OmbudsmanSA | Media Release

MEDIA RELEASE – FOR IMMEDIATE RELEASE

by Mr Wayne Lines, South Australian Ombudsman

10 September 2020

Aboriginal and Torres Strait Islander readers are advised that this report contains content about a person who has died.

Outcome of investigation concerning Mr Wayne Morrison – Department for Correctional Services

Background

Today the SA Ombudsman, Mr Wayne Lines, caused a report to be tabled in Parliament concerning the Department for Correctional Services' (**the department**) handling of various issues before and after the death of an Aboriginal prisoner, Mr Wayne Fella Morrison. Mr Morrison died following an incident at Yatala Labour Prison which occurred on 23 September 2016.

The Ombudsman did **not** investigate the incident preceding Mr Morrison's death and expressed no view about that incident. Instead, the Ombudsman's 'own initiative' investigation focused on the department's actions before and after the incident. Mr Morrison's death is the subject of a separate, ongoing coronial enquiry.

While they were not complainants, the Ombudsman expressed his gratitude that Mr Morrison's mother, Ms Caroline Andersen and his sister, Ms Latoya Rule made themselves available to be interviewed. Ms Andersen also provided detailed submissions to the investigation.

The Ombudsman's report includes a number of serious criticisms of the department. The Ombudsman acknowledges that while it is easy in hindsight to criticise the department, it is essential for the purposes of good administrative practice that the department is held to a high yet achievable standard.

While there appeared to be some initial reluctance, the department ultimately acknowledged that certain matters could have been better handled. The department also outlined steps already taken to improve its processes. The Ombudsman considered that the most recent responses from the department showed a detailed and genuine engagement with the issues raised and, generally, a willingness to implement the Ombudsman's recommendations.

In considering this matter, the Ombudsman had particular regard to the Royal Commission into Aboriginal Deaths in Custody Report from 1991.

Considerations

The Ombudsman's investigation considered nine issues and formed the view that there was error in relation to eight of those nine issues. The issues included that the department:

- failed to raise a 'notification of concern' and treat Mr Morrison as an 'at risk' prisoner, despite his past attempted suicide and family history of suicide
- failed to have proper processes in place to identify Mr Morrison as an Aboriginal person (and to provide support accordingly)
- transported Mr Morrison in a van without video recording capacity and failed to record meaningful footage of Mr Morrison's restraint by Correctional Officers
- failed to provide Mr Morrison's family with sufficient:
    - information
    - support
    - access to Mr Morrison while he was in hospital
- failed to maintain official records.

The investigation highlighted a number of broader issues including:

- the need for risks and issues experienced by Aboriginal prisoners (as identified in the Royal Commission into Aboriginal Deaths in Custody Report) to be addressed on an ongoing basis by the department
- the need for cross-checking of information provided by SAPOL, South Australian Prison Health Services and other agencies upon prisoner induction
- the limited resources allocated to Aboriginal Liaison Officers
- the need for improvement in recording footage of incidents and prisoner movement, particularly after a use of force incident
- the need for senior oversight, and the sensitive exercise of discretion in situations of critical injury or death
- the extent to which officers are trained and equipped to deal with sensitive, emotional situations and to have regard to the privacy needs of a prisoner's family at time of critical injury and/or death.

The Ombudsman observed that the department appeared to underestimate its duty to Mr Morrison's family, noting that Mr Morrison died while in the department's care.

The Ombudsman observed that the department did not appear to have any structured process in place for offering support to Mr Morrison's family. The Ombudsman considered it particularly shameful that:

- the family were directed to an Aboriginal Liaison Officer at the hospital without that officer being able to access information about Mr Morrison's health status
- it took between five to six hours before there were approvals in place for Mr Morrison's family to visit him at hospital when he was in a coma and close to death
- no support was offered to Mr Morrison's family in terms of counselling or emotional support.

The Ombudsman stated:

> My overall impression is that the department did not clearly and directly take responsibility for informing Mr Morrison's family of events that occurred while Mr Morrison was in the department's custody, or his whereabouts and health status, relying instead on third parties such as [Aboriginal Legal Rights Movement] or [Hospital] staff. That said, I accept that responsibility for providing detailed health information lay with the [Hospital]. My point is that the department could have done more to facilitate access to information and provide support.

The Ombudsman observed that there appeared to have been no consideration of Mr Morrison's family in the development of a plan to manage the incident and that:

> …appropriately and sensitively dealing with Mr Morrison's family should have been another main objective to be considered as part of any plan.

The Ombudsman was 'appalled' at the family's treatment and he stated:

> In my view, Mr Morrison's family were not treated with the openness, frankness and sensitivity that they deserved. It is not at all surprising that Mr Morrison's family appeared to regard the department's actions with suspicion. The department's actions did not instil confidence or trust in its dealing with Aboriginal prisoners in custody.

The Ombudsman made 17 recommendations which include that the department:

- apologise to Mr Morrison's family for various errors
- review and change its internal procedures and remind relevant staff of their obligations
- take steps to implement body-worn cameras in all prisons (with a recommendation to the State Government that it consider allocation of funds accordingly).

The Ombudsman will continue to monitor the department's implementation of his recommendations and have requested the department to report to him on its implementation by 30 November 2020.