JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	19 - 21 NOVEMBER 2025
DELIVERED	**:**	17 DECEMBER 2025
FILE NO/S	**:**	CORC 3051 of 2023
DECEASED	**:**	GINN, JAMIE FREDERICK

Legislation:

Coroners Act 1996 (WA)

Cases:

Briginshaw v Briginshaw (1938) 60 CLR 336

Counsel Appearing:

Ms S Markham appeared to assist the coroner.

Ms P Femia and Ms N Worthy (State Solicitor's Office) appeared on behalf of the Western Australia Police Force.

Mr T Pontre (of counsel) and Mr P Keays (Moray & Agnew Lawyers) appeared on behalf of the St John Western Australia Limited.

Mr T Emmerton-Ginn attended the inquest as an interested person.

SUPPRESSION ORDER

On the basis it would be contrary to the public interest, I make an Order under section49(1)(b) of the Coroners Act 1996 (WA) that there be no reporting or publication of: 1. Reports prepared by Detective Acting Sergeant B Wright (including annexures), or of Detective Acting Sergeant Wright's oral evidence at this inquest which details WA Police Force policy and operations at the Perth Watch House; and 2. Reports prepared by Inspector D Newman (including annexures), or of Inspector Newman's oral evidence at this inquest, which details WA Police Force policy and operations at the Perth Watch House.

Order made by Coroner MAG Jenkin (19.11.25)

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Jamie Frederick GINN*** with *an inquest held at the Perth Coroner's Court, Central Law Courts, Court 51, 501 Hay Street, Perth on 19 - 21 November 2025 find that the identity of the deceased person was* ***Jamie Frederick GINN*** *and that death occurred on 10 October 2023 at the Perth Watch House, 2 Fitzgerald Street, Northbridge from cocaine toxicity in the following circumstances:*

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INTRODUCTION

1. Jamie Frederick Ginn (Mr Ginn) was 50 years of age when he died at the Perth Watch House in Northbridge (PWH) on 10 October 2023 from cocaine toxicity.[1,2,3,4,5,6,7,8,9]

2. At about 1.00 pm on 10 October 2023, Mr Ginn voluntarily met with police at an industrial unit in Gnangara where he was arrested in relation to alleged firearms offences. Mr Ginn was then present when police searched the unit and the hotel room he had slept in the night before.

3. After Mr Ginn was refused bail, he was taken to the PWH and he arrived there at about 5.00 pm. Following assessments by a registered nurse, and police auxiliary officers (PAOs) Mr Ginn was strip searched and placed in a cell by himself.

4. At 6.53 pm, a PAO found Mr Ginn on the floor of his cell having what appeared to be a seizure. Other officers arrived and Mr Ginn was placed in the recovery position. Cardiopulmonary resuscitation was started at 7.15 pm when Mr Ginn stopped breathing, and ambulance officers arrived a short time later. Despite extensive resuscitation efforts, Mr Ginn could not be revived and he was declared deceased at 8.05 pm.

5. Pursuant to the *Coroners Act 1996* (WA) (the Act) Mr Ginn's death is a "*reportable death*", and because of the possibility that his death may have been caused or contributed to by a member of the Western Australia Police Force (WA Police), a coronial inquest was mandatory. Further, as Mr Ginn was "*in care*" at the time of his death, I am required to comment on the quality of the supervision, treatment and care that Mr Ginn received whilst he was in that care.[10]

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[1] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (20.06.24)
[2] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[3] Exhibit 1, Vol. 1, Tab 3, Life Extinct Forms (10.10.23)
[4] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of Deceased Person by Visual Means (11.10.23)
[5] Exhibit 1, Vol. 1, Tab 4.1, P92 - Identification of Deceased Person by Other than Visual Means (13.10.23)
[6] Exhibit 1, Vol. 1, Tab 4.1, Affidavit, Sen. Const. W Pugh (13.10.23)
[7] Exhibit 1, Vol. 1, Tab 4.1, Coronial Identification Report (13.01.23)
[8] Exhibit 1, Vol. 1, Tabs 5 & 5.1, Supplementary Post Mortem Report (16.05.24) & Post Mortem Report (16.10.23)
[9] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (23.10.23)
[10] Sections 3, 22(1)(a), 22(1)(b) and 25(3), *Coroners Act 1996* (WA)

6. I held an inquest into Mr Ginn's death on 19 - 21 November 2025, that was attended by members of Mr Ginn's family. The documentary evidence tendered at the inquest comprised four volumes, and the inquest focussed on the conduct of police officers and PAOs who interacted with Mr Ginn in the period before his death, as well as the quality of the supervision, treatment and care Mr Ginn received.

7. The following witnesses gave evidence at the inquest:

a. Det. Sgt. P Pieri, Arresting police officer (Officer Pieri);[11]
b. Ms K Godfrey, Registered nurse, PWH (Ms Godfrey);[12]
c. PAO S Singh, Police Auxiliary Officer, PWH (Officer Singh);[13]
d. PAO A Gardiner, Police Auxiliary Officer, PWH (Officer Gardiner);[14]
e. PAO L Skulley, Police Auxiliary Officer, PWH (Officer Skulley);[15]
f. PAO P O'Brien, Police Auxiliary Officer, PWH (Officer O'Brien);[16]
g. Dr V Kueppers, Forensic Pathologist (Dr Kueppers);[17]
h. Prof. D Joyce, Physician, Pharmacologist & Toxicologist (Prof. Joyce);[18]
i. Det. Sgt. T Moran, Coronial Investigation Squad (Officer Moran);[19]
j. PAO P Cooper, Police Auxiliary Officer, PWH (Officer Cooper);[20]
k. Det. A'Sgt. B Wright, Author, IAU[21] Report (Officer Wright);[22]
l. Insp. D Newman, WA Police (Officer Newman);[23,24] and
m. Mr A Clyne, St John Ambulance WA Ltd, (Mr Clyne).[25,26]

8. When assessing the available evidence and deciding whether to make any adverse findings, I have applied the standard of proof set out in the High Court's decision in the case known as ***Briginshaw v Briginshaw***[27] (the Briginshaw case).

[11] Exhibit 1, Vol. 1, Tabs 18 & 18.1, Statement & Handwritten notes - Det. Sgt. P Pieri (18.01.24) & ts 19.11.25 (Pieri), pp11-18
[12] Exhibit 1, Vol. 1, Tabs 24-24.3, Statements - Ms K Godfrey (undated, 18.10.23 & 15.10.25) & ts 19.11.25 (Godfrey), pp18-30
[13] Exhibit 1, Vol. 1, Tab 22, Statement - PAO S Singh (02.11.23) & ts 19.11.25 (Singh), pp30-43
[14] Exhibit 1, Vol. 1, Tabs 21 & 21.1, Statements - PAO S Gardiner (28.10.23 & 03.11.23) & ts 19.11.25 (Gardiner), pp44-52
[15] Exhibit 1, Vol. 1, Tab 32, Statement - PAO L Skulley (11.10.23) & ts 19.11.25 (Skulley), pp53-73
[16] Exhibit 1, Vol. 1, Tab 45, Statement - PAO P O'Brien (09.11.23) & ts 19.11.25 (O'Brien), pp74-95
[17] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24) & ts 20.11.25 (Kueppers), pp99-124
[18] Exhibit 1, Vol. 1, Tabs 8 & 8.1, Reports - Prof. D Joyce (12.01.24 & 19.01.24) & ts 20.11.25 (Joyce), pp124-144
[19] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (10.10.23) & ts 20.11.25 (Moran), pp145-158
[20] Exhibit 1, Vol. 1, Tabs 33 & 33.1, Statement & Notes - PAO P Cooper (11.10.23 & 10.10.23) & ts 20.11.25 (Cooper), pp159-174
[21] IAU is the abbreviation for WA Police's Internal Affairs Unit
[22] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24) & ts 21.11.25 (Wright), pp174-194
[23] Inspector Newman is WA Police's Assistant Divisional Officer, Custodial Services and Mental Health Division
[24] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25) & ts 21.11.25 (Newman), pp199-247
[25] Mr Clyne is the Head of Industry Medical Services and Event Health Services for St John Ambulance Western Australia Ltd
[26] Exhibit 1, Vol. 1, Tab 10.2, Report - Mr A Clyne (19.11.25) & ts 21.11.25 (Clyne), pp248-262
[27] (1938) 60 CLR 336, per Dixon J at pp361-362

9. The Briginshaw case is authority for the proposition that a consideration of the nature and gravity of the relevant conduct is required when deciding whether a finding adverse in nature has been proven on the balance of probabilities.

10. I have also been mindful not to insert any "*hindsight bias*" into my assessment of the actions taken by members of the WA Police. Hindsight bias is the well-known tendency after an event, to assume the event was more predictable or foreseeable than it actually was at the time.[28] In this case the relevant event is Mr Ginn's death by cocaine toxicity.

11. I would also point out that section 22(1)(b) of the Act is enlivened whenever the issue of causation or contribution in relation to a death arises as a question of fact, irrespective of whether there is fault or error on the part of any member of WA Police.

12. In this case, after careful consideration of the available evidence, I have concluded that the actions of the police officers who arrested Mr Ginn and transported him to the PWH on 10 October 2023 did not cause or contribute to his death. I have also concluded that the actions of the PAOs who interacted with Mr Ginn during his detention did not cause or contribute to his death.

13. Instead, it is my view that Mr Ginn died at 8.05 pm on 10 October 2023, after ingesting a fatal amount of cocaine. Although the cause of Mr Ginn's death (i.e.: cocaine toxicity) is not in doubt, on the basis of the available evidence I have been unable to determine the manner in which Mr Ginn ingested the cocaine which caused his death.

14. In passing I note there were a number of duplicated documents in the Brief of evidence tendered at the inquest. In order to avoid confusion in the footnotes in this finding, I have chosen (with one exception) to identify documents by reference to the first volume of the Brief in which they appear.[29]

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[28] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015), p10

[29] The exception is a document entitled "*Surveillance Review Document - PWH*", which appears in Vol.2 and Vol. 3 of the Brief. However, I have relied on the version that appears in Vol. 3 because the quality is superior quality.

MR GINN

Background[30,31,32]

15. Mr Ginn was born on 17 January 1973 and he was 50 years of age when he died on 10 October 2023 at the Perth Watch House from cocaine toxicity. Mr Ginn was a bricklayer, and he held a bachelor's degree in sports science and psychology. He had a son from a previous relationship, and at the relevant time, Mr Ginn was the State President of the Rebels Outlaw Motorcycle Gang (ROMG). Mr Ginn regularly attended a gym and was known to smoke cigarettes, and use alcohol, steroids, and cocaine.

16. As an adult, Mr Ginn accumulated 45 convictions for offences including: traffic matters, possession of prohibited drugs, breaking and entering, stealing, robbery whilst armed, breach of violence restraining order, and displaying prohibited insignia.[33]

Medical history[34,35,36,37,38,39]

17. Ms Odendaal (who was with Mr Ginn the night before he died) says that he was a frequent user of "*steroids*" (which he injected), and that she "*noticed his Cocaine use had increased recently as a result of him being very stressed out about some club issues*".[40,41]

18. Mr Ginn's former partner (Ms White) says in late-2019, Mr Ginn "*started talking about depression and mental health issues but he would never go to see anyone about this*". Ms White also says that in early 2020, Mr Ginn was "*very moody*" and "*quite short*" with her.[42] On the other hand, Ms Odendaal says "*I am not aware of (Mr Ginn) ever suffering with mental health issues*".[43] However, there is no evidence Mr Ginn was ever diagnosed with any mental health illness.

