Deaths in custody (prison, youth detention) since 1996 in the ACT (last updated July 2026)

Date of death	Gender	Indigenous Status	Age	Cause of death	Specifics of death	Type of custody	Remand/Sentenced	Coronial Finding Date	Location	Recommends Made?	Government response	OICS Review
13/06/1996	Male	Not specified	17	Suicide	Hanging	Youth detention (Quamby)	Remand	28/06/1999	Hospital (injuries sustained in youth detention)	1. An inquiry into the problems caused by the dynamics and mixing of the children resident at Quamby 2. Construction of a 'proper facility' which young people involved in the criminal justice system with mental health or behavioural problems are able to be detained under proper medical supervision 3. There be only one governmental division responsible for all administration of Corrections within the Territory. 4. The role of Director be changed in such a way as to ensure that it is not occupied by a person who has an active day to day role in the management of Quamby 5. The abolition of the present system of on call managers and would recommend that it be replaced by a system suggested in the Stevenson Report of paying the actual manager a special allowance to be on call at all times. 6. Review of all policies and procedures 7. Change to the policy relating to the availability of keys to workers particularly on the night shift at Quamby 8. A review and change to the policy relating to access to units by individual workers. Commensurate with interests of safety and security of the residents it is essential that a single worker be able to access immediately a unit when there is an emergency situation 9. Require a full and complete inspection and search of any unit in which an incident of self-harm has occurred and there be a full report in substantial detail provided by any workers involved in such an incident.	The Government tabled its response on 24 August 1999, accepting the recommendations of the Coroner including that recommendation 1 and 3 be referred to a separate inquiry. In 2001, a Legislative Assembly Committee examined the Government response to Recommendations 1 and 3. That Committee made various recommendations regarding the former Quamby youth detention centre. In 2008, the ACT established a new youth detention centre – Bimberi.	No

Last updated: 02/11/2026

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										10. Review of the administrative procedures relating to file keeping particularly in relation to individual young people maintained at Quamby so that all information relating to an individual is maintained in the one file. 11. Careful consideration be given to the role of the control room log book and the special observation book. Workers must understand the role of those books and the necessity for them to be accurately and honestly completed. 12. Policy provide for a formal shift handover. 13. Development of a protocol between the Mental Health Crisis Team and the administration of Quamby to ensure that all information obtained by members of the Mental Health Crisis Team concerning the circumstances of a person residing at Quamby who has engaged in conduct that required the attendance of the Mental Health Crisis Team is to be passed on in full to the relevant authorities at Quamby.		
12/7/2008	Female	No	44	Suicide	Hanging	Court Transport Unit	Remand	27/03/2009	Hospital (injuries sustained in secure transport vehicle)	1. I recommend that where an agency presents a person in custody for an assessment of his or her mental state more than once in a 24 hour period that patient must be seen by a Psychiatric Registrar 2. I am of the view that the deficiencies in the protocols, practices and procedures for dealing with persons held in custody contributed to the unfortunate death. During this hearing I took what has been described as *"an unusual step"* of inviting the Director of Public Prosecutions for the ACT to act as a facilitator between agencies in an endeavour to	The Coroner notes in his findings that 'I formed the view that in the interests of the protection of Prisoners At Risk these amended procedures, practices and protocols should be implemented as soon as practicably possible and that is why the Director was asked to facilitate this task whilst the hearing was on foot, rather than following the handing down of my findings and comments. In answer to a Question on Notice on 17 September 2009, the Minister for Corrections stated: 'ACT Corrective Services has completed their response to the Coroner's findings into the death in custody in 2008. This response has been forwarded to the Coroner. ACT Corrective Services' actions in relation to recommendations made by the Coroner are outlined in the response to the Coroner. The issues identified by the Coroner had been addressed by ACT Corrective Services by the	

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										implement agreed procedures and protocols between relevant agencies for the safety of persons in custody deemed *"at risk"* I agree that the deficiencies in information sharing between the agencies were regrettable and sustained efforts must be made to eliminate them through protocols and mutually agreed practices and procedures. Ongoing training and supervision must become a part of this process to eliminate complacency and inappropriate deviation from these practices and procedures and to provide an opportunity to review and update them. I recommend that the agencies which have met with the Director of Public Prosecutions meet regularly in a spirit of mutual co-operation to review and revise the agreed protocols and procedures. 3. The Custodial Officers should have been advised of the prisoner's sustained threats of suicide to members of the AFP during her time in custody with that agency. I recommend that persons whose files are specifically marked *"Prisoner At Risk"* be afforded access to the Court Liaison Officer from Forensic Services for Mental Health ACT. This should take place as soon as is practicable after the prisoner is transported from the Police cells to the Court cells. Priority should be also given to access to legal advice to the prisoner. The Prosecution should then be advised of the custody of the prisoner so that he or she can advise the Court and arrangements made to have	time the formal findings were handed down, and the recommendations had already been implemented or were in the process of being implemented.'	

