of atrioventricular node artery dysplasia (described below). Toxicological analysis of Jordan's blood had detected methamphetamine in a concentration where potentially toxic levels overlap with lethal levels. Small concentrations of cannabis and naloxone were also present.

19. 'Atrioventricular node artery dysplasia' describes abnormality in the atrioventricular, or 'AV' node of the heart. The AV node controls the heart rate, by slowing electrical currents from the upper chambers of the heart before they reach the lower chambers. Prolonged use of stimulant drugs is associated with structural change such as AV node artery dysplasia.

20. In her report Dr Burger commented that methamphetamine can cause potentially fatal electrical rhythm disturbances in the heart. In Jordan's case the abnormalities in his AV node may have made him more susceptible to this phenomenon. In addition his flight from police, most likely involving production of adrenaline, may have increased the effect.

The manner of Jordan's death

21. As Jordan's death occurred in the course of a police operation to arrest him, it was necessary to examine the conduct of the police officers involved and whether they performed their duties lawfully. At the inquest the court heard evidence about the night's events from the following officers:
    - the Officer in Charge, Detective Inspector Bradley Ainsworth
    - Detective Sergeant Jason Hogan
    - Detective Sergeant Mark Watson
    - Senior Constable Jessica Thomas
    - Inspector David Cockram
    - Senior Constable Justin Kelly.

22. Having reviewed their evidence and the other evidence contained in the coronial brief I am satisfied that the police officers involved in this operation did not act unlawfully or improperly. I accept the submission of Counsel for the Commissioner and for the involved officers, that the warrant for Jordan's

arrest was lawfully obtained and that the officers were subject to a duty to execute it. I accept further that their entry into the house in Samuel Street and subsequent foot chase of Jordan did not involve any illegality or impropriety.

23. At the inquest Officers Watson, Thomas, Cockram and Kelly each gave evidence that they had not physically contacted Jordan that night, except in the case of Officers Cockram and Kelly who performed CPR upon him at Katela Street. Each gave further evidence that at no time had they used their arms or appointments on Jordan, nor seen any other police officer do so. It was important for Jordan's family to hear this, as in the aftermath of his death rumours had circulated that he had been harmed by police officers and that this may have caused or contributed to his death.

24. The cause and manner of Jordan's death are thus able to be established. I turn now to consider an issue raised by Jordan's mother Debbie Walker which was of particular concern to the inquest.

Communications with Jordan's family

25. Visual identification of a son or daughter who has died is likely to be the saddest experience a parent can ever have. But it is also a precious opportunity for the parent to see their loved one for the last time. Jordan's mother never saw him again after being told of his death, and this has added to her sorrow. The reasons why Ms Walker was not given the opportunity to see Jordan were examined at the inquest.

26. Immediately after Jordan's death, NSW Police's Professional Standards Command took appropriate action and declared it to be a Critical Incident. This requires that a death be investigated by a team from another police district to that where the death occurred. Detective Chief Inspector Bradley Ainsworth of Wollongong Police District was appointed as the Critical Incident Investigation team leader, with the assistance of Detective Sergeant Jason Hogan.

27. At about 4.30am on the morning Jordan died DCI Ainsworth arrived at Nowra Police Station where he met with Superintendent Stephen Hegarty, the District Commander of South Coast Police District. Together they went to the home of Debbie Walker to give her the tragic news. Present with Ms Walker was her de facto partner Tim Foster. It was by then about 6.15am.

28. In his evidence DCI Ainsworth described how Ms Walker became extremely upset upon hearing what happened, retreating into her bedroom and shutting the door. DCI Ainsworth then spoke to Mr Foster, explaining there would be an independent police investigation into Jordan's death and giving him his contact number.

29. DCI Ainsworth did not tell either Ms Walker or Mr Foster that Ms Walker had the right to view Jordan's body, which was at Shoalhaven District Memorial Hospital. This information is required to be given to the family, pursuant to the

Professional Standard Command's Critical Incident Guidelines (further described below). Nor did he tell Ms Walker that she was able to formally identify Jordan's body herself.