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[30] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24), p3
[31] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23)
[32] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23)
[33] Exhibit 1, Vol. 3, Tab 1.2, History for Court - Criminal & Traffic
[34] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24), pp4-6 & 13-14
[35] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23)
[36] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23)
[37] Exhibit 1, Vol. 1, Tab 38, Medical Records - Mindarie Keys Medical Centre
[38] Exhibit 1, Vol. 1, Tab 39, Medical Records - Joondalup Health Campus
[39] Exhibit 1, Vol. 1, Tab 40, Western Diagnostic - Pathology reports
[40] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23), paras 33-36
[41] See also: ts 20.11.25 (Joyce), pp125-126
[42] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23), paras 40-41
[43] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23), para 42

19. Ms White says that in 2020 and 2021, Mr Ginn experienced "*the odd blood nose*", and that these increased in frequency from July 2022. At the same time, Ms White also noticed Mr Ginn's cigarette and cocaine use increased, and she was also seeing blood on Mr Ginn's pillow "*three to four times a week*".[44] Ms Odendaal says she noticed the frequency of Mr Ginn's blood noses increased after his return from Malta in July 2023, and she attributed this to the "*blood thinning medication*" Mr Ginn was prescribed while he was in Malta.[45]

20. Ms White says Mr Ginn "*was diagnosed with sleep apnoea*" and that he used a "*mask*" he had bought "*off eBay*".[46] Ms Odendaal also says Mr Ginn was diagnosed with sleep apnoea and "*was a terrible sleeper*", and that although he had a CPAP[47] machine "*he hardly ever used it*".[48]

21. Ms White says Mr Ginn: "*would never go to a doctor unless he absolutely had to*"[49] and this is consistent with the available evidence which shows that from June 2022 to October 2023, Mr Ginn saw doctors at Mindarie Keys Medical Centre (MKMC) on four occasions.

22. On 2 June 2022, Mr Ginn saw a doctor at MKMC and complained of swelling in his shoulder. He also disclosed that he self-injected testosterone, and he was prescribed antibiotics for a possible abscess.[50] The following day (i.e.: 3 June 2022), Mr Ginn attended Joondalup Health Campus (JHC) complaining of pain and swelling in his left upper shoulder.[51,52]

23. During his assessment at JHC, Mr Ginn disclosed "*occasional cocaine use*" and he was diagnosed with an abscess. On 4 June 2022, Mr Ginn underwent a surgical procedure under general anaesthetic, during which the abscess in his shoulder was drained and packed.[53]

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[44] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23), paras 51-57, 78 & 106-107
[45] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23), paras 57-58
[46] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23), paras 51-57, 78 & 106-107
[47] A CPAP machine (continuous positive airway pressure) uses mild air pressure to help keep airways open during sleep
[48] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23), paras 33-35
[49] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23), para152
[50] Exhibit 1, Vol. 1, Tab 38, Medical Records - Mindarie Keys Medical Centre (02.06.22)
[51] Exhibit 1, Vol. 1, Tab 39, Medical Records - Joondalup Health Campus
[52] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23), paras 153-159
[53] Exhibit 1, Vol. 1, Tab 39, Medical Records - Joondalup Health Campus

24. During his admission at JHC, Mr Ginn was observed to snore loudly when he was asleep, and shortly after the procedure (at about 7.10 pm on 4 June 2022) Mr Ginn discharged himself from JHC against medical advice. When JHC staff contacted Mr Ginn on 5 June 2022 to check on him, Mr Ginn said he was "*feeling well and had no fever*".[54]

25. On 7 June 2022, Mr Ginn saw a doctor at MKMC, who noted Mr Ginn had: "*blood +++ pouring from* (the) *wound site*". Mr Ginn's wound was "*redressed and packing inserted*" and he was told he would need daily dressings and should continue to take his prescribed antibiotics. During this consultation, Mr Ginn denied "*any injectables or testosterone use*". On 8 June 2022, Mr Ginn saw the same doctor who noted: "*wound/cavity improving…dress again tomorrow and then after w/e, packing inserted*", however there is no evidence Mr Ginn returned to MKMC for this.[55]

26. On 13 July 2023, Mr Ginn saw a doctor at MKMC who noted a history of facial pain with swelling and tenderness in "*the infraorbital region and upper lip*". Mr Ginn reported experiencing the pain "*for a few weeks*" and said it had been getting worse over the past four days. The doctor noted: "*patient used to sniff substance using right nostril. I think he needs IV antibiotics as it is a cellulitis in the danger fascial zone*".[56]

27. Despite the doctor advising him not to do so, Mr Ginn travelled to Malta that night to visit a friend. While Mr Ginn was in Malta, his feet reportedly became so swollen he "*couldn't get his pants off*". Mr Ginn saw a doctor in Malta who told him "*he didn't have a blood clot*" but prescribed "*blood thinners*". This medication was reportedly a small "*red tablet*" which Mr Ginn took irregularly. On his return from Malta, Mr Ginn's "*feet and ankles still remained generally swollen, with the swelling fluctuating*".[57,58,59]

[54] Exhibit 1, Vol. 1, Tab 39, Medical Records - Joondalup Health Campus
[55] Exhibit 1, Vol. 1, Tab 38, Medical Records - Mindarie Keys Medical Centre (07.06.22 & 08.06.22)
[56] Exhibit 1, Vol. 1, Tab 38, Medical Records - Mindarie Keys Medical Centre (13.07.23)
[57] Exhibit 1, Vol. 1, Tab 38, Medical Records - Mindarie Keys Medical Centre (13.07.23)
[58] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23), paras 43-53
[59] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23), paras 110-118 & 143-144

28. Ms White says she caught up regularly with Mr Ginn in the six weeks before his death. She says Mr Ginn was "*clearly stressed*" and that his health had visibly declined during this time. Ms White says Mr Ginn told her he had been feeling "*really tired*" since returning from Malta and "*even more so in the last week or two*", that his feet and ankles were swollen, and that "*he had bites all over his feet from midgies*".[60,61]

29. Ms Odendaal says that after Mr Ginn returned from Malta, she noticed that his cocaine use increased, and also that:

> (Mr Ginn) was very stressed out over some club issues and also the fact that he believed was going to be incarcerated in relation to some charges currently before the Court. (Mr Ginn) had become paranoid about the club issues and would often sit at the warehouse watching the CCTV cameras. He said that he needed to get out of the warehouse for a bit and away from the CCTV cameras to clear his mind.[62]

30. In passing, I note that during his detention at PWH, CCTV footage appears to show Mr Ginn's feet shaking at various times before the onset of an apparent medical event.[63] However, in her statement, Ms White says that she last saw Mr Ginn on 8 October 2023, and that:

> (Mr Ginn) was fatigued and all he wanted to do was sit down on the couch. **Whilst he was sitting down, I watched as his feet started shaking. He told me this had only started in the last week or so but he wouldn't go and see a doctor**. I knew (Mr Ginn) wasn't taking the blood thinners regularly. (Mr Ginn) had a habit of only taking the start of prescribed medications until he thought he had taken enough and then he would just stop taking them.[64] (Emphasis added)

[60] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23), paras 119-130
[61] See also: Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23), paras 52-54
[62] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23), paras 59-62
[63] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (10.10.23)
[64] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23), paras 140-144

EVENTS LEADING TO MR GINN'S DETENTION

Arrest & search - 27 September 2023[65,66,67,68,69]

31. At about 11.55 am on 27 September 2023, Mr Ginn's car was stopped by members of WA Police's Gang Crime Squad. A handgun was located in the vehicle and Mr Ginn was arrested and taken to an industrial unit in Gnangara where he had been living (the Unit). Police executed a search warrant and searched the Unit, and Mr Ginn disclosed bottles of testosterone and steroids, which police seized.

32. During the search, Mr Ginn asked attending police if he could take his "*blood thinning medication which he obtained from Malta*", and he mentioned his feet had started to swell "*but didn't declare why he was experiencing this*". Mr Ginn was told that unless he produced a prescription for the medication he would not be permitted to take it, and he (Mr Ginn) declined offers of medical attention, and an ambulance. Towards the end of the search Mr Ginn was seen to experience a nose bleed, which he said was due to hay fever.

Arrest & searches - 10 October 2023[70,71,72,73,74,75,76,77,78,79,80,81,82]

33. On the afternoon of 9 October 2023, Mr Ginn and Ms Odendaal checked into a room at the Rendezvous Hotel in Scarborough (the Hotel). As previously noted, Mr Ginn had told Ms Odendaal that he wanted to get away from the Unit and "*clear his head*". Ms Odendaal says Mr Ginn had some cocktails, and that he made "*frequent trips*" to the bathroom where she assumed he used the cocaine she was aware he had with him.

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[65] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[66] Exhibit 1, Vol. 1, Tab 14, Statement - Det. Sen. Const. J Bonser (23.10.23), paras 2-20
[67] Exhibit 1, Vol. 1, Tab 15, Statement - Det. Sen. Const. C Murray (24.11.23), paras 2-13
[68] Exhibit 1, Vol. 1, Tab 16, Statement - Det. FC Const. T Eades (16.10.23), paras 2-27
[69] Exhibit 1, Vol. 1, Tab 43, WAPOL Incident Report 270923 1230 16579 (27.09.23)
[70] Exhibit 1, Vol. 1, Tab 12, Statement - Ms J Odendaal (21.11.23), paras 62-88
[71] Exhibit 1, Vol. 1, Tab 15, Statement - Det. Sen. Const. C Murray (24.11.23), paras 14-28
[72] Exhibit 1, Vol. 1, Tab 16, Statement - Det. FC Const. T Eades (16.10.23), paras 28-57
[73] Exhibit 1, Vol. 1, Tab 17, Statement - Det. Sen. Const. S McHugh (13.10.23)
[74] Exhibit 1, Vol. 1, Tab 18, Statement - Det. Sgt. P Pieri (18.01.24) & ts 19.11.25 (Pieri), pp11-18
[75] Exhibit 1, Vol. 1, Tab 18.1, Handwritten notes - Det. Sgt. P Pieri (10.10.23)
[76] Exhibit 1, Vol. 1, Tab 19, Statement - Sen. Const. J Bull (13.10.23)
[77] Exhibit 1, Vol. 1, Tab 20, Statement - Const. C Otieno (13.10.23)
[78] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[79] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25) & ts 21.11.25 (Wright), pp174-194
[80] Exhibit 1, Vol. 1, Tab 43.1, WAPOL Incident Report 101023 2030 12913 (10.10.23)
[81] Exhibit 1, Vol. 3, Tab 1.8, Surveillance Review Document - Rendezvous Hotel (10.10.23)
[82] Exhibit 1, Vol. 3, Tab 1.13, BWC Footage - Unit (10.10.23)

34. Ms Odendaal says when she left the Hotel at about 10.00 am on 10 October 2023 to go to work, Mr Ginn was still asleep. Later, after police contacted her, Ms Odendaal went back to the Hotel to wake Mr Ginn after hotel staff had been unable to do so. Ms Odendaal managed to wake Mr Ginn, and after she told him officers from the Gang Crime Squad were at the Unit, Mr Ginn contacted police and arranged to meet them there.

35. When Mr Ginn arrived at the Unit at about 1.00 pm, he was arrested by police and advised that he would be charged with firearms offences. Mr Ginn was placed in handcuffs and "*pat searched*", and police conducted a search of the Unit, and later the room at the Hotel Mr Ginn had occupied the previous evening. Both searches were recorded on the body worn cameras of attending police, and Mr Ginn was present.

36. As Mr Ginn watched police conduct the search of the Unit, he told one of the attending officers (Constable Otieno) that he was "*not feeling too good*" and that he had not "*been feeling too good*" since he returned from Malta a couple of months earlier. Mr Ginn declined the offer of medical attention, and police removed Mr Ginn's handcuffs on a couple of occasions so he could have a cigarette and refreshments.

37. No cocaine was found either at the Unit or at the Hotel, but police located a shotgun wrapped in a towel in a bush close to the Unit's entrance. Mr Ginn denied any knowledge of the weapon, but his handcuffs were reapplied and he was placed in a police vehicle.

Transport to PWH[83,84,85,86,87,88]

38. After Mr Ginn was refused bail, he was transported to the PWH by Officers Pieri and Bull. During the trip, Mr Ginn fell asleep from time to time, and he snored intermittently. After Mr Ginn arrived at the PWH just after 5.00 pm, he was handed over to PWH staff. At that time, the plan was that Mr Ginn's release on bail would be considered by a magistrate the following day.

[83] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[84] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[85] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25) & ts 21.11.25 (Wright), pp174-194
[86] Exhibit 1, Vol. 1, Tabs 18 & 18.1, Statement & Handwritten notes - Det. Sgt. P Pieri (18.01.24) & ts 19.11.25 (Pieri), pp11-18
[87] Exhibit 1, Vol. 1, Tab 19, Statement - Sen. Const. J Bull (13.10.23)
[88] Exhibit 1, Vol. 3, Tab 1.12, Surveillance Review Document - PWH Admission (10.10.23)

Detention at PWH[89,90,91,92,93,94,95,96,97,98,99,100,101,102,103,104,105,106,107,108,109,110,111]

39. Shortly after his arrival at the PWH, and while he was still in the police vehicle, Mr Ginn was asked a series of health and welfare questions by PAO Embry and PAO Ivan. When Mr Ginn disclosed he was taking medication for "*blood clots in his feet*", PAO Embry arranged for him to be reviewed by Ms Godfrey, the registered nurse on day shift at the PWH.