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										priority given to that matter. This practice will, of necessity, depend on the co-operation of both Mental Health ACT and the Legal Aid Office.		
16/07/2013	Male	Not specified	30	Suicide	Hanging	Prison	Remand	18/12/2015	Prison (AMC)	The findings do not appear to be publicly available. The 2015/16 Coroners Court Annual Report notes: "In my findings I have made references to a number of matters concerning policy and procedure in place at the AMC at the time that were raised at the hearing particularly by Professor Ogloff. I make no formal finding as to those matters. Clearly procedures concerning the management of mentally ill offenders were undergoing significant change at the time of [MP]'s death. However, as noted above, it is beyond the scope of this Inquest to make findings as to those changes and the effectiveness of the implementation. I recommend that ACT Corrective Services engage a suitably qualified expert to provide a report to the Attorney-General as to the effectiveness of changes to practice and procedures relating to the management of "at risk" detainees that have been made since October 2012, and to report on the implementation of the recommendations made in the internal review into [MP]'s death."	The 2015/16 Coroners Court Annual Report notes: "A letter was received from the Minister for Corrections in relation to the inquest into the death of MP (CD 181 of 2013), dated 22 July 2016, attaching the ACTCS response to the Coroner's findings. The letter advised that ACTCS has acted promptly on the Coroner's recommendation and engaged Professor James Ogloff to undertake a review of the effectiveness as to changes to practices and procedures, and to report on the implementation of the recommendations of the internal review. A copy of Professor Ogloff's report was included. The letter went on to say, "[w]hile the report found that ACTCS complies with international standards of best practice, it also made 10 recommendations for further improvement". The letter also enclosed a report outlining the progress made against the Professor's recommendations. Additionally, a letter was received from the Minister for Health in relation to the inquest into the death of MP (CD 181 of 2013), dated 23 February 2016, acknowledging the coronial report and stating "ACT Health has a collaborative working relationship with the Justice and Community Safety Directorate and will continue to work in an integrated manner in the provision of health services to detainees"."	No
27/05/2016	Male	Aboriginal and/or Torres Strait Islander	25	Other	Drug overdose	Prison	Remand	11/04/2018	Prison (AMC)	1. The ACT Government should review the then existing practices and to remove inconsistencies in policies and procedures relied upon by correctional services officers so as to ensure prisoner safety and welfare checks through musters and headcounts which require eye contact and facial recognition to be complied with. The extent of compliance with those procedures, given their purpose is to ensure the safety and well-being of a detainee, should be evaluated	Government response tabled on 23 August 2018 1. Agreed. A review of the existing policy and procedures in relation to 'Detainee roll check' is currently in progress. ACTCS agrees and is committed to ensuring that any policy or procedure developed in relation to detainee roll call checks includes a requirement of eye contact and/or facial recognition of a detainee. 2. Agreed in principle. ACTCS encourages detainees to maintain or improve their physical fitness while in custody. Subject to security classifications and operational requirements, detainees at the AMC have access to outdoor gym equipment stations, basketball courts, a multipurpose recreational facility, as well as an outdoor	No. But see 'So Much Sadness in our lives' review by Philip Moss.

