**2025**

# THE LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

## TABLING STATEMENT

## INQUESTS INTO THE DEATH OF LUKE ANTHONY RICH – GOVERNMENT RESPONSE

**Presented by**
**Marisa Paterson MLA**
**Minister for Corrections**
**February 2025**

Mister Speaker

I welcome the ACT Coroner Court's report titled *Inquest into the death of Luke Anthony Rich* (Coroner's Report), and the ACT Custodial Inspector (the Inspector) report titled *Death in Custody at the Alexander Maconochie Centre on 1 February 2022* (Inspector's Report).

Mr Rich sadly passed away at the Alexander Maconochie Centre while accommodated in the Management Unit and I would like firstly to extend my sympathies to Mr Rich's family and friends.

Luke was 27 years old at the time of his death. He was born on 15 October 1994, in Gosford NSW. He left behind three siblings - two brothers and a sister. Prior to his passing, Luke was working as a site foreman at a construction company, and he was described by family and friends as a hard worker.

The Coroner's Report found that, while Mr Rich's suicide could not have reliably been predicted, failures in the care and supervision of Mr Rich contributed to his death.

Similarly, the Inspector found that while the apparent suicide of Mr Rich was not reasonably foreseeable by ACT Corrective Services (Corrective Services), the potential for actual or attempted suicide through the method employed by Mr Rich had previously been identified.

The ACT Government has reviewed both reports and carefully considered their findings and recommendations.

The Coroner's Report provided 19 findings and 3 recommendations. The ACT Government notes the Coroner's findings and I am pleased to announce that the ACT Government agrees to all three recommendations.

The Inspector's Report contained 11 findings and 5 recommendations, and I would like to take this opportunity to report on the work that the ACT Government has commenced or completed in relation to these matters.

First and foremost, Corrective Services has been progressing the development of a Suicide Prevention Framework (Framework). The Framework is well-progressed and expected to be released by 31 March 2025.

The Government is committed to ensuring the wellbeing of detainees and recognises the need for suicide prevention as a shared responsibility for all staff in both custodial and community correctional environments.

The second recommendation outlined in the coroner's report was in relation to publishing guidance to staff on the requirement and process for undertaking detainee observations. I note that the coroner's recommendation regarding detainee observations was also identified in a recent report by the ACT Integrity Commission titled Investigation Report – Operation Falcon – Alexander Maconochie Centre, which found that a correctional officer failed to conduct mandatory medical observations of a detainee and falsified records on 16 October 2020.

A new *Detainee Observations Operating Procedure 2024* was notified on 30 October 2024 to facilitate improvements to detainee observations. This included updates to the Observation Forms and guidance provided to staff.

Furthermore, correctional officers are now personally issued with Intervention Hoffman knives to further improve responses to suicide-incidents.

Finally, the Code Blue Triple Zero Checklist, which addresses processes relating to calling ambulance services to the Alexander Maconochie Centre, was implemented in September 2024.

Upgrades to the Management Unit's rear cell doors to address the risks associated with Mr Rich's death were completed on 31 May 2022, and a process is underway to scope and commission a further review to assess the safety of the rear doors in the Management Unit in light of the evidence in the inquest. Corrective Services will make this review public to the greatest extent possible, subject to operational sensitivities as well as safety and security considerations.

As you will note, the ACT Government is in strong agreement with the recommendations provided and has proactively taken steps to realise improvements for detainees and staff.

More broadly, reviews of critical incidents by independent agencies ensures policy, procedures and legislation promote best correctional practice, and support transparency with the public around such incidents.

*Conclusion*

In conclusion, I would note my appreciation to the Coroner and Inspector in providing their reviews and assisting the ACT Government to identify and address issues which are key to ensuring the health and wellbeing of detainees. The work done by both the Coroner and Inspector is crucial to building and maintaining public confidence in the ACT's correctional system, and ensuring the continuous improvement of the correctional services provided to our community, including for staff and detainees.

ENDS