40. Ms Godfrey (who was accompanied by another nurse completing an orientation shift) conducted a brief health assessment to determine whether Mr Ginn was fit to enter custody. Mr Ginn told Ms Godfrey he was prescribed blood thinner medication, which he had last taken the day before. Mr Ginn did not disclose any other medical conditions or health problems, and at the end of her assessment Ms Godfrey determined that Mr Ginn was fit to be detained.

41. As a result of the separate assessments of two PAOs, and Ms Godfrey's brief nursing assessment (during which Mr Ginn denied he had consumed any alcohol or illicit drugs), Mr Ginn was classified as a "*general risk*" detainee. This meant he was to be the subject of "*cell welfare checks*" every 20 minutes for the first hour, with hourly checks thereafter. Like all cells at PWH, Mr Ginn's cell was monitored by a close circuit television (CCTV) camera.[112]

[89] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[90] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[91] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25) & ts 21.11.25 (Wright), pp18-30
[92] Exhibit 1, Vol. 1, Tabs 21 & 21.1, Statements - PAO S Gardiner (28.10.23 & 03.11.23) & ts 19.11.25 (Gardiner), pp45-52
[93] Exhibit 1, Vol. 1, Tabs 18 & 18.1, Statement & Handwritten notes - Det. Sgt. P Pieri (18.01.24) & ts 19.11.25 (Pieri), pp11-19
[94] Exhibit 1, Vol. 1, Tab 19, Statement - Sen. Const. J Bull (13.10.23)
[95] Exhibit 1, Vol. 1, Tab 22, Statement - PAO S Singh (02.11.23) & ts 19.11.25 (Singh), pp30-43
[96] Exhibit 1, Vol. 1, Tab 23, Statement - PAO J Emery (11.01.24)
[97] Exhibit 1, Vol. 1, Tabs 24-24.3, Statements - Ms K Godfrey (undated, 18.10.23 & 15.10.25) & ts 19.11.25 (Godfrey), pp18-30
[98] Exhibit 1, Vol. 1, Tab 25, Statement - Ms H Stow (03.11.23)
[99] Exhibit 1, Vol. 1, Tab 27, Statement - Sgt. J Jones (12.12.23)
[100] Exhibit 1, Vol. 1, Tab 28, Statement - PAO D Fielder (02.11.23)
[101] Exhibit 1, Vol. 1, Tab 29, Statement - Prob. PAO M Beresford (02.11.23)
[102] Exhibit 1, Vol. 1, Tab 30, Statement - PAO N Vuk (26.10.23)
[103] Exhibit 1, Vol. 1, Tab 31, Statement - PAO M Ivan (02.11.23)
[104] Exhibit 1, Vol. 1, Tab 32, Statement - PAO L Skulley (11.10.23) & ts 19.11.25 (Skulley), pp53-73
[105] Exhibit 1, Vol. 1, Tabs 33 & 33.1, Statement & Notes - PAO P Cooper (11.10.23 & 10.10.23) & ts 20.11.25 (Cooper), pp159-174
[106] Exhibit 1, Vol. 1, Tab 34, Statement - PAO J Madden (11.10.23)
[107] Exhibit 1, Vol. 1, Tab 45, Statement - PAO P O'Brien (09.11.23) & ts 19.11.25 (O'Brien), pp74-95
[108] Exhibit 1, Vol. 1, Tab 35, Statement - Ms A Keenan (18.10.23)
[109] Exhibit 1, Vol. 4, Tabs 1 & 1.1-1.28, Report & Annexures - Insp. D Newman (10.11.25) & ts 21.11.25 (Newman), pp199-247
[110] Exhibit 1, Vol. 4, Tabs 2 & 2.1-2.4, Report & Annexures - Insp. D Newman (12.11.25)
[111] Exhibit 1, Vol. 1, Tab 44, Custodial Management Records (10.10.23)
[112] Exhibit 1, Vol. 4, Tab 2, Report - Insp. D Newman (12.11.25), pp19-22, paras 79-106

Perth Watch House and observation regimes[113,114,115,116,117,118]

42. Prior to the start of the inquest, I made an order (the Order) prohibiting the publication of reports (including annexures) authored by Inspector Newman (Officer Newman), and the report (including annexures) authored by Detective Acting Sergeant Wright (Officer Wright) respectively, as well as the evidence of these officers at the inquest.[119]

43. The reports of each of Officer Newman and Wright deal (at least in part) with policies and procedures at the PWH. The reason I made the Order was that I concluded that it would be contrary to the public interest for information about these policies and procedures to be published.[120]

44. For that reason, I do not intend to detail the admission procedures or the observation regimes that Mr Ginn was the subject of following his arrival at the PWH. However, after reviewing the available evidence, I am satisfied that Mr Ginn was treated appropriately and in accordance with relevant policies during his reception into the PWH.

45. I also note that for the entire time Mr Ginn was detained at the PWH, his movements were recorded by CCTV cameras with one exception. For a brief period starting at around 5.44 pm, Mr Ginn was taken to a private room where he was strip searched by PAO Singh and PAO Gardiner. For privacy reasons strip searches are not recorded visually, but an audio recording of Mr Ginn's strip search confirms that he was dealt with in a professional way in accordance with relevant policies.

46. Neither the preliminary search in the sallyport at the PWH, nor the general and strip searches Mr Ginn was subjected to found anything of interest. In view of his association with the ROMG, Mr Ginn was segregated and he was the sole occupant of Cell B4 in B Block at the PWH.

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[113] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[114] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[115] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25)
[116] Exhibit 1, Vol. 1, Tab 42, WA Police Force State Custody Standard Operating Procedures 2023
[117] Exhibit 1, Vol. 4, Tabs 2 & 2.1-2.4, Report & Annexures - Insp. D Newman (12.11.25)
[118] Exhibit 1, Vol. 3, Tab 1.22, PWH Standing Operating Procedures
[119] Order - Coroner MAG Jenkin (19.11.25)
[120] Section 49(1)(b), *Coroners Act 1996* (WA)

47. As noted, during the reception procedure at PWH Mr Ginn was asked health and welfare questions by PAOs, and he was also briefly reviewed by Ms Godfrey. Although Mr Ginn told Ms Godfrey he was prescribed "*blood thinners*" for "*blood clots*" in his feet, his reliability as an historian is doubtful.[121] In her statement, Ms White says:

> In around July, (Mr Ginn) was going over to Malta. His nose was infected and starting to swell up. He reluctantly went and saw a GP where he received antibiotics. Upon landing in Malta, (Mr Ginn) sent me a picture of his feet which had swollen up. (Mr Ginn) went and saw a doctor in Malta. **The doctor tested** (him) **and advised him that he didn't have a blood clot** but did prescribe him with blood thinners.[122] (Emphasis added)

48. Ms Godfrey asked further questions and after some internet research, she concluded (apparently correctly) that the "*red pills*" Mr Ginn had been prescribed were not warfarin. Ms Godfrey noted that the afternoon of 10 October 2023 "*was probably one of the busiest afternoons*" she had experienced in the eight years she had worked at PWH. However, although she was mentoring a nursing colleague doing an orientation shift and was also dealing with two very demanding detainees who each had high care needs,[123] Ms Godfrey said that:

> Upon reflection I feel I was under added stress that afternoon, however this did not impact on my ability to assess (Mr Ginn) upon his arrival within a professional and objective manner.[124]

49. Mr Ginn was placed in cell B4 at PWH at 5.21 pm on 10 October 2023. He was then the subject of documented cell welfare checks at 5.24 pm, 5.36 pm, 5.47 pm, and 6.04 pm (when he was checked by the Cells Supervisor). Further, I note that at 5.44 pm, Mr Ginn he was the subject of a strip search, and at 6.22 pm, he accepted the offer of a meat pie for dinner and briefly interacted with PAO Cooper.[125,126,127,128]

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[121] ts 19.11.25 (Godfrey), pp21-25
[122] Exhibit 1, Vol. 1, Tab 13, Statement - Ms T White (12.10.23), paras 110-115
[123] Exhibit 1, Vol. 1, Tab 24.3, Statement - Ms K Godfrey (15.10.25), paras 13-28 & 35-49
[124] Exhibit 1, Vol. 1, Tab 24.3, Statement - Ms K Godfrey (15.10.25), para 70 & ts 19.11.25 (Godfrey), p26
[125] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25), paras 157-161
[126] Exhibit 1, Vol. 1, Tab 29, Statement - Prob. PAO M Beresford (02.11.23)
[127] Exhibit 1, Vol. 1, Tab 30, Statement - PAO N Vuk (26.10.23)
[128] Exhibit 1, Vol. 1, Tabs 33 & 33.1, Statement & Notes - PAO P Cooper (11.10.23 & 10.10.23) & ts 20.11.25 (Cooper), pp159-174

50. Having reviewed relevant PWH policies, I am satisfied that Mr Ginn was subject to an appropriate number of cell welfare checks. Mr Ginn's next cell welfare check was to have occurred at 7.22 pm, but as I will explain later in this finding, by that time Mr Ginn had stopped breathing (having been found to be experiencing some sort of medical event) and resuscitation efforts were in progress.[129,130]

Nurses at Perth Watch House[131,132,133,134,135,136,137,138,139]

51. At the relevant time at PWH, there was one registered nurse on duty during the day shift (6.00 am to 6.00 pm), and one registered nurse on duty during the night shift (6.00 pm to 6.00 am). The nurses were supplied by St John Ambulance Western Australia Ltd. (SJA), pursuant to a contract for service with WA Police.

52. At the relevant time, the nurses tended to be casual employees of SJA, and they were required to go through an orientation process before working at PWH. At that time, there were only about 13 nurses in the casual pool and in 2023, there were 201.5 hours where there was no nurse coverage at PWH. Since then, recruiting efforts have seen the casual pool increase to 23 nurses, supplemented by four permanent employees. As a result, there were only 14.5 hours of unfilled shifts from January to May 2025.[140,141]

53. Although the relevant policy requires that where possible all detainees received at PWH are assessed by the nurse, in practice this is not always possible. That is because the nurse may have been providing care to a detainee in another part of the PWH, or the nurse may have been taking a mandated meal break during their 12-hour shift.[142]

[129] Exhibit 1, Vol. 1, Tab 32, Statement - PAO L Skulley (11.10.23)
[130] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (10.10.23)
[131] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[132] Exhibit 1, Vol. 1, Tab 10.1, Report - Dr J Stewart (12.06.25)
[133] Exhibit 1, Vol. 1, Tab 10.2, Report - Mr A Clyne (19.11.25) & ts 21.11.25 (Clyne), pp248-262
[134] Exhibit 1, Vol. 1, Tab 26, Statement - Ms T Mill (13.12.23)
[135] Exhibit 1, Vol. 1, Tab 27, Statement - Sgt. J Jones (12.12.23)
[136] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[137] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25)
[138] Exhibit 1, Vol. 4, Tabs 1 & 1.1-1.28, Report & Annexures - Insp. D Newman (10.11.25)
[139] Exhibit 1, Vol. 4, Tabs 2 & 2.1-2.4, Report & Annexures - Insp. D Newman (12.11.25)
[140] Exhibit 1, Vol. 1, Tab 10.2, Report - Mr A Clyne (19.11.25), pp2-4
[141] See also: Exhibit 1, Vol. 1, Tab 10.1, Report - Dr J Stewart (12.06.25)
[142] Exhibit 1, Vol. 4, Tab 1, Report & Annexures - Insp. D Newman (10.11.25), p28, para 131

54. On 10 October 2023, the rostered night shift nurse was unavailable due to illness. Unsuccessful efforts were made to find a replacement, and the issue was communicated to Sergeant Jones (the officer in charge of the PWH) at 3.00 pm.[143] Ms Godfrey was also advised, and she made various arrangements in relation to the overnight care of detainees.

55. It is obviously regrettable that a nurse was unavailable for the night shift on 10 October 2023. However, I acknowledge that efforts were taken by SJA to fill that shift, and I accept that neither Ms Godfrey, nor the nurse who was completing an orientation day shift were able to extend their shifts at the PWH. I also note that the nurse who was rostered to do the day shift on 11 October 2023 had volunteered to start her shift earlier.