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										and tested periodically to ensure they are effective and practical and minimise complacency through their routine application 2. The ACT Government should consider the viability or effectiveness that a daily structured compulsory physical education and training session might have on a prisoner focusing on the prisoner's well-being and rehabilitation coupled with drug rehabilitation counselling. Any consideration of such a course would need, I acknowledge, to be factored into current alcohol and drug support programs within the AMC and the various sentencing periods for detainees. 3. The ACT Government should ensure that minimising the infiltration of illicit substances into custodial facilities remains at the forefront of screening technology. 4. ACT Health should consider obtaining either by consent from a prisoner or through reliance on legislation, a prisoner's medical records and all relevant reports from alcohol and drug perspective created prior to incarceration for incorporating into a detainee electronic medical file for the purposes of an AMC induction or prior to any assessment for access to pharmacotherapy treatment. Further, for detainees who are placed onto pharmacotherapy programs, such as the MMP, that in the interest of the health and safety of the detainee and his or her wellbeing, information of this type should be shared	recreation and sporting area. ACTCS is unable to agree to the recommendation entirely as the Corrections Management Act 2007 does not support the introduction of compulsory physical education or training sessions. As part of the AMC's operating philosophy, ACTCS is embedding a structured day for all detainees. The structured day will improve the delivery of programs, employment and constructive activity at the AMC. The structured day will include dedicated time for physical activity and recreation. 3. Agreed. ACTCS has an existing Contraband Reduction Plan that details the activities adopted to reduce the infiltration of illicit substances into the AMC. Strategies include intelligence processes to identify and target areas of exposure, staff and visitor searching regimes, control and registration of items entering the AMC, the use of detection dogs and regular perimeter patrols and checks. The use of screening technology, such as closed-circuit television (CCTV), x-ray, metal detection and electronic identification equipment, is a critical component of the plan. Further, a significant upgrade to CCTV capabilities at the AMC has been completed to enhance monitoring capability across the centre. ACTCS also works closely with ACT Policing to prevent the introduction of contraband at the AMC. A memorandum of understanding between ACTCS and ACT Policing has strengthened arrangements for the exchange of information and intelligence. A broader contraband strategy that will enhance current measures for the prevention of contraband introductions is being finalised by ACTCS. Proactive activities have commenced and have already proven to be successful. In the 2016-17 financial year, corrections officers undertook more than 7,000 searches and detected more than 700 items of contraband. 4. Agreed. In November 2017, ACT Health rolled out an integrated electronic clinical record system across Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS). This system has	

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										with ACT Corrective Services conducting prisoner headcounts and musters for the very purpose of determining a detainee's location, safety and well-being. Equally, any independent urinalysis results undertaken by ACTCS should be placed on the detainee's medical record to enable medical staff to have a complete picture of the detainee's use of illicit substances compared to those substances, if any, prescribed through the Hume Medical Centre. 5. The ACT SOP's should be reviewed and the focus should be on prescribing individualised treatment setting out the parameters for commencement doses of Methadone for instance be anywhere from 5 to 20 mg with the ability to increase daily on medical review only. 6. The SOP should be reviewed to ensure that those who have only recently commenced on the Methadone program not be allowed to self-prescribe increases for a set period of time to ensure they are in a physiological sense, capable of accommodating the increased amount of Methadone. Further and in the alternative, the ACT Government should consider whether not it is even appropriate to allow such increases to occur for a Schedule 8 drug 7. ACT Justice Health Services to consider whether or not adopting the National Guidelines to replace the ACTOMTG and incorporating random urinalysis or blood	improved access to clinical information between health services to support and enhance detainee continuity of care. 5 Further, since November 2017, Justice Health Services (JHS) staff have been able to access Court Alcohol and Drug Assessment Services (CADAS) reports prepared by ACT Health's Alcohol and Drug Service electronically through the integrated electronic clinical record system. JHS also requests previous medical histories from other health providers through established release of information processes. The information requested by JHS may include the detainee's previous drug and alcohol history, psychosocial histories on opioid dependence, Opioid Replacement Therapy (ORT) program history, substance use history, current and previous dosing histories and a detainee's prior history of compliance, successes and barriers to previous ORT pharmacotherapies in the community. As part of the ACT Government's commitment to the Moss Review recommendations, in November 2017, a high-level arrangement was developed and implemented to support the sharing of information between ACT Health and ACTCS. Information-sharing between the agencies has improved by: a. The provision of formal notification to ACTCS by ACT Health, by way of a Health Notification Form, when a detainee has commenced opioid replacement treatment. b. ACT Health access to ACTCS' Urinalysis Drug Screening (UDS) reports through ACTCS' Custodial Information System. Further schedules to the arrangement will be developed to support collaborative working and information sharing arrangements between ACT Health and ACTCS. 5. Agreed in principle. A number of actions have been taken by Justice Health that address the substance of this recommendation. JHS' Clinical Procedure, Canberra Hospital and Health Services Opioid Replacement Treatment – Justice Health Services was implemented in	

