2025

THE LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

INQUEST INTO THE DEATH OF LUKE ANTHONY RICH
GOVERNMENT RESPONSE

Presented by
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February 2025

INTRODUCTION

The ACT Government welcomes the report from the Coroner's Court of the Australian Capital Territory ('the Coroner') titled *Inquest into the death of Luke Anthony Rich* ('the Coroner's Report'), which was provided to the ACT government pursuant to section 57 of the *Coroners Act 1997* on 22 August 2024. The Coroner's Report included findings as well as recommendations about matters of public safety.

Section 57(4) of the *Coroners Act 1997* states that "If a report under this section contains comments or recommendations about a matter of public safety, or findings about a risk to public safety, the Attorney-General or another Minister must —

(a) present the report to the Legislative Assembly not later than the first sitting week after the end of 6 months after the day the Attorney-General receives the report; and
(b) present a response to the report on the same day the report is presented to the Legislative Assembly.

The Coroner's Report makes three recommendations. The ACT Government has carefully considered these and:

- Agreed to all three recommendations.

A table summarising the ACT Government response to these recommendations, including proposed actions and timeframes for completion, can be found at Annexure 1.

In addition, the ACT Government welcomes the related report from the ACT Custodial Inspector ('the Inspector') – formerly known as the Inspector of Correctional Services – titled *Death in custody at the Alexander Maconochie Centre on 1 February 2022* ('the Inspector's Report'), which was tabled in the Legislative Assembly on 3 August 2022.

In order not to interfere with the coronial process, the ACT Government was unable to comment on the Inspector's Report while the inquest took place, however is pleased to provide updates to the recommendations made in the Inspector's Report as part of this Government Response.

CORONER'S REPORT

The Coroner's Report describes the circumstances surrounding the death of Mr Luke Anthony Rich, who passed away at the Alexander Maconochie Centre ('AMC') on 1 February 2022.

The Coroner's Report found that, while Mr Rich's suicide could not reliably have been predicted, failures in the care and supervision of Mr Rich contributed to his death. These included inadequate observations and staff numbers on the day, reliance on CCTV observations, a poor observation recording process, the absence of a Hoffman knife that could have assisted in removing Mr Rich from the ligature, and the failure to address issues with the rear cell doors of the Management Unit which included a potential ligature point.

The Coroner's Report made a total of three recommendations and ACTCS have progressed all agreed recommendations in the report. The following summarises progress to date.

The ACT Government agrees to *Recommendation A* that published guidance on the conduct of observations be developed for staff. Following extensive consultation, ACTCS notified a new *Detainee Observations Operating Procedure* on 31 October 2024, which provides detailed instructions to staff on conducting and recording effective observations of detainees. It is noted 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.

The ACT Government agrees to *Recommendation B* to address the dangers represented by rear cell doors of the Management Unit. ACTCS will seek to engage an external consultant to conduct a review consistent with the Coroner's recommendation by 30 June 2025.

The ACT Government agrees to *Recommendation C* that a Suicide Prevention Framework be developed as a priority. Development of a Suicide Prevention Framework is well-progressed, being informed in part by the equivalent Victorian Government framework. The ACTCS framework is expected to be finalised by the end of March 2025.

INSPECTOR'S REPORT

The Inspector's Report similarly describes the circumstances surrounding Mr Rich's death.

The Report concludes that while the apparent suicide of Detainee A (Mr Rich) as an individual was not reasonably foreseeable by ACTCS, the potential for actual or attempted suicide through use of the potential ligature point had been known by ACTCS since 2015.

Among the Report's findings are that while mental health assessments appear thorough, ACTCS's induction assessment of Mr Rich contained factual errors. It also found that no in-person observations occurred at 5:00pm on the day despite being signed off as occurring, and that no case note was recorded on the ACTCS electronic system of a 2020 Management Unit incident where an Indigenous detainee attempted suicide using the back door of the cell.

The Inspector's Report made a total of five recommendations and the following summarises progress to date.