56. Nevertheless, at the time Mr Ginn was found experiencing what appeared to be a medical event, there was no nurse present, and he was given first aid by PAOs (from 6.54 pm), and SJA ambulance officers (who arrived at 7.17 pm). As to what difference a nurse would have made had they been at the PWH at the relevant time, I note the uncontradicted evidence of Dr Stewart (SJA's Medical Director - Community Stream) who noted in his report that:

> **Treatment and care from nurses at PWH for a prolonged seizure would not exceed that provided by the PWH staff.** Interim measures, having called for an emergency ambulance, would be in accordance with basic first aid, as was administered, given that definitive treatment would be an anticonvulsant. All PWH nursing post equipment, medical supplies and consumables are supplied by (WA Police). No medication able to terminate seizures (anticonvulsants) are held at PWH.[144] (Emphasis added)

57. I also note that very high levels of cocaine were found in Mr Ginn's blood and stomach contents, and as Professor Joyce observed, Mr Ginn's death from cocaine toxicity was probably inevitable.[145,146]

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[143] Exhibit 1, Vol. 1, Tab 26 - Statement - Ms T Mill (13.12.23)
[144] Exhibit 1, Vol. 1, Tab 10.1, Report - Dr J Stewart (12.06.25), p2, paras 10-11
[145] ts 20.11.25 (Joyce), pp143-144, and see also: ts 20.11.25 (Joyce), pp127 & 133
[146] See also: Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24), pp10-11, para 36

58. Professor Joyce notes that Mr Ginn's dilated cardiomyopathy was probably related to his use of anabolic steroids, and that "*coronary artery disease was established*".[147]

59. In relation to Mr Ginn's cocaine toxicity, Professor Joyce made the following observations:

> It may be speculated that the conditions sensitized him to the cardiac lethal effects of cocaine, but the overall toxicological evidence points to cocaine poisoning that was probably unsurvivable, even for a person with a perfectly healthy heart.[148]
>
> The concentration we're looking at here though is very far above anything that has ever been deemed survivable. There is no previous case in my own experience that approaches this concentration.[149]

60. At the inquest, Mr Emmerton-Ginn asked Professor Joyce "*what could have helped*" if Mr Ginn had been found as soon as he began to have seizures,[150] and his (Professor Joyce's) response was:

> No, I'm…not sure if it…was survivable under…any circumstances. The…only similar oral cocaine ingestion cases that have come to me personally, have died there. **So, I think, when…that much cocaine is present in the…stomach and gut, and is ultimately going to find its way into the circulation, then it's just going to ensure that…the poisoning is lethal**…and…So, my answer to the question would be that there might have been hope if he was transferred to medical care immediately after the ingestion there, but I'm not confident that there was any hope.[151] (Emphasis added)

61. On the basis of the evidence before me, I have been unable to conclude (to the relevant standard) that the outcome in Mr Ginn's case would have been different had a nurse been available to attend to Mr Ginn when he was discovered having a medical episode by PAO Skulley at 6.53 pm on 10 October 2023.

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[147] Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24), pp10-11, para 36
[148] Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24), p11
[149] ts 20.11.25 (Joyce), p131
[150] ts 20.11.25 (Emmerton-Ginn), p143
[151] ts 20.11.25 (Joyce), pp143-144

Cell welfare checks and evening meal

62. After Mr Ginn was placed in a cell at PWH at 5.21 pm on 10 October 2023, he was the subject of cell welfare checks at 5.24 pm, 5.36 pm, 5.47 pm, and 6.04 pm. At 5.44 pm, Mr Ginn was the subject of a strip search, and at 6.22 pm he accepted the offer of a meat pie for dinner and briefly interacted with PAO Cooper. During these cell welfare checks, and during the other interactions Mr Ginn had with PAOs no unusual behaviour was observed.

63. On 10 October 2023, PAO O'Brien was rostered on duty as the Cells Control Officer (CCO), and she was sitting in one of the control rooms at PWH. In addition to other tasks (including making entries into the custody management system, remotely opening and closing access doors, and answering cell intercom calls from detainees) at the relevant time the CCO was responsible for "*continuous observation of CCTV in compliance with standing processes outlined in PWH SOPs*".[177,178,179]

[152] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[153] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[154] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25) & ts 21.11.25 (Wright), pp174-194
[155] Exhibit 1, Vol. 1, Tab 18, Statement & Handwritten notes - Det. Sgt. P Pieri (18.01.24 & 10.10.23) & ts 19.11.25 (Pieri), pp11-18
[156] Exhibit 1, Vol. 1, Tab 19, Statement - Sen. Const. J Bull (13.10.23)
[157] Exhibit 1, Vol. 1, Tabs 21 & 21.1, Statements - PAO S Gardiner (28.10.23 & 03.11.23) & ts 19.11.25 (Gardiner), pp44-52
[158] Exhibit 1, Vol. 1, Tab 22, Statement - PAO S Singh (02.11.23) & ts 19.11.25 (Singh), pp30-43
[159] Exhibit 1, Vol. 1, Tab 23, Statement - PAO J Emery (11.01.24)
[160] Exhibit 1, Vol. 1, Tabs 24-24.3, Statements - Ms K Godfrey (undated, 18.10.23 & 15.10.25) & ts 19.11.25 (Godfrey), pp18-30
[161] Exhibit 1, Vol. 1, Tab 25, Statement - Ms H Stow (03.11.23)
[162] Exhibit 1, Vol. 1, Tab 27, Statement - Sgt. J Jones (12.12.23)
[163] Exhibit 1, Vol. 1, Tab 28, Statement - PAO D Fielder (02.11.23)
[164] Exhibit 1, Vol. 1, Tab 29, Statement - Prob. PAO M Beresford (02.11.23)
[165] Exhibit 1, Vol. 1, Tab 30, Statement - PAO N Vuk (26.10.23)
[166] Exhibit 1, Vol. 1, Tab 31, Statement - PAO M Ivan (02.11.23)
[167] Exhibit 1, Vol. 1, Tab 32, Statement - PAO L Skulley (11.10.23) & ts 19.11.25 (Skulley), pp53-73
[168] Exhibit 1, Vol. 1, Tabs 33 & 33.1, Statement & Notes - PAO P Cooper (11.10.23 & 10.10.23) & ts 20.11.25 (Cooper), pp159-174
[169] Exhibit 1, Vol. 1, Tab 34, Statement - PAO J Madden (11.10.23)
[170] Exhibit 1, Vol. 1, Tab 35, Statement - Ms A Keenan (18.10.23)
[171] Exhibit 1, Vol. 4, Tabs 1 & 1.1-1.28, Report & Annexures - Insp. D Newman (10.11.25) & ts 21.11.25 (Newman), pp199-247
[172] Exhibit 1, Vol. 4, Tabs 2 & 2.1-2.4, Report & Annexures - Insp. D Newman (12.11.25)
[173] Exhibit 1, Vol. 1, Tabs 11.1-11.3, St John Ambulance Patient Care Records: 23161359, 23161380 & 23161383 (10.10.23)
[174] Exhibit 1, Vol. 1, Tab 35, Statement - Ms A Keenan (18.10.23)
[175] Exhibit 1, Vol. 1, Tab 36, Statement - Mr A Dagnell (12.10.23)
[176] Exhibit 1, Vol. 1, Vol. 3, Tab 1.20, Statement - Ms M Hall (16.10.23)
[177] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25), p29, para 136
[178] Exhibit 1, Vol. 1, Tab 45, Statement - PAO P O'Brien (09.11.23), paras 4-7 & ts 19.11.25 (O'Brien), pp74-95
[179] See also: Exhibit 1, Vol. 3, Tab 1.22, PWH Standing Operating Procedures

64. On 10 October 2023, PAO Skulley and PAO Cooper were conducting the evening meal service at the PWH and handing out meat pies to those detainees who wanted them. The meat pies were delivered to the PWH in bulk containers and placed in a pie warmer before being transferred to a food trolley for service. At 6.22 pm, PAO Cooper offered Mr Ginn a meat pie which he accepted. CCTV footage shows PAO Skulley taking a meat pie from the food trolley at random, before handing it to PAO Cooper who gave it to Mr Ginn.[180,181,182]

65. As meat pies were given to each detainee PAO Skulley used her radio to contact PAO O'Brien who used the custody management system on the PWH computer to create "*multi episode meal events*" recording whether or not a meal was accepted. PAO O'Brien (who had started her 12-hour shift at 6.00 pm) recalled that 10 October 2023 was "*a busy night and there were quite a few detainees in custody*".[183]

66. PAO Skulley said: "*the whole process of delivering dinner took about 10 minutes*", and "*Nothing caught my eye about this detainee* (i.e.: Mr Ginn) *and I had no concerns in relation to him*" during dinner.[184]

67. As I will explain in more detail shortly at 6.53 pm, PAO Skulley made an emergency radio call after finding Mr Ginn apparently having a seizure in his cell. Although PAO O'Brien cannot recall what she was doing at the time she heard PAO Skulley's emergency call, PAO O'Brien believes she was "*still on the computer entering information*". PAO O'Brien also says that while making computer entries, she is "*too busy to look at the cameras* (i.e.: the CCTV cameras showing detainees in their cells).[185]

68. As to Mr Ginn's medical event, Officer O'Brien says: "*I did not see* (Mr Ginn) *at any time on the CCTV monitors displaying any behaviour in his cell that made me believe he was having a fit/seizure or anything to indicate he required any medical assistance*".[186]

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[180] Exhibit 1, Vol. 1, Tab 32, Statement - PAO L Skulley (11.10.23), paras 18-31 & ts 19.11.25 (Skulley), pp53-73
[181] Exhibit 1, Vol. 1, Tab 33, Statement - PAO P Cooper (11.10.23) , paras 17-26 & ts 20.11.25 (Cooper), pp159-174
[182] See also: ts 19.11.25 (O'Brien), pp77-78
[183] Exhibit 1, Vol. 1, Tab 45, Statement - PAO P O'Brien (09.11.23), paras 8-11
[184] Exhibit 1, Vol. 1, Tab 32, Statement - PAO L Skulley (11.10.23), paras 32-33 & 35
[185] Exhibit 1, Vol. 1, Tab 45, Statement - PAO P O'Brien (09.11.23), paras 12-16
[186] Exhibit 1, Vol. 1, Tab 45, Statement - PAO P O'Brien (09.11.23), para 24

Mr Ginn is discovered fitting[187,188,189,190,191,192,193]

69. At 6.53 pm, PAO Skulley was conducting cell welfare checks when by mistake, she turned into B Block instead of C Block. As she did so, out of the corner of her eye, PAO Skulley saw movement in Cell B4. On approaching the cell, PAO Skulley found Mr Ginn lying on the cell floor having what appeared to be a fit.

70. PAO Skulley realised something was wrong but was unable to open the cell door without another officer being present. PAO Skulley used her radio to make an emergency call and she requested the attendance of a nurse. She was told there was no nurse on duty, but less than one minute later several PAOs Cooper, Madden, Jones and Lacey arrived in B Block, and Mr Ginn's cell door was opened.

Resuscitation efforts[194,195,196,197,198,199,200]

71. Seconds after the PAOs entered the cell, PAO Cooper placed his hands under Mr Ginn's head to prevent any injury, and this was replaced by a blanket moments later. Mr Ginn was then moved onto the cell mattress and placed into the recovery position.

72. The efforts of PAO Cooper appear to have been successful because specialist post mortem examination of Mr Ginn's brain confirmed there was: "*no macroscopic or microscopic features to support a diagnosis of recent traumatic brain injury*".[201]

73. Whilst in the recovery position, Mr Ginn was monitored closely by the PAOs in his cell, and he was clearly breathing and making snoring noises.