30. At the inquest DCI Ainsworth was asked why he had not told Ms Walker she would be able to see Jordan's body if she wished. He was aware this was a right afforded to families under the Critical Incident Guidelines. DCI Ainsworth explained that Ms Walker had been so upset he didn't want to further distress her.

31. DCI Ainsworth agreed he could have given this information to Mr Foster when Ms Walker had gone into her bedroom. He also agreed, on the basis of his experience, that even when a relative is deeply distressed he or she may very much want and need to see the body of their loved one. He conceded that Ms Walker ought have been given the opportunity to see Jordan and that he could see this was important to her.

32. Attempts were made to contact Jordan's father for the purpose of visually identifying his body. Police officers went to his address that morning but he was not there, nor was he when they visited on subsequent days. Jordan's body was formally identified by comparison with police fingerprint records.

The Critical Incident Guidelines

33. NSW Police Force guidelines are available to assist police with the difficult task of notifying a family that their relative has died in the course of a critical incident. In particular:
    - The local area commander is to personally inform relatives of any deceased person, or to delegate the responsibility to a fully briefed senior officer
    - The local area commander should ensure all reasonable requests of the family of the deceased, including viewing the body and the scene, are discussed with the investigation team leader
    - If possible, arrangements are to be made for other family members to be in attendance as support, '*particularly if the deceased is from the Aboriginal or Torres Strait Island community or non-English-speaking background'*
    - Unless the on duty Coroner directs, '*the family of the deceased or their representative have the right to view the body..'*

    [Part 4.2.3 of the Critical Incident Guidelines.]

34. The Guidelines further provide that if the deceased person is from the Aboriginal or Torres Strait Island community '*it is important to consider local aboriginal protocols and ensure the requisite notifications are made'*. These include notifications to the Aboriginal Legal Service and the Aboriginal Community Liaison Officer [ACLO].

35. The above guidelines are appropriate in that they recognise the importance to a bereaved family of being able to spend time with their loved one and to be personally involved in his or her identification. They recognise further the

value of calling upon the resources of the Aboriginal and Torres Strait Island community when one of their community has died in the course of a police operation, to ensure as far as possible that communications with the family are conducted sensitively and appropriately.

36. In closing submissions Counsel for the NSW Commissioner properly conceded that more should have been done that morning to observe the letter and spirit of these guidelines. I agree with this submission. I accept that in their communications with Jordan's family the police officers wished to avoid causing Ms Walker further distress; nevertheless in doing so they did not place sufficient importance on her very human need to be with her deceased son for the last time and to make her goodbyes.

37. Submissions were made by Counsel Assisting that it would be beneficial for there to be reinforcement of the importance of the above guidelines. Ms Hopper proposed that the Commissioner of Police consider adding an item to the Senior Critical Incident Checklist, of advising the next of kin of their right to view the body of the deceased. The court heard that this Checklist is routinely used by local area commanders and their delegates to ensure they fulfil the many duties and obligations they must perform in the event of a critical incident. The Checklist does not currently contain any reference to this task.

38. I accept this submission. So too does the NSW Commissioner, whose Counsel Mr Edwards conveyed the Commissioner's support for the above proposal. Mr Edwards advised that the current Critical Incident Guidelines are in the process of being reviewed, and that this process will include updating the Critical Incident Checklist to include the specific action of advising relatives of their right to view the body of the deceased.

39. Counsel Assisting proposed a further recommendation. This is that the Commissioner consider introducing a training course or training material regarding the obligations of relevant officers under Part 4.2.3. of the current Critical Incident Guidelines. The training would focus on the need for senior police to familiarise themselves with the relevant local contacts within the Aboriginal and Torres Strait Island community. Counsel for the Commissioner indicated that the Commissioner accepted that this proposal too would be appropriate.

    It is encouraging and welcome news that the two proposed recommendations are supported by the Commissioner of Police. They are also supported by the Aboriginal Legal Service.

