ICS
ACT Inspector of Correctional Services

REPORT OF A REVIEW OF A CRITICAL INCIDENT

by the

ACT INSPECTOR OF CORRECTIONAL SERVICES

Assault of a detainee at the Alexander Maconochie Centre on 16 December 2018

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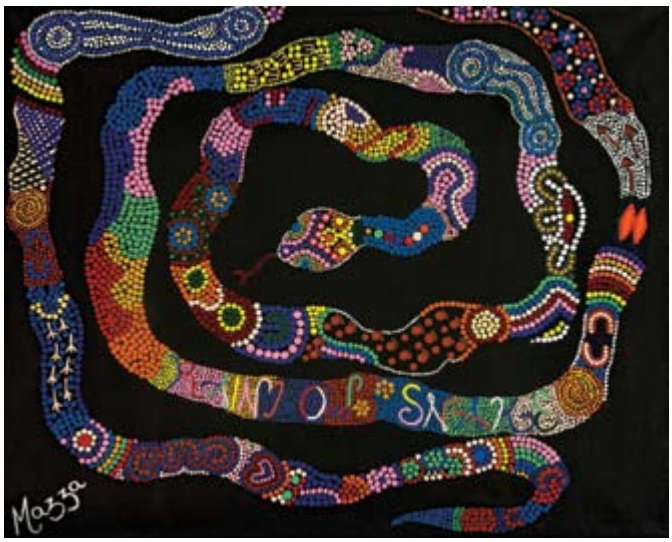

Rainbow Serpent (above and cover detail)
Marrilyn Kelly-Parkinson of the Yuin Tribe (2018)

ABOUT THIS REPORT

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We acknowledge the traditional custodians of the ACT, the Ngunnawal people. We acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

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Neil McAllister
ACT Inspector of Correctional Services
16 May 2019

Foreword by the Inspector

This is the third review of a critical incident that I have submitted to the ACT Legislative Assembly, following which the reports have been available to the general public. This routine publication of reports on critical incidents in corrections is unique in Australia, if not internationally. However, I would understand if some readers thought that the reports are somewhat cryptic at times. This is because my Office must ensure that the content of reports do not provide information about individuals that could lead to their identification, particularly where there may be a risk of retribution to someone involved in an incident.

Nonetheless, it is important that we don't overlook matters that may need to be addressed by ACT Corrective Services but are not appropriate to be aired publicly. For that reason this report, as did a previous report, has a confidential appendix that is only provided to the Minister for Corrections and the Director-General of the Justice and Community Safety Directorate. The use of confidential appendices should not be taken to infer any wrongdoing on the part of ACT Corrective Services.

Neil McAllister
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Letter of Transmittal

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Madam Speaker

I am pleased to provide you with a report entitled 'Report of a Review of a Critical Incident by the ACT Inspector of Correctional Services: Assault of a detainee at the Alexander Maconochie Centre on 16 December 2018' for tabling in the Legislative Assembly pursuant to Section 30 of the *Inspector of Correctional Services Act 2017* (ACT) (the Act).

This report was prepared pursuant to Section 17(1)(c) and (d) of the Act.

As required under Section 29 of the Act a draft copy of the review has been provided to The Hon Shane Rattenbury MLA, Minister for Corrections and Ms Alison Playford, Director-General of the Justice and Community Safety Directorate. There were no comments made on the draft report.

Yours sincerely

Neil McAllister
ACT Inspector of Correctional Services
20 May 2019

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EXECUTIVE SUMMARY

On 16 December 2018 a detainee was assaulted in his unit at the Alexander Maconochie Centre (AMC) by up to two detainees resulting in significant head injuries that led to his admission to hospital. The assault occurred in the detainee's cell and so was not directly captured on CCTV, however, ACT Corrective Services (ACTCS) were able to quickly identify possible perpetrators by viewing CCTV to ascertain who was present in his cell at the time of the assault. The victim of the assault remained in hospital for six nights and was discharged back to the AMC.

Based on the circumstances of the assault and the correctional and criminal history of the detainees involved, the review team concludes that this assault was not reasonably foreseeable by ACTCS. The actions of ACTCS following the assault were appropriate in the circumstances.