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[187] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[188] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[189] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (6.53 pm, 10.10.23)
[190] Exhibit 1, Vol. 1, Tab 32, Statement - PAO L Skulley (11.10.23), paras 37-54 & ts 19.11.25 (Skulley), pp61-73
[191] Exhibit 1, Vol. 1, Tabs 33 & 33.1, Statement & Notes - PAO P Cooper (11.10.23 & 10.10.23) & ts 20.11.25 (Cooper), pp159-174
[192] Exhibit 1, Vol. 1, Tab 34, Statement - PAO J Madden (11.10.23)
[193] Exhibit 1, Vol. 3, Tab 1.39, Statement - PAO J Jones (20.06.24)
[194] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[195] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[196] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (6.54 pm - 8.05 pm, 10.10.23)
[197] Exhibit 1, Vol. 1, Tab 32, Statement - PAO L Skulley (11.10.23), paras 55-70 & ts 19.11.25 (Skulley), pp53-73
[198] Exhibit 1, Vol. 1, Tab 33, Statement - PAO P Cooper (11.10.23) paras 38-69 & ts 20.11.25 (Cooper), pp159-174
[199] Exhibit 1, Vol. 1, Tab 34, Statement - PAO J Madden (11.10.23)
[200] Exhibit 1, Vol. 1, Tabs 11.1-11.3, St John Ambulance Patient Care Records: 23161359, 23161380 & 23161383 (10.10.23)
[201] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (23.10.23), p2

74. PAO Skulley ran to the nurse's station to fetch a defibrillator, and when Mr Ginn stopped breathing at 7.15 pm, PAOs Cooper, Madden and Lacey immediately started cardiopulmonary resuscitation (CPR). PAO Madden placed a "*finger monitor*" on Mr Ginn's finger, and a crew of paramedics (who had been called by PAO Madden) arrived at the PWH at 7.17 pm.

75. This first crew of paramedics was joined a short time later by another paramedic crew, and then a clinical support paramedic. A defibrillator was attached to Mr Ginn's chest, and paramedics (assisted by PAOs) made extensive resuscitation efforts, including giving Mr Ginn oxygen, intravenous saline, and multiple intravenous doses of adrenaline.

76. Although the defibrillator did not advise a shock should be administered, a "*return of spontaneous circulation*" (i.e.: the resumption of a sustained heart rhythm that perfuses the body after cardiac arrest) was achieved at 7.41 pm. Mr Ginn was closely monitored, and when he went into cardiac arrest again at 7.46 pm, CPR was recommenced.

77. Despite the ongoing resuscitation efforts of the paramedics and PAOs, it eventually became clear that further efforts were futile. Following a phone consultation between the clinical support paramedic and the on-call SJA doctor, resuscitation efforts were ceased and Mr Ginn was declared deceased at 8.05 pm.[202,203,204,205,206,207,208,209,210,211]

[202] Exhibit 1, Vol. 1, Tab 36, Statement - Mr A Dagnell (12.10.23), paras 61-74
[203] Exhibit 1, Vol. 1, Tab 3, Life Extinct Forms (10.10.23)
[204] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of Deceased Person by Visual Means (11.10.23)
[205] Exhibit 1, Vol. 1, Tab 4.1, P92 - Identification of Deceased Person by Other than Visual Means (13.10.23)
[206] Exhibit 1, Vol. 1, Tab 4.1, Affidavit - Sen. Const. W Pugh (13.10.23)
[207] Exhibit 1, Vol. 1, Tab 4.1, Coronial Identification Report (13.01.23)
[208] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24)
[209] Exhibit 1, Vol. 1, Tab5.1, Post Mortem Report (16.10.23)
[210] Exhibit 1, Vol. 1, Tab 6, Final Toxicology Report (22.11.23)
[211] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (23.10.23)

CAUSE OF DEATH

Post mortem examination[212,213,214]

78. On 12 and 16 October 2023, a forensic pathologist (Dr Kueppers) conducted a post mortem examination of Mr Ginn's body at the State Mortuary and reviewed post mortem CT scans.

79. The reason the post mortem examination was conducted over two days was that during the initial examination, Mr Ginn's family requested a second doctor be present.[215] Although further examination was temporarily paused, the doctor nominated by Mr Ginn's family lived interstate and was unable to attend the State Mortuary. As a result, when the post mortem examination resumed it was videotaped.[216]

80. Dr Kueppers noted Mr Ginn had a "*very muscular build*" and his body "*showed evidence of resuscitative efforts*". Minor "*staining*" by bodily fluids to Mr Ginn's face was noted, as was minor bruising to the back of his elbows and head. However, there were no significant injuries.[217]

81. When Dr Kueppers examined Mr Ginn's body, an airway (placed there by paramedics) was still in his mouth, and this was of concern to some members of Mr Ginn's family. At the inquest, Dr Kueppers said:

> It's really important for everything to stay in place so the trace evidence can be taken appropriately and so that I can see exactly what was done by first responders, ambulance staff, before the body comes to me.[218]

82. Mr Ginn's lungs were congested and fluid laden (a non-specific finding), his heart was "*enlarged and appeared dilated*", and there was "*focally moderate coronary artery disease*". As noted, Mr Ginn's heart damage appears to be related to his anabolic steroid use.[219,220]

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[212] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24) & ts 20.11.25 (Kueppers), pp99-124
[213] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (16.10.23)
[214] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (23.10.23)
[215] Section 35, *Coroners Act 1996* (WA)
[216] ts 20.11.25 (Kueppers), pp107-108 & 119-121
[217] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24), p1
[218] ts 20.11.25 (Kueppers), pp102-103
[219] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24), p1 & ts 20.11.25 (Kueppers), pp122-123
[220] Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24), pp10-11, para 36

83. At the conclusion of her post mortem examinations, Dr Kueppers stated that the cause of Mr Ginn's death was "*undetermined*" pending further investigations. These investigations included microscopic examination of major body tissues which showed "*enlargement of heart muscle cells and mild interstitial cardiac fibrosis*" and the presence of "*focally moderate coronary artery atherosclerosis was confirmed*".[221]

84. Biopsies from Mr Ginn's scalp and elbows "*confirmed the presence of haemorrhage without an inflammatory reaction*", and at the inquest Dr Kueppers said these injuries were minor and could well have occurred during Mr Ginn's seizures.[222]

85. Specialist examination of Mr Ginn's brain showed "*bilateral non-specific hippocampal gliosis and gliosis in the left temporal lobe cortex*", but there was no macroscopic or microscopic features of recent traumatic brain injury. Biochemistry, microbiology and virology testing was not relevant to Mr Ginn's cause of death.[223,224]

Toxicological analysis[225,226,227]

86. Toxicology analysis detected very high levels of cocaine in Mr Ginn's system along with cocaine metabolites, confirming Mr Ginn's history of cocaine use. Mr Ginn's stomach contents also contained very high levels of cocaine (and its metabolites), and as I will explain, Professor Joyce estimated that Mr Ginn must have consumed about a rounded teaspoon of cocaine hydrochloride to achieve the detected levels.

87. Mr Ginn's carbon monoxide and methaemoglobin saturations were found to be low, and an insignificant amount of cyanide was also detected. Specialised testing also confirmed the presence of an anabolic steroid in Mr Ginn's system (i.e.: a metabolite of trenbolone).[228,229]

[221] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24), p1
[222] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24), p1
[223] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24), pp1-2 & ts 20.11.25 (Kueppers), p105
[224] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (23.10.23)
[225] Exhibit 1, Vol. 1, Tab 6, Final Toxicology Report (22.11.23)
[226] Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24) & ts 20.11.25 (Joyce), pp124-144
[227] Exhibit 1, Vol. 1, Tab 8.1, Report - Prof. D Joyce (19.01.24)
[228] Exhibit 1, Vol. 1, Tab 6.3, Report - National Measurement Institute (16.11.23)
[229] ts 20.11.25 (Kueppers), pp108-109

Cocaine toxicity[230,231]

88. Because of the very high levels of cocaine detected in Mr Ginn's system, an opinion was sought from Professor Joyce, who is a physician, clinical pharmacologist, and toxicologist.[232] Professor Joyce provided two reports to the Court and he also gave evidence at the inquest.

89. Before I briefly summarise Professor Joyce's views about cocaine toxicity, I note his observation about Mr Ginn's cause of death:

> Literature on cocaine-related deaths emphasises that predisposing cardiovascular conditions are commonly present…in cases of sudden cardiac death and where there is post mortem evidence for a cardiovascular catastrophe, like coronary artery dissection or obstruction or cerebral artery thrombosis or aneurysmal rupture. In Mr Ginn's case, dilated cardiomyopathy was present, presumably consequent on anabolic steroid use, and coronary artery disease was established. It may be speculated that the conditions sensitized him to the cardiac lethal effects of cocaine, but the overall toxicological evidence points to cocaine poisoning that was probably unsurvivable, even for a person with a perfectly healthy heart.[233,234]

90. In summary, Professor Joyce expressed the following opinions:[235,236]

a. The very high levels of cocaine found in Mr Ginn's blood and stomach mean he ingested a large amount of cocaine orally;

b. The amount of cocaine hydrochloride (the cocaine salt most widely used illicitly) would have been between 3,000 mg to 6,700 mg, which is roughly equivalent to one rounded teaspoon;

c. It is credible to propose Mr Ginn consumed packaged cocaine before his arrest at 1.02 pm with the package subsequently ruptured causing cocaine poisoning. However, there is no specific evidence of any packaging to support this conjecture;

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[230] Exhibit 1, Vol. 1, Tabs 8 & 8.1, Reports - Prof. D Joyce (12.01.24 & 19.01.24) & ts 20.11.25 (Joyce), pp124-144
[231] Exhibit 1, Vol. 1, Tabs 8.2 & 8.3, Emails - Prof. D Joyce (16.04.25 & 02.05.25)
[232] ts 20.11.25 (Kueppers), p113
[233] Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24), pp10-11, para 36
[234] See also: ts 20.11.25 (Joyce), pp127 & 133 & 143-144
[235] Exhibit 1, Vol. 1, Tabs 8 & 8.1, Reports - Prof. D Joyce (12.01.24 & 19.01.24) & ts 20.11.25 (Joyce), pp124-144
[236] Exhibit 1, Vol. 1, Tabs 8.2 & 8.3, Emails - Prof. D Joyce (16.04.25 & 02.05.25)

d. If Mr Ginn had ingested a lethal dose of cocaine before he was arrested it is very unlikely he would have remained free from definite signs of poisoning for five hours after the ingestion. Thus, it is likely Mr Ginn's peak concentration of cocaine occurred closer to his death; and

e. The available literature on rates of absorption of cocaine consumed orally is very limited, so it is impossible to be precise about when Mr Ginn's peak concentration of cocaine occurred.[237]

How did Mr Ginn ingest cocaine?[238,239,240,241,242]

91. As noted, Mr Ginn started to show signs of a medical event that appeared to be a seizure at about 6.38 pm on 10 October 2023, while he was detained at the PWH. Mr Ginn was declared deceased at 8.05 pm after extensive resuscitation efforts, and the cause of his death was eventually deemed to be cocaine toxicity.

92. The obvious question that arises is how Mr Ginn came to ingest the "*rounded teaspoon*" of cocaine that caused his death? There appear to be three possible explanations, namely:

a. *Ingestion before arrest*: Mr Ginn may have ingested a package containing cocaine prior to his arrest on 10 October 2023. The package may then have ruptured in Mr Ginn's stomach sometime before 6.38 pm, causing fatal toxicity. On basis of Professor Joyce's evidence, I have discounted the possibility that Mr Ginn consumed "*loose*" cocaine prior to his arrest.[243]

b. *Ingestion of packaged cocaine after arrest*: Mr Ginn may have concealed a package of cocaine on his person, which he then ingested at some point after his arrest. The ingestion event may have occurred before or after Mr Ginn's arrival at PWH at about 5.00 pm on 10 October 2023, and the package may then have ruptured causing fatal cocaine toxicity.

[237] ts 20.11.25 (Joyce), pp132-135
[238] Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24) & ts 20.11.25 (Joyce), pp124-144
[239] Exhibit 1, Vol. 1, Tab 8.1, Report - Prof. D Joyce (19.01.24)
[240] Exhibit 1, Vol. 1, Tab 9, Email - Dr V Kueppers (13.05.25) & ts 20.11.25 (Kueppers), pp99-124
[241] Exhibit 1, Vol. 1, Tab 9.1, Photograph of Mr Ginn's stomach contents
[242] Exhibit 1, Vol. 1, Tabs 8.2 & 8.3, Emails - Prof. D Joyce (16.04.25 & 02.05.25) & ts 20.11.25 (Joyce), pp124-144
[243] Exhibit 1, Vol. 1, Tab 8.3, Email - Prof. D Joyce (02.05.25)

c. *Ingestion of loose cocaine after arrest*: Mr Ginn may have secreted a small package containing cocaine in or about his body prior to his arrest at 1.02 pm on 10 October 2023. The package may then have evaded detection during his pat search when arrested, and the basic and strip searches he was subjected to at the PWH. At some point shortly before 6.38 pm while he was in his cell at the PWH, Mr Ginn may have ingested a fatal amount of cocaine which caused him to start having seizures.

