MEDIA RELEASE

EMBARGOED UNTIL 12 NOON ON 17 APRIL 2023

Directed Review into the Department of Justice's performance in responding to recommendations arising from coronial inquiries into deaths in custody

This review was commenced following a direction to the Inspector of Custodial Services 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).

Despite making noticeable improvements in governance and internal oversight practices, a report released today by Inspector of Custodial Services, Eamon Ryan, found the Department of Justice (the Department) was often prematurely closing coronial recommendations without fully addressing the spirit and intent of the recommendation.

Between 2017 and 2021, the Coroner's Court made 35 formal recommendations to the Department following 13 inquests into the deaths of 17 prisoners in custody. The report examined the Department's closure evidence for 10 of these recommendations and assessed how changes implemented may help prevent future deaths. Mr Ryan found that, in several cases, the Department's focus was more about closing recommendations than implementing effective change on the ground:

> While I feel the Department takes seriously its responsibility to prevent future deaths in custody, it was disheartening to find many recommendations were closed with little evidence of any meaningful change to practices. We found this was the case across a range of issues, including additional mental health resources, reducing ligature points across prison infrastructure, and providing staff with sufficient training.

Many coronial recommendations related to improving the quality of mental health care provided to prisoners. This focus did not come as a surprise. In December 2022, nearly 12 per cent of adult prisoners and young people in detention were assessed as having a psychiatric condition or requiring further assessment for a suspected psychiatric condition. Mr Ryan said:

> My Office has long reported that mental health services for prisoners in crisis or with acute needs was inadequate and often inaccessible. This report confirms that, despite several coronial recommendations, mental health services in prisons remain under-resourced. Custodial staff are not adequately trained in mental health care and clinical staff are under significant pressure. However, the Department has made improvements to their triage system and has improved information sharing across health staff.

Just over one third of all deaths in prison custody between 2000 and 2021 were people identifying as Aboriginal. Noting the recent anniversary of the Royal Commission into Aboriginal Deaths in Custody, and the many outstanding recommendations of that report, Mr Ryan said:

> 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 be supported and implemented by government to help prevent future deaths in custody.

> One unnatural death in custody is one too many, but one that could have been foreseen and prevented is entirely unacceptable.
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> With this in mind, it was disappointing to find many vacancies in the Aboriginal Visitor Scheme (AVS) and in Prison Support Officer (PSO) positions. These support-based roles were created in response to the Royal Commission into Aboriginal Deaths in Custody to help prevent self-harm and suicide. The Department must ensure that AVS and PSO positions are filled across the prison estate if its role in preventing future deaths is to succeed.

Mr Ryan welcomed that the Department, in response to this review, shared many of the concerns raised in the report and had recently changed their approach to responding to coroner's recommendations. He noted:

> The Department now takes a more pragmatic approach to coronial recommendations. The level of support for each recommendation now reflects a more balanced assessment of what they feel is achievable within their existing resources or through additional resources they may be able to secure.

The Department supported 11 of the 14 recommendations made in the report and noted they would perform a one-off audit of all closed recommendations, including those previously audited.

Eamon Ryan
Inspector

For Further Media Information

The Inspector, Mr Eamon Ryan, will be available for comment from 12 noon on 17 April 2023 and can be contacted on 0421 480 925.

The full report will be available on the Inspector's website (www.oics.wa.gov.au).