ATTORNEY-GENERAL

Parliament House
State Square
Darwin NT 0800

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REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and Recommendations regarding the death of Mr Mati Tamwoy

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Pursuant to section 46B of the *Coroners Act 1993* (the Act), I provide this Report on the findings and recommendations of Local Court Judge Elisabeth Armitage, Territory Coroner, delivered on 10 January 2025, regarding the death of Mr Mati Tamwoy, also known as Michael Sagigi (the Deceased) (Attachment A refers).

This report includes the response to the recommendations of the Territory Coroner by Mr Matthew Varley, Commissioner, Department of Corrections (DoC).

The Deceased was a 66 year old male who was being held in custody at the time of the Deceased's death. The Deceased had extensive medical issues and passed away at the Royal Darwin Hospital on 17 November 2023 due to infectious complications of his blood cancer.

Recommendations of the Coroner

The Coroner made three formal recommendations to DoC in regards to the death of the Deceased:

> '75. **I recommend** that the NT Department of Corrections conduct a thorough review of all Directives and Standard Operating Procedures concerning the use of restraints on prisoners under medical escort and prisoner in-patients, to ensure consistency and clarity, and to ensure any correctional officer discretions are appropriate to their training and role. All correctional officers should receive training on any new or updated Directives and SOPs.
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> 76. **I recommend** that any Directives and Standard Operating Procedures referable to the maintenance of the Hospital Journal or Hospital Bedsit Log, be reviewed and consolidated into one Directive or SOP. The procedure should include a requirement that the application of restraints be clearly identified in the journal/log. All correctional officers should receive training on the consolidated Directive or SOP.

77. **I recommend** that relevant Directives and Standard Operating Procedures be reviewed to ensure that up-to-date next of kin and/or emergency contact details are accurately recorded, and alternatively, that it is clearly recorded that a prisoner declines to provide such details and/or declines to consent to persons being contacted.'

Response to Coroner's recommendations

A copy of the Coronial Findings was provided to the Commissioner of Corrections on 10 April 2025, in accordance with section 46A(1) of the Act.

A written response was received from the Commissioner of Corrections dated 10 July 2025, as required by section 46B(1) of the Act. The response was as follows:

Recommendation 75

'The Department has commenced a review of relevant Commissioner Directives and Standard Operating Procedures (SOPs) for the Correctional Centres at Darwin, Alice Springs and Berrimah that relate to the use of restraints on prisoners under medical escorts and for prisoner in-patients. This review has been inclusive of engagement with senior management teams of the Centres and relevant staff.

This process has identified inconsistencies between SOPs and the Directives do exist, and they have been mapped. There have also been opportunities identified for updating the Directive to provide greater clarity on requirements for all security classifications of prisoners. Engagement has commenced with unions with regards to proposed updates to the SOPs, upon finalisation of the updating to the Directive.

The timeline for finalising the updates to the Directive and SOPs, inclusive of formal implementation, is to be by 31 July 2025. Engagement has already been undertaken with the Department's Staff, Learning and Development unit on the review process, and planning has commenced on review of the relevant training packages for inducting new staff into the Department. Upon implementation of the updated SOPs and Directive, a training/communication package will be distributed to all existing staff to ensure awareness of the updates.'

Recommendation 76

'The Department has commenced a review of relevant Commissioner Directives and the Prisoner In-Patient Standard Operating Procedures (SOPs) for the Correctional Centres at Darwin, Alice Springs and Berrimah that relate to the maintenance of the Hospital Journal or Hospital Bedsit Log, and whether they could be consolidated into a single SOP.

Currently the review has identified that the Directive and Correctional Centre SOPs need to be maintained as separate policy documents. However, there have been areas identified in the SOPs that require amendments for consistency with the content of the Directive, and to ensure enhanced clarity for officers to sufficiently record the use of restraints within the Hospital Journal.

The timeline for finalising the SOPs at the three Correctional Centres is 31 July 2025 and will be inclusive of engagement with the Department's Staff, Learning and Development unit to ensure inclusion within foundational training material as well as a training/communication package to be distributed to all existing staff to ensure awareness of the updates.'

Recommendation 77

'As part of the review into the Coronial Findings, the Department has confirmed that the policy position on the recording of next of kin (NOK) information is contained within the Commissioner's Directive for Deaths in Custody. However, the relevant Directives and SOPs for Medical Escorts and Prisoner In-Patient do not reference the requirement for ensuring up-to-date next of kin and/or emergency contact details are accurately recorded, or alternatively, a prisoner's refusal to provide such details.

Work has commenced to draft updates to the Directives and SOPs for the Centres to ensure there are clear directions and consistency on these requirements. The timeline for finalising the updates to the Directives, and SOPs at the three Correctional Centres is 31 July 2025 and will be inclusive of engagement with SLD to ensure inclusion within foundational training material as well as a training/communication package to be distributed to all existing staff to ensure awareness of the updates.

The Department remains committed to continual improvement and upholding the highest standards in prisoner care and custodial practice. In addition to the review work already undertaken, the final reform to the policies to meet the coroner's findings will be prioritised and finalised by 31 July 2025. These actions reflect our commitment to ensuring transparency, accountability, and improved outcomes for those in our custody, particularly the most vulnerable.'

I am satisfied that the Commissioner of Corrections has considered the recommendations of the Territory Coroner and that they have responded to the recommendations.

DATE:

MARIE-CLARE BOOTHBY

28 JUL 2025