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										tests where there is no objective medical history of opioid dependence prior to placement on to the MMP	August 2017 and is aligned with the National Guidelines for Medication-Assisted Treatment of Opioid Dependence 2014 (the National Guidelines). The JHS clinical procedure outlines the general recommended therapeutic minimum dose to commence a person on to manage opioid dependence, which is 20-30 mg daily. In addition, the JHS clinical procedure and the National Guidelines recognise that there may be some clinical assessments where a lower dose needs to be prescribed. Further, as a part of the principle of individualised prescribing, a detainee may request to increase or decrease their dose of methadone. These parameters are individually discussed with each person at the time of prescribing and may be reviewed by a medical officer. Dose adjustments are not to 6 occur for three to five days from the commencement of treatment, as the patient will experience increasing effects from the methadone each day, particularly when first commenced on methadone. 6. Agreed in principle. The JHS Clinical Procedure outlines the process that allows for a prescription of methadone to incorporate a determined sliding scale of clinically appropriate dosing ranges every three to five days. This is done in consultation with the detainee and takes into consideration the detainee's Alcohol and Other Drug assessment, while also keeping within the National Guidelines. The National Guidelines endorse the practice of patient input into treatment decisions, including the determination of dosing levels. The recognised practice of allowing increases to a detainee's methadone dosage, is not a process for a detainee to self-prescribe methadone. While the sliding scale of a clinically appropriate dosing range increase enables the titration of the methadone dose to achieve an appropriate and individualised dosage regime, the prescribed dose of methadone is determined on clinical assessment and with clinical oversight. 7. Agreed. The JHS Clinical Procedure is aligned with the National Guidelines and documents the process for the assessment	

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											and management of ORT at the AMC. The JHS Clinical Procedure acknowledges the benefits of improving the process of assessment for suitability for the ORT program. Urine screening is to be considered by medical officers when inducting a detainee onto the ORT program. The JHS Clinical Procedure recognizes that, while random UDS are helpful in determining opioid dependency, they are not considered the only measure of opioid dependence. Medical, alcohol and other drug, psychiatric and psychosocial histories are also integral components 7 of assessing opioid dependence. The determination of the utility of urine screening or blood tests as a measure of opioid dependence is at the discretion of the medical officer and will continue to be considered in conjunction with clinical assessment and collateral information.	
13/5/2017	Male	Not specified	Not specified	Other	Drug overdose	Prison	Sentenced	26/06/2019	Prison (AMC)	No formal recs. Coroner noted "that the submissions made on behalf of the Territory contains an undertaking by the Territory that it would undertake a review into the practice of detainees passing items through cell doors" "I also note that the issue of drugs entering and circulating within the AMC has been touched upon by other inquiries. I will therefore only note the issue, and leave it to the Executive to investigate and manage further."	A brief prepared for the Minister for Corrections in 2019 noted: "An Internal Management Review was conducted by ACTCS into the death of Mr O'Connor and four recommendations were made"	n/a
1/2/2022	Male	Not specified	Not specified	Suicide	Hanging	Prison	Remand	22/08/24	Prison (AMC)	1. 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.	Government response tabled 6/2/2025, which included the Government's response to the report of the ACT Custodial Inspector. Recommendation 1: 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	Yes: Death in Custody ACT AMC on 1 February 2022 See also: ACTIC Operational Falcon

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										(b) Dangers represented by Rear Cell doors of the Management Unit. 2. (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. (c) The Absence of a Suicide Prevention Strategy 3. (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 shared responsibility at the AMC; (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.	detainees. The procedure is accessible on the ACT Legislation Register. ACTCS closed this recommendation on 11 November 2024 Recommendation 2: 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. Recommendation 3: 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 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	
26/02/23	Male	No	34	Suicide	Hanging	Prison	Remand	23 October 2026	Prison (AMC)	1) Canberra Health Services take the steps necessary to extend the operation of MHCALS to all days on which bail hearings are held, including weekends and public holidays 2) ACTCS extend the system that applies in SCC North, whereby razors are handed out to detainees by Corrections officers and then signed back in, when they have been used, to SCC West 3) (a) Correctional Officers in each unit conduct and document spot checks on the system for storing mops and brooms and recording their use by detainees to ensure that such items are not being retained by detainees for	TBA	Yes (pending)

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										purposes other than cleaning their cells. (b) The Deputy Commissioner Custodial Operations take such steps as are necessary to revise the Corrections Management (Searching – Cell Infrastructure Checks) Operating Procedure so that it provides that: (i) in performing such a cell infrastructure check, corrections officers are required to enter a cell to undertake the visual check; and (ii) excess property for the purpose of that operating procedure, includes items that are available to detainees within the AMC but are not being used for their intended purpose, such as broom or mop handles.		
December 2023	Male		51				Remand	Pending				
12/7/24	Male	No	93	Complications of squamous carcinoma of the scalp	Death due to a natural disease that was likely present prior to his time in custody and progressed over time while in custody.	Prison	Sentenced	26 May 2026	Hospice	None	n/a	No
31/07/24	Male		35			Prison		Pending				
29/08/24	Male		34			Prison		Pending				
12/02/25	Male		73				Remand	Pending	Hospital			
17/02/25	Male		38			Prison		Pending	Prison (AMC)			

For more information on deaths in custody across Australia see the University of Queensland Deaths in Custody project

And the Australian Institute of Criminology's Deaths in Custody dashboard.

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