93. I note some members of Mr Ginn's family have suggested that the meat pie Mr Ginn was given for dinner at 6.22 pm on 10 October 2023 may have contained cocaine. Presumably the allegation is that cocaine was placed in the meat pie either by a PAO at the PWH, or by some other person or persons unknown. Despite the sensational nature of this allegation, there is simply no evidence to support it.[244]

94. Before briefly summarising some of the problems with the possible ways Mr Ginn came to ingest the cocaine that caused his death, I note Professor Joyce's succinct observation that:

> There is a piece missing from the puzzle. We have got two sets of evidence which just seem to be irreconcilable. One is the rapid onset of cocaine intoxication which can really only be explained by a recent dose and can't be explained by a dose taken at 1 o'clock. And then we have, as I understand it, CCTV footage which doesn't identify that event. The proposition that we might put to make up this missing piece, which was ingestion and wrapping, and the wrapping breaking off, again we have no reason to believe that that actually happened either. So, there is simply a piece missing from the puzzle.[245]

95. In my view, the problems with identifying how and when Mr Ginn consumed a lethal dose of cocaine include:

a. No cocaine was found in Mr Ginn's room at the Hotel, or at the Unit on 10 October 2023 and after his arrest at 1.02 pm, Mr Ginn made no apparent attempts to ingest cocaine;[246,247]

[244] See: ts 19.11.26 (Skulley), p65 & ts 20.11.26 (Cooper), pp166 & 170
[245] ts 20.11.26 (Joyce), p139
[246] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24)
[247] ts 19.11.25 (Pieri), p18

b. At the inquest, Dr Kuepper confirmed she had inspected Mr Ginn's rectum during her post mortem examinations, and that it contained nothing relevant to his cause of death. Coupled with the very high levels of cocaine in Mr Ginn's stomach, this means that oral ingestion is the most likely explanation for how cocaine entered his body;[248,249]

c. Officer Moran completed an exhaustive review of the CCTV footage from Mr Ginn's cell at PWH and compiled a report.[250] At the inquest Officer Moran was asked whether that footage showed Mr Ginn removing something concealed on his body, and Officer Moran's response was:

> **I didn't see any period where (Mr Ginn) has appeared to have removed something or had something concealed on his body**. There were different times where he was snorting, whether his hand was near his face or he was just in general, he was snorting and making different noises, which I documented in the review. But no, I don't think that he has removed anything concealed and put it to his mouth or his nose.[251] (Emphasis added)

d. Mr Ginn underwent a basic search, and a strip search at PWH, neither of which found anything of interest, and PAO Singh and PAO Gardiner both said the strip search they conducted was "*thorough*". However, cavity searches are not performed, and detainees are not asked to pull their buttocks apart;[252,253]

e. There are isolated examples of prohibited items (e.g.: scissors and illicit drugs) evading detection at PWH. I also note that at the relevant time (and presently) detainees who are strip searched are not required to walk through PWH's body scanner;[254]

f. Mr Ginn's movements were recorded by CCTV cameras while he was detained at PWH, and he was the subject of four cell welfare checks;[255]

[248] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24) & ts 20.11.25 (Kueppers), pp109-112
[249] Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24) & ts 20.11.25 (Joyce), pp127-128
[250] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (10.10.23)
[251] ts 20.11.25 (Moran), p152
[252] Exhibit 1, Vol. 1, Tabs 21 & 21.1, Statements - PAO S Gardiner (28.10.23 & 03.11.23) & ts 19.11.25 (Gardiner), pp47-48
[253] Exhibit 1, Vol. 1, Tab 22, Statement - PAO S Singh (02.11.23) & ts 19.11.25 (Singh), pp35 & 38-43
[254] ts 19.11.25 (Singh), pp35 & 40-43 & ts 19.11.25 (Skulley), pp65-66
[255] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (10.10.23)

g. CCTV footage from Mr Ginn's cell (the Footage) shows him "*snorting*", touching, and wiping his face at various times as well as drinking water from a paper cup he filled using the cell's drinking fountain. Mr Ginn also placed his fingers inside the cup and appeared to use his tongue to lick the inside of the cup;[256,257]

h. At the inquest, Mr Emmerton-Ginn said that in his opinion the Footage shows Mr Ginn ingesting cocaine, which Mr Ginn may have dissolved in the paper cup;[258]

i. However, despite Mr Emmerton-Ginn's confident assertion that the Footage shows Mr Ginn ingesting cocaine, neither Officer Moran (who reviewed CCTV footage from the PWH) nor Officer Wright (who authored the IAU report) agreed that the Footage shows an "*ingestion event*";[259,260,261,262,263,264,265,266]

j. The paper cup in Mr Ginn's cell was disposed of following his death, most likely by paramedics as they cleared up debris after Mr Ginn's death. This is very unfortunate because the paper cup cannot be analysed to see if it contained traces of cocaine;[267,268]

k. PAO Skulley and PAO Cooper, who did the dinner service at PWH on 10 October 2023, each denied they had put anything in the meat pie that was given to Mr Ginn, or that they had any reason to harm him;[269,270]

l. Having watched the relevant portion of the CCTV footage from the PWH, I am satisfied that PAO Skulley selected a meat pie at random from the food service trolley which she then handed to PAO Cooper who gave it to Mr Ginn;[271]

[256] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (10.10.23)
[257] Exhibit 1, Vol. 4, Tab 1.29, Insp. D Newman - Summary of events in Cell B4 (5.21 pm - 6.54 pm, 10.10.23)
[258] ts 20.11.25 (Emmerton-Ginn), p9
[259] See for example ts 19.11.25 (Emmerton-Ginn), p9
[260] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (10.10.23)
[261] Exhibit 1, Vol. 2, Tab 2.2, Email Det. Sgt. T Moran (12.03.25) & ts 20.11.25 (Moran), pp145-158
[262] See also: Exhibit 1, Vol. 2, Tabs 2.2.1-2.2.3, Photographs of a disposable cup similar to that used by Mr Ginn
[263] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[264] ts 21.11.25 (Wright), pp178-179
[265] See also: Exhibit 1, Vol. 2, Tab 2.1, Email - Det. Sen. Const. S Leo (09.04.25)
[266] See also: Exhibit 1, Vol. 2, Tabs 2.1.1-2.1.5, Screenshots of CCTV from Cell B4 (10.10.23)
[267] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (8.05 pm - 8.08 pm, 10.10.23)
[268] Exhibit 1, Vol. 2, Tab 2.2, Email Det. Sgt. T Moran (12.03.25)
[269] ts 19.11.25 (Skulley), pp61 & 65 & ts 20.11.25 (Cooper), pp166 & 170
[270] See also: ts 20.11.25 (Kueppers), pp118-119
[271] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (6.22 pm, 10.10.23)

m. Dr Kueppers said that given the levels of cocaine found in Mr Ginn's stomach contents it was unlikely that if he had swallowed packaged cocaine, the packaging would not have been visible either in his stomach or in the first part of his duodenum both of which she inspected during her post mortem examination;[272,273,274]

n. As to whether packaging could have been present in Mr Ginn's small or large bowels, Dr Kuepper said:

> I do not recall whether I opened the small and large bowels along their entire lengths during the post mortem examination, and my examination of these structures is not captured on the video recordings; however, it is not routine practice to open the entire bowel and it seems unlikely I would have done it in this case. There was no indication for it at the time. In hindsight, it would have been useful for completeness. However, in this case I do not believe this to be a big issue as it is unlikely that any packaging would have moved down the (gastrointestinal) tract beyond the parts that were directly visualised, given the time frame.[275]

o. At the inquest Dr Kuepper said it was "*quite unlikely*" that any remnants from cocaine packaging would have moved past the first portion of Mr Ginn's duodenum, however she could not exclude the possibility that this had in fact occurred.[276]

96. After carefully considering all of the available evidence, I have concluded that at some point prior to 6.53 pm on 10 October 2023, Mr Ginn ingested a fatal amount of cocaine. However, I have been unable to make any finding (to the relevant standard) about how and when Mr Ginn ingested a fatal amount of cocaine.

97. For the sake of clarity, I wish to point out that there is **no** evidence that the meat pie Mr Ginn was given at the PWH contained cocaine.[277] In my view, in the absence of any evidence to support this assertion, the allegation is nothing more than unsubstantiated speculation.

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[272] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24) & ts 20.11.25 (Kueppers), pp99-124
[273] Exhibit 1, Vol. 1, Tab 6, Final Toxicology Report (22.11.23)
[274] Exhibit 1, Vol. 1, Tab 9, Email - Dr V Kueppers (13.05.25)
[275] Exhibit 1, Vol. 1, Tab 9, Email - Dr V Kueppers (13.05.25)
[276] ts 20.11.25 (Kueppers), pp109-112
[277] ts 19.11.25 (Skulley), p61; ts 20.11.25 (Cooper), p and see also: ts 20.11.25 (Kueppers), pp118-119

Cause and manner of death[278,279,280,281,282]

98. At the conclusion of her post mortem examination, Dr Kueppers expressed the opinion that the cause of Mr Ginn's death was "*cocaine toxicity*".[283] I adopt Dr Kuepper's opinion, and find Mr Ginn died from complications after he ingested a fatal amount of cocaine.

99. There is no evidence that when Mr Ginn ingested the cocaine which caused his death he intended to take his life, nor is there any evidence of criminality or the involvement of a third party in relation to his death. I therefore find Mr Ginn's death occurred by way of accident.[284,285]

100. While Mr Ginn was detained at the PWH he was either under visual observation, or his movements were being recorded by CCTV cameras. In my opinion, an exhaustive analysis of the CCTV footage from the PWH failed to identify definitive evidence of an "*ingestion event*" during which Mr Ginn consumed a fatal amount of cocaine.[286]

101. If Mr Ginn did consume packaged cocaine prior to his arrest, then it is possible that shortly before his death, the package ruptured inside his stomach, causing the cocaine it contained to enter his bloodstream, leading to his death.[287,288,289,290] However, as Professor Joyce noted:

> Instances of unheralded cocaine toxicity may emerge when packaging, for example condoms swallowed hours or days earlier, rupture in the gut. The absence of observable packaging in the gut at post-mortem examination may not entirely disprove this possibility, but it would be difficult to reconcile ingestion before arrest at 13:02 hr with the content of a ruptured package still being present in the stomach five hours later.[291]…and…

[278] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24) & ts 20.11.25 (Kueppers), pp99-124
[279] Exhibit 1, Vol. 1, Tab 5.1, Post Mortem Report (16.10.23)
[280] Exhibit 1, Vol. 1, Tab 7, Neuropathology Report (23.10.23)
[281] Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24) pp10-11, para 36 & ts 20.11.25 (Joyce), pp124-144
[282] Exhibit 1, Vol. 1, Tab 8.1, Report - Prof. D Joyce (19.01.24)
[283] Exhibit 1, Vol. 1, Tab 5, Supplementary Post Mortem Report (16.05.24), p1
[284] ts 20.11.25 (Moran), p152
[285] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24), pp17 & 18
[286] See also: ts 19.11.25 (Skulley), p67
[287] Exhibit 1, Vol. 1, Tabs 5 & 5.1, Supplementary Post Mortem Report (16.05.24) & Post Mortem Report (16.10.23)
[288] Exhibit 1, Vol. 1, Tabs 8 & 8.1, Reports - Prof. D Joyce (12.01.24 & 19.01.24)
[289] Exhibit 1, Vol. 1, Tabs 8.2 & 8.3, Emails - Prof. D Joyce (16.04.25 & 02.05.25)
[290] Exhibit 1, Vol. 1, Tab 9, Email - Dr V Kueppers (13.05.25)
[291] Exhibit 1, Vol. 1, Tab 8, Report - Prof. D Joyce (12.01.24), p8, para 29

> It would be credible to propose that packaged cocaine was ingested before arrest at 13:02 hr, then followed by breaching of the package around 5 hours later and cocaine poisoning. **There is no specific evidence of any packaging, though, to support this conjecture**.[292] (Emphasis added)

102. In the absence of any definitive evidence of an ingestion event while he was at PWH, the more likely explanation for the mechanism which led to Mr Ginn's death seems to be the rupture of a package of cocaine he had previously swallowed. However, the absence of any packaging in Mr Ginn's stomach or the first part of his duodenum, has meant that I have been unable to make any finding (to the relevant standard) about this issue.