The review makes six findings and one recommendation. Most findings identify appropriate practice, however two findings identify areas for improvement in practice in relation to ensuring internal incident review practices align with written procedure; and timely updating of detainee records relating to next of kin. The recommendation relates to ACTCS ensuring those involved in traumatic events are offered support after the event.

We are pleased to note that the Inspectorate received full cooperation from ACTCS in the conduct of this review.

RECOMMENDATION & FINDINGS

Recommendation 1:	That ACTCS ensure that victims and secondary victims of traumatic events in correctional centres are offered appropriate support from mental health professionals or counsellors as soon as possible after the event. Such offers of support and responses from detainees must be recorded on relevant files.

Findings

Finding 1:	That proper adherence to detainee muster procedure by ACTCS staff ensured the timely discovery of the victim after the assault, limiting the potential severity of his injury.
Finding 2:	That the detainees involved in the incident were appropriately classified in each instance.
Finding 3:	That there was no intelligence information on ACTCS systems to indicate that the victim was at risk of assault by anyone in the unit, including the actual suspected assailants.
Finding 4:	That there were no failings of security procedures or practices that contributed to the assault on the victim.
Finding 5:	That Detainee V's next of kin details should have been updated following the death of his previously nominated next of kin.
Finding 6:	That the operational practice around conducting an internal written review of the incident did not fully align with the relevant procedure for a formal debrief.

INTRODUCTION

Authority to conduct a review of a critical incident

Section 18(1)(c) of the *Inspector of Correctional Services Act 2017* (ACT) (the Act) provides that the Inspector 'may review a critical incident on the inspector's own initiative or as requested by a relevant Minister or relevant director-general'. This review was conducted at my own initiative.

What is a 'critical incident'?

Section 17(2) of the Act provides a list of events that are critical incidents, including at part (g) 'an assault or use of force that results in a person being admitted to a hospital'. This review concerns an event relevant to s17(2)(g) in that it was an assault that resulted in a detainee being admitted to The Canberra Hospital (TCH).

What must the Inspector report on?

Section 27 of the Act requires that the Inspector must include certain things in a report of a review. In a previous report[1] the Inspector noted that this section was directed towards the content of 'examination and reviews' of correctional centres and correctional services but was ambiguous in relation to the content of reviews of critical incidents. This report, like the previous critical incident reports of my Office tabled in the ACT Legislative Assembly, has been structured to capture the intent and spirit of s27 of the Act but without specific reference to some of the topics.

Public interest considerations relating to this report

Certain information that might reveal the identities of detainees and staff involved in the incident has been withheld in this report on public interest grounds in accordance with s28(2)(d) of the Act. Further, I have decided not to make public Appendix 1 to this report as the content could result in the identification of individuals by inference. However, the appendix will be provided to the Minister for Corrections and the Director-General of the Justice and Community Safety Directorate.

The Review Team

The review team comprised:

- Rebecca Minty,
  Deputy Inspector of Correctional Services; and
- Holly Fredericksen,
  Research and Inspections Officer.

1 Report of a Review of a Critical Incident by the ACT Inspector of Correctional Services (2018) *Assault of a detainee at the Alexander Maconochie Centre on 23 May 2018,* 6.

FORM OF THE REVIEW

The Act does not specify what form a review must take. In order to take a consistent approach to the review of critical incidents, the Inspectorate has devised two types of reviews that may be conducted.

The first is a "desk-top" review of documents and reports, including audio/visual records if applicable, provided by ACTCS and other agencies, e.g. ACT Health. A desk-top review does not involve the Inspectorate in direct action such as interviewing staff or detainees and is more likely to be conducted where the circumstances of an incident are reasonably self-evident and unproblematic.

The second form of review is one carried out by the Inspectorate utilising if necessary, the full power of the Inspector under the Act (for example, the power to require someone to attend an interview and answer questions). This type of review could be conducted following or instead of a desk-top review and is more likely to be conducted in response to very serious or problematic incidents such as an escape from secure custody.

