

Inspector's Overview

Governance and oversight have improved considerably but there is more work to do

This review was commenced following a direction to me by the Minister for Corrective Services, the Hon. Bill Johnston MLA, under Section 17(2)(b) of the *Inspector of Custodial Services Act 2003* (WA). The objective of the review was to examine the Department of Justice's (the Department's) performance in responding to recommendations that arise from the Western Australian Coroner's inquiries into deaths in custody.

Following my acceptance of the direction, the Minister endorsed the draft terms of reference to examine deaths publicly reported on between 2017 and 2021 to determine the following:

- Does the Department implement recommendations made by the Western Australian Coroner appropriately?
- How effectively does the Department monitor its continued compliance with the recommendations made by the Western Australian Coroner?

In order to answer these questions, we selected a sample of closed recommendations and examined the evidence relied upon by the Department to close them, including looking at any changes implemented and their likely impact on preventing future deaths in custody. The details of these findings are set out in this report.

Overall, we found noticeable improvements in the governance and oversight processes, including independent oversight by the Department's Risk Management and Audit Committee, but there was more work required.

Not surprisingly, we saw significant similarities between the risks, issues and shortfalls identified by various Coroners and those identified during our inspection and review work. Common themes included: the adequacy of mental health services and supports available to prisoners; the availability of clinical and custodial staff resources; the level of appropriate staff training; and significant infrastructure limitations.

From our examination of the individual case studies, it was clear that the Department did not take the coroner's recommendations lightly. But it was hard not to form the view that in several cases the focus was more about closing the outstanding recommendation rather than implementing sustained change in a way that met the spirit and intent of the recommendation.

The Department's response to the draft copy of this report noted many of the concerns we had raised about closed recommendations. The Department also advised that more recently they had amended how they responded to coroner's recommendations. It appears they are now taking a more robust and pragmatic approach to proposed recommendations and their level of support is now balanced against what they feel is achievable and within resource limitations. They said they are also willing to proactively seek additional resources to address coroner's recommendations.

Unnatural deaths in custody are an absolute tragedy that have far reaching impacts for everyone involved, but none more so than for the families of those who pass. It is imperative that every preventative measure that is reasonably possible should be supported and implemented. Equally important is to ensure that preventative measures have a front-line impact and that adequate steps are in place to monitor and sustain those changes.

One unnatural death in custody is one too many, but one that could have been foreseen and prevented is entirely unacceptable.

Acknowledgements

It is important to acknowledge the contribution and assistance we received in undertaking this review from key personnel in the Department and at Serco, the private operator of Acacia Prison.

I acknowledge the contribution and hard work of the staff in our office who were involved in undertaking this review. I would particularly acknowledge and thank Cherie O'Connor for her hard work in leading this review and as principal drafter of this report.

Eamon Ryan
Inspector of Custodial Services

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