Conclusion

40. Notwithstanding the high level of methamphetamine found in Jordan's post mortem blood sample, there is no evidence that he ingested the drug that day or evening with the intention of ending his own life. On behalf of the Coroner's Court and the assisting team I offer my deepest sympathy to Jordan's family for their loss, and thank Ms Walker for sharing her loving memories of her son.

I express my appreciation to Counsel Assisting Ms Justine Hopper, and the NSW Crown Solicitor's Office for their excellent assistance throughout the inquest. I also thank Counsel for the NSW Commissioner of Police and Ms Crellin of ALS for their assistance throughout the inquest.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I make the following findings.

Identity
The person who died is Jordan Cruickshank.

Date of death:
Jordan Cruickshank died on 6 May 2018.

Place of death:
Jordan Cruickshank died at Shoalhaven District Hospital, Nowra NSW 2541

Cause of death:
The cause of Jordan Cruickshank's death is methamphetamine toxicity in the background of atrioventricular node artery dysplasia.

Manner of death:
Jordan Cruickshank died in the course of a police operation.

Recommendations pursuant to section 82 of the Act.

3. The Commissioner of Police consider adding an item to the Senior Critical Incident Checklist, of advising the next of kin of their right to view the body of the deceased.

4. The Commissioner of Police consider introducing a mandatory training course and/or disseminating training material on the obligations of senior police under the equivalent section to the current Part 4.2.3 of the Critical Incident Guidelines, which includes:

- that specific notifications need to be made if the deceased person is from the Aboriginal or Torres Strait Island community; and
- emphasis on the need for officers to familiarise themselves with the appropriate local contacts for those notifications, including Aboriginal Community Liaison Officers.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner

Date 10 October 2019

ANNEXURE 1

TERMS OF ORDER

Pursuant to sections 65 and 74 of the *Coroners Act 2009* (NSW), the Court orders:

1. There shall be no disclosure, by publication or otherwise of :
    a) Tabs 1, 2, 3, 4 and 6 in the Confidential Exhibit AC-1 to the Confidential Affidavit of Anthony Crandell sworn 15 July 2019 ("the Confidential Affidavit"): the information outlined in red.
    b) Tab 5 in the Confidential Exhibit AC-1: the information outlined in red at the bottom of the first page only.
    c) Tab 7 in the Confidential Exhibit AC-1: the last row in the table outlined in red.
    d) Tab 11 in the Confidential Exhibit AC-1: references to the names of persons at tabs 25, 26 and 39 in the index to the brief of evidence.
    e) the Confidential Affidavit.
2. Order 1 does not prevent the disclosure of information to and between the following people for the proper purposes of these proceedings:
    a) The State Coroner, Coroners and staff of this Court;
    b) The solicitor assisting the Coroner and Counsel assisting the Coroner; and
    c) The Commissioner of Police, his legal representatives, and staff and officers of the NSW Police Force.
3. Order 1 does not prevent the disclosure of the documents in Confidential Exhibit AC-1 to the interested parties in a redacted form and an unredacted version to be provided to the deputy State Coroner only.
4. In the alternative, Order 1 is made on the basis of public interest immunity.

5. The Confidential Affidavit and Confidential Exhibit AC-1 be returned to the legal representatives for the Commissioner of Police on this application, following the delivery of findings, subject to the undertaking of the Crown Solicitor to make ther available as required by the Court.

SIGNATURE

Name

Capacity Deputy State Coroner E. Ryan

Date 29.7.19.

Further Non-Publications Orders dated 3 September 2019

1. Criminal records of Jordan Cruickshank (Tab 78)
2. Criminal records of Edward Cruickshank (Tab 79)
3. Criminal records of Warren Wellington (Tab 133)
4. CSNSW documents (Tabs 132C & 132D)
5. Information not related to Jordan Cruickshank in audio recordings of the NSWPF VKG at (Tabs 29, 30 and 43).

Deputy State Coroner Ryan

3 Sept. '19