In the case of the incident that is the subject of this report, we decided to conduct a desk-top review because we were of the opinion that the officer reports and CCTV recording were such that further enquiries were not warranted. The review team did visit the unit in question and talked to staff and ACT Police informally about the incident.

THE REVIEW

How, when and where the incident occurred

The incident occurred on 16 December 2018 in a cell within a two storey male unit, at approximately 5:10pm, shortly after afternoon muster[2]. The CCTV footage shows Detainee V (the victim) enter his cell, followed some minutes later by Detainees X and Y, with the door being closed behind them by another detainee.

Approximately 90 seconds later, Detainees X and Y exited the cell. Around the same time (5:10pm), the Corrections Officers (COs) rostered on the unit received an order to do a 'muster recount'[3] and go cell-to-cell in the unit to instruct detainees to reassemble in the external exercise yard for the muster recount.

During the muster recount it quickly became apparent that not all detainees were accounted for in that unit, which lead a CO to check Detainee V's cell at approximately 5:18pm. The CO found Detainee V on his bed unresponsive, with the left side of his face 'extremely swollen and bloody'[4]. Detainees W and Z were also in the cell at the time (apparently rendering assistance). The CO called a Code Pink (Medical Emergency).

Staff from the AMC Health Centre arrived within minutes and an ambulance was called shortly after, with AMC Health Centre staff providing assistance until the paramedics arrived. Detainee V was transported to TCH by ambulance where he was admitted to intensive care for serious head injuries and intubated. His injuries were listed as 'critical' on the AMC Detainee Injury

2 Accounting for detainees by sight, that occurs in the external exercise yard connected to the cell block.

3 A not uncommon occurrence where detainees must be counted again as the first muster did not account for all detainees.

4 Custodial Officer Incident report, 16 December 2018.

Form (on a scale of fatal/critical/moderate/minor) indicating the significant impact of the assault on him. After six days in TCH he was returned to AMC under medical observation at the Crisis Support Unit (CSU) on 22 December 2018.

Whilst still in the CSU on 24 December 2018 staff observed Detainee V unsteady on his feet and with slurred speech. Medical assistance was called immediately and it was deemed necessary to send him to hospital for further checks. Detainee V was taken by ambulance at 2:30pm to the Canberra Hospital and returned at 11:45pm on the same day to CSU at the AMC to continue observations.

It is not indicated on ACTCS records viewed by the Inspectorate what time ACT Policing were called, but they arrived at 7:40pm on the evening of the incident. The police investigation is ongoing at the time of writing.

The timeliness and effectiveness of ACTCS' response to the incident

The need for a centre muster recount on the afternoon of the incident was a fortunate occurrence given it led to the timely discovery of Detainee V soon after the assault occurred. The actions of the unit COs in their proper adherence to muster recount procedure is important to acknowledge as the cell check process resulted in the timely discovery of the victim and the subsequent prompt medical response, which was crucial given the severity of the injuries sustained in the assault.

Finding 1:

That proper adherence to detainee muster procedure by ACTCS staff ensured the timely discovery of the victim after the assault, limiting the potential severity of his injury.

Once Detainee V was discovered, AMC staff acted in an appropriate and timely way. There were sufficient custodial staff on hand to provide the necessary support for medical staff and for the rest of the unit to be locked down while treatment was underway.

At the point the assault was discovered, AMC staff took steps to identify possible perpetrators by reviewing CCTV footage within approximately 20 minutes of the incident occurring. Four detainees who entered the cell around the time in question (Detainees W, X, Y and Z) were removed to the admissions unit for investigative segregation. Detainees W and Z were returned to their unit although to different cells (as four cells, including theirs, had been secured as a crime scene as required by AMC procedures). The suspected clothing of the four detainees was taken into evidence ("bagged and tagged") for police.

ACT Policing did not raise any specific concerns around preservation of the crime scene and the preservation of evidence.

A staff debrief was held within an hour of Detainee V being transported to hospital, and was attended by most relevant staff available. No issues of concern were raised, which appears reasonable in the circumstances. A formal debrief report was completed some weeks later (discussed further below).