In relation to *Recommendation 1* that written guidance be developed relating to the calling of ambulances to the AMC, ACTCS' *Code Blue Triple Zero Checklist* was developed in consultation with the ACT Ambulance Service, Canberra Health Services, MHJHADS and selected senior custodial staff, and implemented in September 2024.

In relation to *Recommendation 2* that action be taken to address foreseeable risks associated with rear cell doors at AMC, upgrades to the rear cell doors of the Management Unit at the AMC were completed on 31 May 2022, reducing the risk of the horizontal bars being used as ligature points.

As noted above, development of a Suicide Prevention Framework (*Recommendation 3*) is well-progressed and expected to be finalised by the end of March 2025.

In relation to *Recommendation 4* that guidance for operations of the COVID-19 unit be developed to ensure the least restrictive environment possible in the circumstances, ACTCS custodial practice is guided by Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS) and is consistent with the community standard.

Finally, in relation to *Recommendation 5* that each Correctional Officer is issued a Hoffman knife at the start of their shift, ACTCS implemented an *Intervention (Hoffman) Knife Operating Procedur*e in November 2023. This procedure formalises arrangements for the issuing of Intervention Hoffman knives and establishing appropriate recordkeeping and reporting.

Conclusion

The ACT Government welcomes this opportunity to respond the Coroner's Report and provide updates in relation to recommendations in the Inspector's Report. These recommendations, which have either already been addressed or are currently being completed, contribute to the continuous improvement of safety and wellbeing of detainees, which is paramount to the ACT Government.

Annexure 1

ACT Government Response to Coroner's Recommendations

Recommendation	Government Response	Implementation timeframe
Recommendation A: Observations I recommend that ACTCS publish guidance to staff, pursuant to s 14 of the Corrections Management Act 2007 (ACT), that addresses, in light of the findings of this inquest: a) the purposes of detainee observations; b) how observations are to be recorded; c) the role that CCTV is to play in the observation process; and d) what is to be done when cameras are intentionally covered by detainees.	Agreed. The Government acknowledges the scope for increasing the quality and utility of detainee observations and the need to make related guidance available to staff. Pursuant to that, a new *Detainee Observations Operating Procedure 2024* was notified on 31 October 2024, which addresses each concern identified by the Coroner, i.e. the purpose of detainee observations, how observations are to be recorded, the role that CCTV is to play in the observation process, and what is to be done when cameras are intentionally covered by detainees. The procedure is accessible on the ACT Legislation Register. ACTCS closed this recommendation on 11 November 2024.	Completed
Recommendation B: **Dangers represented by Rear Cell doors of the Management Unit** I recommend that: a) external consultants be engaged to assess the safety of the rear doors in the Management Unit in light of the evidence in this inquest; and b) the outcome of that review be published.	Agreed. The Government acknowledges the need to ensure that all identified risks associated with the rear doors of the Management Unit cells are reviewed and appropriately addressed. To that end, ACT Corrective Services (ACTCS) is in the process of scoping a review consistent with the Coroner's recommendation and will seek to engage an external consultant to conduct this review within the specified timeframe. ACTCS will make the outcomes of the review public to the greatest extent possible.	30 June 2025
Recommendation C: **The Absence of a Suicide Prevention Strategy** I recommend that: a) a Suicide Prevention Framework for ACTCS be developed as a priority; b) it gives expression to the need for suicide prevention to be accepted as a shared responsibility at the AMC;	Agreed. 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. ACT Corrective Service (ACTCS) has been progressing the development of a Suicide Prevention Framework (the Framework) informed in part by the equivalent Victorian Government framework. ACTCS will engage with its Victorian counterpart for further insights into	31 March 2025

Recommendation	Government Response	Implementation timeframe
c) the terms of the Victorian Framework be considered in that process; and d) an attempt be made as to assess the efficacy of the introduction of the Framework in the Victorian Prison system and reflect those learnings in the process of developing the framework document to apply at the AMC.	the framework and its implementation, including any assessments of its effectiveness and how ACTCS can access the outcomes for that work. Development of the Framework is well progressed and expected to be completed and released by 31 March 2025.	