[292] Exhibit 1, Vol. 1, Tab 8.3, Email - Prof. D Joyce (02.05.25)

POLICE INVESTIGATIONS

Homicide Squad investigation[293,294]

103. Detective Senior Constable Leo (Officer Leo) conducted a Homicide Squad investigation into Mr Ginn's death and prepared a report. Having carefully reviewed the available evidence, I agree with Officer's Leo's conclusions that:

> A thorough assessment and investigation by Homicide Squad and (Forensic Field Operations) found no evidence of criminality, and/or third-party involvement that contributed to (Mr Ginn's) death…(Mr Ginn) was located alone inside cell B4 at the PWH whilst in the middle of a violent seizure, which was more than likely instigated by cocaine toxicity.[295]

Internal Affairs Unit investigation[296,297]

104. In accordance with WA Police policy, Officer Wright conducted an IAU investigation of the conduct of the actions of police officers and PAOs who interacted with Mr Ginn on 10 October 2023.[298] The PAOs were tested for illicit drugs and alcohol and all returned negative results.[299,300] Officer Wright did not identify any breaches of policy or legislation by any of the arresting police or PAOs,[301] and I agree with his conclusion that:

> The investigation has determined that the death of (Mr Ginn) was not as a result of any failings by officers of the Gang Crime Squad or Perth Watch House staff and his death was as a result of illicit substances consumed in large quantity by the deceased. (Mr Ginn) was treated in accordance with policy and procedure whilst in custody and during the time of his medical episode the staff provided a swift and appropriate response to provide medical aid to the deceased.[302]

[293] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[294] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25) & ts 21.11.25 (Wright), pp174-194
[295] Exhibit 1, Vol. 1, Tab 2, Report - Det. Sen. Const. S Leo (20.06.24), pp17 & 18
[296] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24)
[297] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25) & ts 21.11.25 (Wright), pp174-194
[298] Exhibit 1, Vol. 3, Tab 1.4, CP-01.00: Critical Incident Involving Police
[299] Exhibit 1, Vol. 3, Tab 1.18, AD-84.06: Employee Alcohol and Drug Testing Guidelines
[300] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25), pp14-15 & ts 21.11.25 (Wright), p175
[301] Exhibit 1, Vol. 3, Tab 1, IAU Report - Det. Sen. Const. B Wright (05.11.25) & ts 21.11.25 (Wright), pp179-186
[302] Exhibit 1, Vol. 1, Tab 36, IAU Report - Det. Sen. Const. B Wright (06.09.24), p11

COMMENTS ON THE ACTIONS OF POLICE

Overview

105. In this section of the finding, I have expressed my conclusions about the conduct of the police officers and PAOs who interacted with Mr Ginn in the hours before he died. My assessment is based on my review of the available evidence, including relevant PWH policies. I have also considered the witness statements (and in some cases the oral evidence) of the police officers and PAOs who interacted with Mr Ginn, and relevant portions of CCTV footage from PWH.

106. As I noted at the beginning of this finding, I have been mindful not to insert any "*hindsight bias*" into my assessment of the actions taken by members of the WA Police.

107. I have also applied the standard of proof set out in the Briginshaw case.[303] As noted, this requires that I must consider the nature and gravity of the relevant conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities.

Police officers who arrested Mr Ginn

108. Mr Ginn voluntarily surrendered himself to police at 1.00 pm on 10 October 2025, having previously arranged to meet police (the Attending Police)[304] at his industrial unit in Gnangara. After Mr Ginn was arrested, he was asked if he had any medical issues (which he denied) and he was offered a medical review, which he declined.

109. Attending Police treated Mr Ginn in a professional and courteous manner, and while the unit was being searched, Mr Ginn was permitted to have a soft drink, and several cigarettes (during which his handcuffs were removed). I am satisfied that the evidence demonstrates that the Attending Police interacted with Mr Ginn in an appropriate manner and that there is no basis to criticise the actions of any of these officers.

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[303] (1938) 60 CLR 336, per Dixon J at pp361-362

[304] That is: Det. Sgt. P Pieri, Sen. Const. J Bull, Det. Sen. Const. C Murray, Det. FC Const. T Eades, Det. Sen. Const. S McHugh & Const. C Otieno

PAOs who interacted with Mr Ginn at PWH

110. I am satisfied that while he was at PWH, Mr Ginn's immediate basic needs (i.e.: food, water, and warmth) were catered for, and at no stage did Mr Ginn raise any medical or other issues which suggested he required any medical attention. Further, there was nothing about Mr Ginn's behaviour at PWH that gave any cause for concern until about 6.38 pm, when he began to show signs of some sort of medical event.

111. I am satisfied that when Mr Ginn was discovered having what appeared to be a seizure at 6.53 pm, the first aid response of the PAOs at the PWH was timely and appropriate. In addition to immediately providing first aid, emergency services were called and the first of three ambulance crews arrived at the PWH at 7.17 pm. All of the PAOs involved in attending to Mr Ginn received first aid training during their initial training at the WA Police Academy, and this qualification was renewed annually.[305,306]

112. After reviewing the available evidence (including PWH policies and relevant portions of the CCTV footage) I am also satisfied that the PAOs who interacted with Mr Ginn following his admission to PWH (Admitting PAOs)[307] acted appropriately.

Cells Control Officer

113. Having carefully reviewed the available evidence, I am satisfied that the Cells Control Officer (CCO) at the relevant time (i.e.: PAO O'Brien) did not observe Mr Ginn's apparent medical event at any time between about 6.38 pm and 6.53 pm, when Mr Ginn was found by PAO Skulley.

114. I accept that PAO O'Brien had responsibility for other tasks and according to her, that 10 October 2023 was "*a busy night*".[308] Nevertheless, according to the relevant policy at the time, as CCO she was responsible for "*continuous observation of CCTV in compliance with standing processes outlined in PWH SOPs*".[309]

[305] ts 19.11.25 (Singh), pp31-32; ts 19.11.25 (Skulley), pp53 & 68 & ts 20.11.25 (Cooper), p159
[306] See also: ts 19.11.25 (Gardiner), p45
[307] That is: PAOs Beresford, Cooper, Embry, Fielder, Gardiner, Ivan, Madden, Skulley, Singh & Vuk
[308] Exhibit 1, Vol. 1, Tab 45, Statement - PAO P O'Brien (09.11.23). paras 8 & 15
[309] Exhibit 1, Vol. 4, Tab 1, Report & Annexures - Insp. D Newman (10.11.25), pp25-26 & 29

115. In that context, it is difficult to understand how Mr Ginn's obvious seizure-like activity escaped the attention of the CCO for over 15 minutes. Nevertheless, that is the sworn evidence of PAO O'Brien.[310]

116. In fairness to whoever is fulfilling the CCO role, I note that in the control room the CCO is required to monitor three large overhead screens which depict the live feeds from CCTV cameras in cells at PWH. The first of these screens displays the live feeds from 12 cells, while the other two screens each display live feeds from 9 cells.[311,312]

117. In my view, given the size of the CCTV live feeds that are displayed on the three large screens, it would be grossly unfair to compare those images with the full screen images of CCTV camera footage from Mr Ginn's cell that are contained in the Brief.

118. Nevertheless, PAO O'Brien said she scanned the three overhead screens at various times after the start of her shift. It is therefore surprising she did not notice anything unusual in Mr Ginn's cell from about 6.38 pm onwards. One possible explanation may be that from 6.30 pm, PAO O'Brien was using the control room computer to record which detainees had accepted the offer of a meat pie for dinner. As noted, in her statement, PAO O'Brien said that when she is using the computer, she is "*too busy to look at the cameras* (i.e.: the CCTV cameras showing detainees in their cells).[313]

119. In my view, this shows that "*multi-tasking*" the CCO is a mistake. I have therefore recommended that the role of the CCO be reviewed, and that WA Police consider splitting the CCO role between two PAOs. One PAO could have sole responsibility for monitoring cell CCTV camera feeds, whilst the other PAO would undertake the ancillary tasks the CCO is currently responsible for. In my view, these two PAOs should regularly swap roles given how exhausting the monitoring CCTV camera feeds would be over the eight or 10 hour shifts now worked by PAOs at the PWH.

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[310] ts 19.11.25 (O'Brien), pp75-83 & 87-94
[311] Exhibit 1, Vol. 4, Tabs 1.17 & 1.18.1-1.18.6, Photos of screens in control showing CCTV camera feeds from PWH cells
[312] Exhibit 1, Vol. 3, Tab 1.9, Surveillance Review Document - PWH (10.10.23)
[313] Exhibit 1, Vol. 1, Tab 45, Statement - PAO P O'Brien (09.11.23), paras 8-16

QUALITY OF SUPERVISION, TREATMENT AND CARE

Overview

120. In this section of the finding, I have set out my conclusions about the quality of the supervision, treatment and care that Mr Ginn received from the time of his arrest at 1.02 pm on 10 October 2023, until he was declared deceased at 8.05 pm the same day.[314]

121. I have been mindful not to insert any "*hindsight bias*" into my assessment of Mr Ginn's supervision, treatment and care. I have also applied the standard of proof set out in the Briginshaw case,[315] meaning that I must consider the nature and gravity of the relevant conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities.

Supervision, treatment and care while under arrest

122. After carefully considering the available evidence, I am satisfied that Mr Ginn received an appropriate standard of supervision, treatment and care in the period from his arrest until he lodged at the PWH. In my opinion, arresting officers treated Mr Ginn in a courteous and professional manner, and he was offered a medical review (which he declined). Mr Ginn was also permitted to have refreshments, and his handcuffs were removed during several cigarette breaks.

Treatment and care at PWH

123. After carefully considering the available evidence, I am satisfied that Mr Ginn received an appropriate standard of treatment and care during the period he was detained at the PWH. PAOs who interacted with Mr Ginn did so in a courteous and professional manner, and the basic and strip searches he was subjected to were conducted in an appropriate manner. Mr Ginn was also provided with food, water and a blanket, and he was segregated and placed in a cell by himself on the basis of his association with the ROMG.[316]

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[314] Sections 3, 22(1)(a), 22(1)(b) and 25(3), *Coroners Act 1996* (WA)
[315] (1938) 60 CLR 336, per Dixon J at pp361-362
[316] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25), p22, para 97

124. Mr Ginn was asked health and welfare questions by PAOs and by Ms Godfrey, and apart from mentioning "*clots*" in his feet, he did not disclose any medical or mental health issues. Mr Ginn also denied he had taken any illicit substances, and he did not display any behaviours which suggested that he required a medical review.

125. When Mr Ginn was eventually discovered having a medical event and apparent seizures, and he received prompt and effective CPR by PAOs, all of whom had appropriate first aid qualifications.[317]

126. Although a registered nurse was not available at the relevant time, for reasons I have explained, I do not consider that this absence caused or contributed to Mr Ginn's death.[318] The effectiveness of the first aid Mr Ginn was given is clear from the fact that a return of spontaneous circulation was achieved. However as noted, Mr Ginn arrested again and despite extensive resuscitation efforts, he could not be revived.[319]

Supervision at PWH

127. After carefully considering the available evidence, I have concluded that the standard of supervision Mr Ginn received while he was detained in Cell B4 at PWH was **poor**. Although I have been unable to make any finding (to the relevant standard) about when and how Mr Ginn ingested the cocaine that caused his death, in my view this is beside the point.

128. The reason I consider the standard of Mr Ginn's supervision while he was detained in Cell B4 at PWH was poor, is because he experienced a medical event (apparently "*status epilepticus*")[320,321] for at least 15 minutes before he was discovered and given first aid by PAOs and ambulance officers.