Assessment, classification and accommodation of the detainees

Profile of detainees involved in the incident

All detainees had a Protection status, which entails accommodating them separate from the 'mainstream' detainee population.

Detainee V (the victim) is a Medium security detainee serving a sentence for offences including aggravated robbery. He has been in AMC since the second quarter of 2017 and has approximately 20 custodial incidents recorded

for this period. This includes an assault on another detainee and an assault on a staff member early in his period of incarceration.

Detainee X (a suspected perpetrator) is a Maximum security detainee serving a sentence for offences including aggravated robbery. He has a history of escape from secure custody and has perpetrated assaults in the AMC during his current period of incarceration which commenced in the second quarter of 2016. Detainee X had his protection status altered from Strict Protection to Protection in the month prior to the incident at his request. He identifies as Aboriginal.

Detainee Y (a suspected perpetrator) is a Medium security detainee serving a sentence for offences including aggravated burglary. He was admitted to the AMC in the first quarter of 2017 and has approximately 15 custodial incidents for his current period of incarceration, including an assault on a detainee.

Security classification

The Detainee Classification Policy sets out a non-exhaustive list of factors that are to be taken into account in determining a detainee's security classification[5]. These factors include the offence the detainee is charged with or convicted of, as well as their behaviour in custody.

Medium security is the normal classification determined for new receptions to custody, in the absence of especially high levels of risk being identified.[6] Having reviewed the criminal histories, discipline records at AMC, intelligence holdings and related material the review team is satisfied that all detainees in question were appropriately classified.

Finding 2:

That the detainees involved in the incident were appropriately classified in each instance.

Accommodation placement

In addition to giving a detainee a security classification, the AMC must determine which unit in AMC to accommodate the detainee. Accommodation decisions take into account a range of factors in addition to security risks, such as medical/psychiatric needs, protection or non-association requirements, self-harm likelihood and accommodation availability.[7]

Although this list of considerations does not explicitly state a detainee's status as a remandee is a factor to consider in determining accommodation placement, the Detainee Classification Policy states:

> ***Separation remand and sentenced detainees***
> *Remand and sentenced detainees should be accommodated separately consistent with the Corrections Management Act 2007. However, scope exists for different arrangements to be made for unsentenced detainees where it is suspected, on reasonable grounds, that it is necessary to do so for the safety of the detainee or anyone else (such grounds may include protection on non association requirements and special care or management needs).*

The assault occurred in a protection unit and all detainees involved were protection detainees. The unit contained 26 detainees, 12 on remand and the remainder were serving a sentence. Detainees V, X and Y were sentenced prisoners.

5 These include, for example, the nature and severity of charges or offences, offending history, escape history, breaches of court orders, institutional disciplinary record and stability, intelligence holdings, and motivation to address behavior. See generally, *Corrections Management (AMC Detainee Classification) Policy 2012*, NI2012-299.

6 *Corrections Management (AMC Detainee Classification) Policy 2012*, NI2012-299.

7 *Corrections Management (AMC Detainee Classification) Policy 2012*, NI2012-299.

As noted in the Inspectorate's recent review of remand at AMC[8], remand and sentenced detainees are not separated despite the requirement in the *Corrections Management Act 2007* (ACT)[9] and *Human Rights Act 2004* (ACT)[10] that they be separated barring exceptional circumstances. However, as the Detainee Classification Policy notes above, it may be an 'exceptional circumstance' if a remandee is a protection detainee on non-association requirements, as was the case here.

Was the incident reasonably foreseeable?

The review team examined the intelligence notes made on detainees prior to the incident. The only notes that "linked" any of the detainees was a note on both Detainee V's and Detainee Y's file that they had jointly "act[ed]"as an enforcer for a previous detainee". However, intelligence information of this nature would not in itself provide cause to separate detainees V and Y.

Detainees V, X and Y all have an in-custody incident history that may indicate they were illicit drug users, for example, drug paraphernalia located during cell searches, positive urinalysis tests and disciplines for failing to supply a urine sample for urinalysis testing for drugs. All three detainees have intelligence flags noting reported involvement in contraband trade within AMC. However there is nothing specific to suggest conflict with each other over or relating to drugs.

