ICS
ACT Inspector of Correctional Services

MEDIA RELEASE

3 August 2022

Tragic death in custody of a young man at the AMC raises serious concerns about detainee safety

The ACT Inspector of Correctional Services tabled a Critical Incident Review of a death in custody at the Alexander Maconochie Centre (AMC) on 1 February 2022 in the ACT Legislative Assembly today.

A male detainee in his 20s (Detainee A)[1] was found deceased in a cell in the AMC Management Unit at about 7pm on 1 February 2022. The Management Unit at the time was being used as a COVID-19 isolation unit for all new receptions to the AMC. The detainee had been admitted into custody at the AMC at about 3:30pm on 31 January 2022, just 27 hours before his death.

"Detainee A identified a design flaw in the construction of the rear cell door which allowed him to slide a sheet under a horizontal rail and create a hanging point. Most regrettably, this risk had been identified and reported by AMC Facilities Management staff in 2015 but had not been addressed by the then AMC General Manager" said Rebecca Minty, Deputy Inspector and lead reviewer.

Although the design of the cell doors was a contributing factor in the death of Detainee A, Ms Minty said "in our view, Detainee A was properly assessed by mental health professionals on his admission to AMC who did not identify any indicators that he was at risk of self-harm or experiencing suicidal ideations. The review also found that the attempted resuscitation of Detainee A was undertaken very well by custodial and nursing staff."

The review raises concerns about the use of the restrictive environment in the Management Unit for COVID isolation as well as issues relating to prevention and management of self-harm incidents at the AMC that must be addressed by ACT Corrective Services as a matter of urgency. The review makes five recommendations for the ACT government to consider.

Ms Minty said that "A death in custody is a deeply tragic occurrence. We acknowledge the trauma caused by this incident to the deceased's parents and family, friends and loved ones, and extend our sincere condolences to them."

Ms Minty noted that "while this report may be of assistance to the Coroner, the Coroner has separate independent statutory responsibilities in relation to a death in custody."

For more information

The full report can be found at ics.act.gov.au

MEDIA: The Office of the Inspector of Correctional Services (OICS) will not be making any media comments on this report as the death in custody is an ongoing matter for the ACT Coroner.

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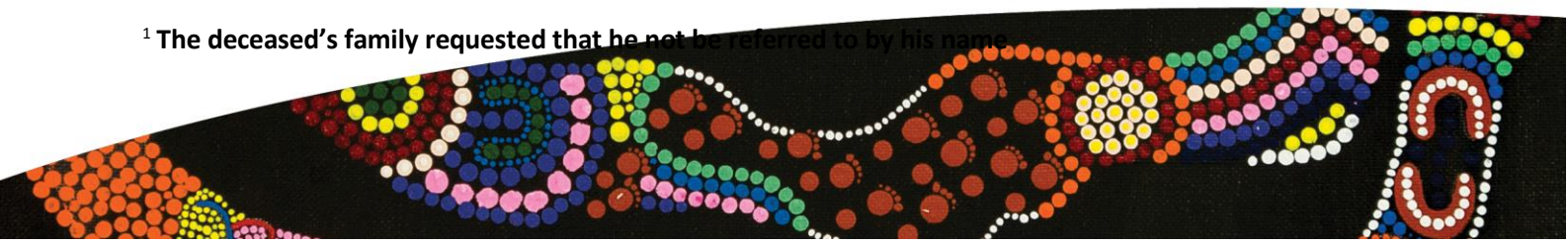
[1] **The deceased's family requested that he not be referred to by his name.**



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MEDIA BACKGROUND

Deputy Inspector: Rebecca Minty

Rebecca Minty has worked in the ACT Office of the Inspector of Correctional Services (OICS) since it commenced operations in 2018.

Previously, Rebecca worked in human rights law and policy for more than ten years, both in the ACT and internationally. Rebecca's work has focused particularly on conditions and treatment of persons deprived of their liberty, including with the Geneva-based non-government organisation, the Association for the Prevention of Torture, on their Asia Pacific Program (2012 - 2016). She also worked in Bangkok in 2016 as Human Rights Officer for the UN Office of the Human Rights Commissioner (OHCHR).

In her spare time, Rebecca is co-founder and chair of the Australia OPCAT Network, a group of civil society, academics, oversight entities and individuals interested in effective implementation of the Optional Protocol to the Convention Against Torture in Australia.

Rebecca holds a LL.M (International Law), University of California, Berkeley School of Law and a MA in International and Area Studies (Indonesian Language) from Berkeley as well a Bachelor of Laws (First Class Honours) and Bachelor of Arts (Political Science) from the Australian National University. Rebecca was also a Rotary World Peace Scholar, 2009-2011. She was admitted to Practice as a Barrister and Solicitor of the Supreme Court of the ACT in 2007.