129. As I have explained, cells at the PWH are fitted with CCTV cameras which are monitored by the CCO, a PAO who is located in a control room. At the time of Mr Ginn's death, the CCO was responsible for:

[317] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25), p28, para 134
[318] See: Exhibit 1, Vol. 1, Tab 10.1, Report - Dr J Stewart (12.06.25), p2, paras 10-11
[319] Exhibit 1, Vol. 1, Tabs 11.1-11.3, St John Ambulance Patient Care Records: 23161359, 23161380 & 23161383 (10.10.23)
[320] Status epilepticus is a medical term used to describe a prolonged seizure
[321] for more detail, see: www.epilepsyfoundation.org.au/understanding-epilepsy/seizures/status-epilepticus/

> [C]arrying out the majority of detainee supervision functions by **continuous observation** of CCTV in compliance with standing processes outlined in PWH SOPs.[322] (Emphasis added)

130. On 12 February 2024, the IAU received correspondence from the Crime and Corruption Commission requesting a report on an allegation that that an unidentified officer (but clearly PAO O'Brien) had breached procedure by not continuously monitoring detainees at the PWH. Officer Wright conducted an investigation and drafted a memorandum in which he stated:

> As detailed in this report it is the opinion of (the investigating officer) that (PAO O'Brien) has not breached policy/procedure as it shows that at the time of the incident, she was positioned in the Cell Control Room as is the requirement. **Further the terminology used in the definition according** (to) **the SOPS of the PWH does not have a literal meaning and it is unreasonable for that officer to maintain continual observations on the CCTV screens as well as being able to perform the other roles and functions that the position demands**. Based on the information provided regarding the wording used, it is the opinion of the investigating officer that Internal Affairs Unit progress this to Operational Support Services business unit for consideration with making amendments to the wording used to describe the role of Cells Control Officer.[323] (Emphasis added)

131. In her first report, Inspector Newman confirmed that the position descriptors for CCO (and other PAO roles at PWH) have been updated. The relevant policy now states that the CCO is responsible for carrying out primary care functions by (amongst other things): "*Observation of CCTV - regularly monitoring persons in custody [detainees] within "A' to "D" block cells and Observation Cells*.[324]

132. The relevant policy also now provides that: "*Updating the* (custody management system) *is a secondary function of this role and should not significantly impact delivery of the primary functions*".[325]

[322] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25), p29, para 136
[323] Exhibit 1, Vol. 1, Tab 36.1, Memorandum - Det. Sen. Const. B Wright (08.01.25), pp2 & 8-9 & ts 20.11.25 (Wright), pp184-185
[324] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25), p35, para 162
[325] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25), p36, para 163

133. Whilst both of these changes were no doubt motivated by a desire to clarify the role of the CCO, in my view both are misguided. There seems to be little point in tasking the CCO to monitor CCTV cameras in cells at the PWH (whether "*continuously*" or "*regularly*") if that officer is (by reason of the pressure of other tasks) unable to detect a detainee having an obvious medical event that continues for at least 15 minutes.

134. While I accept that the CCO is expected to monitor overhead screens showing smaller versions of the live streams from cell CCTV cameras, I find it difficult to understand how Mr Ginn's medical event was not identified before PAO Skulley happened to discover Mr Ginn having an apparent seizure in his cell.

135. If PAO Skulley had not discovered Mr Ginn at 6.53 pm, and arranged immediate first aid, it is unclear whether he would have been observed at any point before his next cell check was due at 7.22 pm.

136. In my view the policy amendments to the role of CCO are misconceived. Rather than being tasked with "*regularly monitoring*" CCTV cameras in PWH (whatever "*regularly*" might mean) as well as a brace of other duties, the sole focus of the CCO should be the monitoring of the CCTV cameras. In my view, the other tasks currently assigned to the CCO should be given to another PAO who should also be located in the control room.

137. In my view it is ludicrous to suggest that a PAO would be capable to monitor CCTV cameras for hours on end, even noting that shift times for PAOs are now eight or 10 hours in length, rather than 12 hours as they were at the relevant time. For that reason, the CCO and the additional PAO (I have suggested be located in the PWH control room) should swap roles regularly during their shifts.

IMPROVEMENTS AT PWH

138. In her first and supplementary reports, Officer Newman outlined a number of improvements that have been implemented at PWH, as well as a number of other proposed changes which are being considered.[326,327]

139. Given the Order I made at the start of the inquest, I do not propose to provide any detail about these improvements and proposed changes. However, some of the improvements and proposed changes may be briefly summarised as follows:

a. *Checklist for death or serious incidents*: changes have been made to ensure that after a death in custody or a serious incident at the PWH, the integrity of the relevant scene is preserved.[328]

b. *Sallyport upgrade*: acoustic barriers have been installed to improve the quality of audio surveillance in this area.

c. *New body scanner*: funding has been approved to upgrade the body scanner at PWH, although the new machine has not yet been purchased.

d. *Advanced life support training*: staff at PWH have been provided with nationally accredited advanced life support training to supplement the "*agency baseline basic first aid training*" they receive.[329]

e. *Nursing services*: additional nurses are now rostered on duty at PWH during peak periods of demand.

f. *Access to EPIC*: nurses at PWH now have access to the Emergency Physician in Charge, allowing "*greater access to clinical escalation, review and services*".[330]

g. *Enhancements to health and welfare screening*: new screening tools have been implemented, and there have been updates to the initial nursing assessment.

[326] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25), pp30-37, paras 137-168
[327] Exhibit 1, Vol. 4, Tab 3, Addendum Report - Insp. D Newman (19.11.25)
[328] See also: Exhibit 1, Vol. 3, Tab 1.23, Death, Life-Threatening Injuries, Self-Harm in Police Custody or Presence
[329] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25), p31, paras 141-143
[330] Exhibit 1, Vol. 4, Tab 1, Report - Insp. D Newman (10.11.25), p33, para 152

h. *Proposed upgrade to the Nurses' station*: a "*concept initiation form*" has been completed to enable the feasibility of infrastructure improvements to be considered.[331]

i. *Proposed 24/7 operation of Northbridge Magistrates Court*: WA Police have asked the Department of Justice to consider expanding the hours of operation of the Northbridge Magistrates Court to "*allow persons in custody to appear before a Magistrate to have bail decisions reviewed/considered at the earliest opportunity*".[332]

j. *Proposed upgrades to monitoring technology at PWH*: various upgrades to monitoring and communication technology used at PWH (including the use of Artificial Intelligence enhancements) have either been implemented or are being actively considered.

k. *Changes to position descriptions*: as noted, the position descriptors for PAO positions at PWH have been updated.

140. In my view, with the exception of the changes to the position description for the CCO role (which I consider to be misguided) the improvements and proposed changes referred to by Officer Newman are appropriate and should enhance the safety of both detainees and staff at the PWH.

[331] Exhibit 1, Vol. 4, Tab 3, Addendum Report - Insp. D Newman (19.11.25), p3
[332] Exhibit 1, Vol. 4, Tab 3, Addendum Report - Insp. D Newman (19.11.25), p3

RECOMMENDATIONS

Recommendation No. 1

To ensure the integrity of any scene relevant to a death or serious incident at the Perth Watch House (PWH), the Western Australia Police Force should ensure that all relevant personnel (including PWH staff, registered nurses employed at PWH, and paramedics who may attend PWH) are aware of the **critical importance** of complying with the checklist in the PWH document entitled "*Death or Serious Incident at PWH - Initial Response*". In particular, all relevant personnel should be reminded of the importance of ensuring all relevant items at the scene are seized for possible analysis.

Recommendation No. 2

The Western Australia Police Force should conduct a review of staffing levels at the Perth Watch House (PWH) to determine whether existing staffing levels are appropriate. In particular, the review should consider whether the number of cells officers allocated to each shift at the PWH is sufficient.

Recommendation No. 3

The Western Australia Police Force should conduct a review of the position of Cells Control Officer (CCO) at the Perth Watch House (PWH) to determine whether it is appropriate for that officer to be responsible for monitoring close circuit TV (CCTV) cameras in cells at PWH as well as various other tasks. The review should consider such issues as:

a. whether one Police Auxiliary Officer (PAO) should be solely responsible for monitoring PWH CCTV cameras;

b. whether an additional PAO should be allocated to the control room and take responsibility for data entry and other tasks currently performed by the CCO; and

c. whether the PAOs referred to in (a) and (b) above should swap roles every two hours, or other suitable interval.

Recommendation No. 4

The Western Australia Police Force (WAPOL) should review procedures for basic searches and strip searches for detainees received by the Perth Watch House (PWH) to determine whether those procedures can be enhanced to improve the likelihood that any items which may be concealed by detainees (including illicit drugs) are located. WAPOL should also ensure that all PWH staff who conduct basic and/or strip searches are familiar with relevant policies.

Recommendation No. 5

To improve the likelihood that any items which may be concealed by detainees (including illicit drugs) are found when detainees are admitted to the Perth Watch House, the Western Australia Police Force should consider if all detainees should be required to pass through a body scanner.

Recommendation No. 6

To enhance the safety and welfare of detainees and staff at the Perth Watch House (PWH), the Western Australia Police Force should review whether the close circuit television (CCTV) cameras and other monitoring equipment used at the PWH could be enhanced. The review should consider options including (but not limited to): multiple CCTV cameras in cells; radar-sensing technology, artificial intelligence technologies (including algorithms to detect unusual detainee behaviour), biometric monitoring systems, and body worn cameras for Police Auxiliary Officers employed at PWH.

Recommendation No. 7

In order to ensure that the welfare of detainees at the Perth Watch House (PWH) is optimised, the Western Australia Police Force should conduct a review to determine whether the number of registered nurses available on each shift at the PWH is sufficient, and whether the current shift length for those nurses (i.e.: 12-hours) is appropriate.

Comments on Recommendations

141. In light of the available evidence (and in particular the evidence of witnesses at the inquest), I concluded that it would be appropriate to make seven recommendations (the Recommendations).

142. Ms Markham (counsel assisting the coroner) emailed a draft of the Recommendations to the lawyers for WAPOL and SJA respectively, and to Mr Emmerton-Ginn. Any comments on the Recommendations was requested by close of business on 16 December 2025.[333]

143. By way of an email dated 4 December 2025, Ms Femia advised that WAPOL supported the Recommendations as drafted.[334]

144. By way of an email dated 12 December 2025, Mr Keays advised that SJA did not have any comments on the proposed Recommendations.[335]

145. No feedback was received from Mr Emerton-Ginn before the close of business on 16 December 2025.

[333] Email - Ms S Markham (24.11.25)
[334] Email - Ms P Femia (State Solicitor's Office) to Ms S Markham, (04.12.25)
[335] Email - Mr P Keays (State Solicitor's Office) to Ms S Markham, (12.12.25)

CONCLUSION

146. Mr Ginn was 50 years of age when he died from cocaine toxicity at the PWH during the evening of 10 October 2023. There is no evidence Mr Ginn ingested cocaine with the intention of taking his life, nor is there any evidence of criminality in relation to his death. I therefore found that Mr Ginn's death occurred by way of accident.

147. Although the cause of Mr Ginn's death (i.e.: cocaine toxicity) is beyond doubt, the mechanism by which he ingested the cocaine that killed him is unclear. On the basis of the available evidence, I was unable to make any findings (to the relevant standard) on this issue.

148. In my view, Mr Ginn was appropriately assessed as a "*general risk*" detainee on his admission to the PWH, and he was the subject of an appropriate number of cell welfare checks. I am satisfied that Mr Ginn did not display any concerning behaviour until about 6.38 pm.

149. At the relevant time, one registered nurse was rostered on duty at the PWH during the day shift (6.00 am to 6.00 pm) and the night shift (6.00 pm to 6.00 am). On the night of Mr Ginn's death, a registered nurse was unavailable because of illness. After carefully considering the available evidence, I was unable to conclude (to the relevant standard) that the absence of a nurse at PWH at the relevant time contributed to Mr Ginn's death, or that had a nurse been present, Mr Ginn's treatment would have been different.

150. Since Mr Ginn's death, two nurses are now rostered on duty at the PWH at busier times, and steps have been taken to recruit additional nurses to increase the pool of available staff in an effort to ensure that all rostered shifts are filled.

151. After carefully considering the available evidence, I concluded that neither the actions of police officers who arrested Mr Ginn on 10 October 2023, nor those who transported him to the PWH caused or contributed to Mr Ginn's death. I reached the same conclusion in relation to the actions of the PAOs who interacted with Mr Ginn during the period he was detained at the PWH.

152. However, the CCO (who at the relevant time was responsible for "*continuously monitoring*" detainees at PWH) failed to notice Mr Ginn's obvious medical event between 6.38 pm and 6.53 pm. As a result, although I was unable to conclude (to the relevant standard) that this failure had caused or contributed to Mr Ginn's death, I found that the standard of supervision Mr Ginn received whilst he was detained at PWH was poor.

153. I have made seven recommendations aimed at improving the safety of detainees at the PWH, which I hope will be enthusiastically embraced.

154. I wish to thank members of Mr Ginn's family for their attendance at the inquest, and I also acknowledge Mr Emmerton-Ginn (Mr Ginn's son) who attended as an interested person and questioned witnesses.[336]

155. Finally, as I did at the conclusion of the inquest, I wish to again convey to Mr Ginn's family and friends, on behalf of the Court, my sincere condolences for your loss.

MAG Jenkin
Coroner

17 December 2025

[336] See: s44(1) of the *Coroners Act 1996* (WA)