Finding 3:

That there was no intelligence information on ACTCS systems to indicate that the victim was at risk of assault by anyone in the unit, including the actual suspected assailants.

Security and supervision procedures and practices

The review team considered whether security and supervision procedures and practices were appropriate and complied with.

There were 26 detainees accommodated in the unit at the time under the supervision of two CO1s, with a CO2 (supervisor) working between it and another unit.

The CCTV footage indicates COs on duty followed appropriate practices for a muster, including physically checking each cell to ensure all detainees were in the external courtyard for the count. It was adherence to this procedure that ensured the timely discovery of Detainee V after the assault.

Finding 4:

That there were no failings of security procedures or practices that contributed to the assault on the victim.

Notification procedures and practices

The review team considered whether procedures and practices relating to notifications of serious incidents were complied with.

ACTCS senior management, ACT Ambulance Service, ACT Policing, the Inspector of Correctional Services, and the Minister for Corrections were all notified in a timely manner pursuant to the relevant policy.[11]

Detainee V's nominated next of kin had passed away, something ACTCS was aware of at the time of that next of kin's passing, as Detainee V had sought special leave to attend the funeral.

8 ACT Inspector of Correctional Services (2019), *Report of a review of the care and management of remandees at the Alexander Maconochie Centre*, Canberra.

9 Section 44(2): 'The director-general must also ensure that convicted detainees are accommodated separately from non-convicted detainees'.

10 Section 19(2): 'An accused person must be segregated from convicted people, except in exceptional circumstances'.

11 *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2018 (No 2)*, NI2018-458.

However, the detainee's next of kin information had not been updated on his electronic file, so when the incident occurred, it was not immediately clear who to contact as next of kin. The lack of clarity could have been avoided had ACTCS taken steps to update the detainee's records to reflect a new next of kin.

Finding 5:

That Detainee V's next of kin details should have been updated following the death of his previously nominated next of kin.

Involving Indigenous staff in debriefs

There is nothing on ACTCS' file to indicate any Indigenous Liaison Officers or Indigenous Case Managers attended or were invited to attend the debrief. Given the incident involved two Aboriginal detainees, one of whom was a suspected perpetrator, this would have been desirable.

The review team reiterates a point made in a previous Critical Incident Report[12] that not having an Aboriginal person attend relevant incident debriefs is contrary to an opportunity for improvement identified by ACTCS in its 'Final Report on ACT Corrective Services 2014–15 Internal Review of Relevant Recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC)' (RCIADIC Review), viz:

> *critical incident de-briefing involving an Indigenous detainee include the ILO or Indigenous Case manager.*

Formal debrief report

The incident summary form completed the day after the incident occurred has boxes ticked indicating 'further investigation required' noting a 'General Manager Review' was required.

The *Corrections Management (Incident Reporting) Operating Procedure 2019* does not refer to a 'General Manager Review' but refers to a number of 'post incident debriefs', namely: informal debriefs, hot debriefs and formal debriefs. It notes "a formal debrief will be conducted upon direction of the General Manager or Executive Director and must be conducted within 14 days of the incident occurring". The formal debrief must:

- *Examine an incident in its entirety*
- *Look at how the incident occurred*
- *Consider how the incident was managed*
- *Identify any opportunities to improve responses to incident management*
- *Identify and address any concerns from the incident.*

A formal debrief is intended to identify opportunities for continuous improvement through all of the above.

On 29 January 2019 the Inspectorate was provided an undated four page written review of the assault, that appears to be the 'General Manager's Review' or 'Formal Debrief'. The review examines the incident in its entirety, looks at how the incident occurred, and considers how the incident was managed. It also reflects on 'outcomes' resulting from this incident, noting:

- That the individuals concerned have been relocated to prevent reoccurrence of the event
- That ACT Policing may be in a position to press charges
- That actions by staff to collate information from the incident (including CCTV, clothing, documentation on staff) have positively impacted on the ability of ACT Policing to put forward a prosecution for this assault.

12 ACT Inspector of Correctional Services (2018), *Report of a review of an assault of a detainee at the Alexander Maconochie Centre on 23 May 2018,* OICS, Canberra.

It is useful to reflect on these positive outcomes. This report does not 'identify any opportunities to improve responses' or 'identify and address any concerns' from the incident, headings noted in the Incident Reporting Operation Procedure. It is unclear whether these matters were considered by the author of the report. They may well have been, but with no opportunities for improvement or concerns identified.

The Formal Debrief as articulated in the AMC Procedure is an important aspect of reflective practice, and ACTCS should consider ways to ensure that staff conducting a formal debrief reflect on and document any lessons learned or areas for continual improvement. A simple Formal Debrief template with each required heading as a prompt, or measures to remind or raise awareness amongst staff who conduct Formal Debriefs, would be helpful.

Finding 6:

That the operational practice around conducting an internal written review of the incident did not fully align with the relevant procedure for a formal debrief.

Human rights considerations

The review team considered whether the incident revealed any issues pertinent to the *Human Rights Act 2004* (ACT) (HR Act).

Detainee on detainee violence, as is the case here, potentially engages a number of rights in the HR Act. Of most relevance is the right to protection from cruel, inhuman or degrading treatment in s10(1)(b), and the right to humane treatment when deprived of liberty in s19 of the HR Act.

The scope of these obligations are such that ACTCS is required to take positive steps to protect detainees from violence and ill-treatment by other detainees,[13] including by implementing measures such as conducting screening assessments of detainees, confiscation of weapons, segregating detainees where appropriate, regular supervision of detainees, and ensuring acceptable space for each detainee, with priority for preventive measures over repressive ones.[14] On the basis of the material considered by the review team, the preventive measures were appropriate in this case, and the assault was not reasonably foreseeable.

This matter also raises the right to humane treatment when deprived of liberty, and in particular the right of an accused person to be separated from convicted people, except in exceptional circumstances. We note that one of the detainees exposed to this incident was on remand and was sharing a cell with the victim, a sentenced detainee. This incident occurred in the protection unit, and it may be argued that remandees with protection needs may be an 'exceptional circumstances' permitting departure from the legal requirement to separate remandees from sentenced detainees.

However, exposure to violence is a significant traumatic event for any detainee, including those that are presumed by law to be innocent of the charge for which they are in custody.

13 See, for example, the United Nations Human Rights Committee concluding that Article 10(1) of the ICCPR had been breached where Jamaica had neglected to take measures to protect the complainant from being assaulted regularly by other inmates. *Daley v Jamaica* Human Rights Committee, View of 31 July 1997 Comm. 750/1997, para 7.6.

14 See van Kempen, P 'Positive Obligations to Ensure the Human Rights of Prisoners' in Tak, P and Jendly, M (eds) 2008, *Prison policy and prisoners' rights – the protection of prisoners' fundamental rights in international and domestic law,* Nijmegen: Wolf Legal Publishers.

OTHER MATTERS ARISING FROM THE REVIEW

Post-incident support for detainees

The review team found no evidence that the two detainees who apparently came to the victim's aid after the assault were offered support by mental health professionals or counsellors. This would be appropriate and in keeping with AMC policy which notes that "[i]ncidents can often be a stressful experience for both staff and detainees. It is imperative that appropriate supports are in place"[15] and "[d]etainees affected by the incident will be referred to ACT Mental Health for assessment"[16].

Recommendation 1:

That ACTCS ensure that victims and secondary victims of traumatic events in correctional centres are offered appropriate support from mental health professionals or counsellors as soon as possible after the event. Such offers of support and responses from detainees must be recorded on relevant files.

15 *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2018 (No 2)*, NI2018-458.

16 *Corrections Management (Incident Response) Policy 2014 (No 1)*, NI2014-540 (RESTRICTED).

APPENDIX 1

COMMENTARY ON THE INCIDENT

[This appendix has been fully redacted in the tabled version of this report pursuant to s28 of the *Inspector of Correctional Services Act 2017*]

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