ICS
ACT Inspector of Correctional Services

REVIEW OF A CRITICAL INCIDENT

by the

ACT INSPECTOR OF CORRECTIONAL SERVICES

A Serious Assault of a Detained Person Resulting in Admission to Hospital at the Alexander Maconochie Centre 13 December 2023

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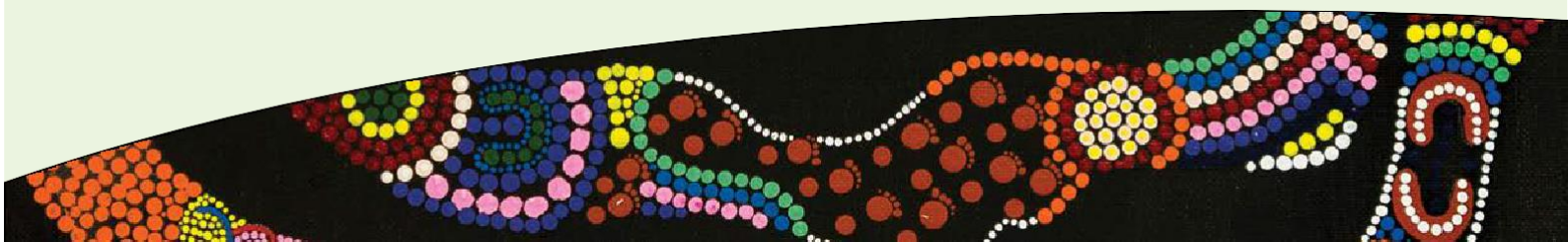

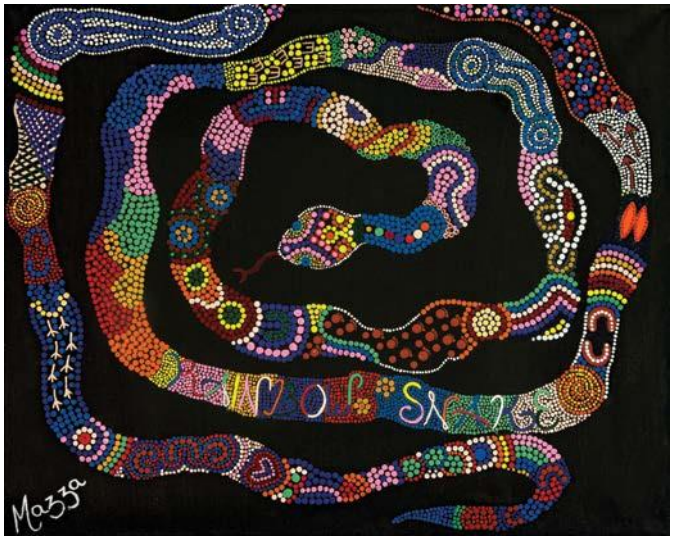

Rainbow Serpent (above and cover detail)
Marrilyn Kelly-Parkinson of the Yuin Tribe (2018)

'There are no bystanders – the standard you walk past is the standard you accept'

— Lieutenant General David Morrison, AO
Chief of Army (2014)

About this report

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ACT Inspector of Correctional Services
GPO Box 1771
Canberra ACT 2601

T 1800 932 010

www.ics.act.gov.au

ACT Inspector of Correctional Services

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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Rebecca Minty
ACT Inspector of Correctional Services
September 2024

ICS

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Glossary

Term	Meaning
ACTCS	ACT Corrective Services
ACTP	ACT Policing (AFP)
AMC	Alexander Maconochie Centre (ACT adult prison)
CM Act	*Corrections Management Act 2007* (ACT)
CO	Corrections Officer
CORIS	ACTCS information management system
Daily Brief	Internal information log specific to accommodation areas at the Alexander Maconochie Centre, located on ACTCS G-Drive
HHC	Hume Health Centre
ICS Act	*Inspector of Correctional Services Act 2017*
Inspector	ACT Inspector of Correctional Services
JHS	Justice Health Service
OICS	Office of the Inspector of Correctional Services
SCC	Special Care Centre, male accommodation unit
SCC-N	Special Care Centre North wing, male accommodation used as the Assisted Care Unit
TCH	The Canberra Hospital
Detained person	A 'detainee' under s6 of the CM Act

1. Executive Summary

This is a Critical Incident review of an assault on a detained person by another detained person at the Alexander Maconochie Centre (AMC), resulting in admission of the victim to hospital. Overall, the post incident response by ACT Corrective Services (ACTCS) was appropriate, though the Office of the Inspector of Correctional Services (OICS) considers that several Corrections Officer (CO) incident reports required more detail to adequately record the incident.

Review of this incident however, revealed a more general concern that important operational information relating to safety and wellbeing of detained people is being recorded on multiple systems – firstly, the CORIS electronic database, and secondly, a Microsoft Word document 'Daily Brief' which is unit-specific and stored electronically on computers in the officer's station. The purpose of and use of the Daily Brief does not appear to be formally articulated anywhere, nor how the two systems should interact. It does not appear that the existence of multiple systems directly affected this incident (as it appears no information was recorded on any system that could have prevented it occurring). However, the lack of information being recorded on either system did potentially affect the incident occurring. Further, having dual systems introduces unnecessary and unacceptable risk in custodial operations and needs to be addressed.

Recommendation 1:

That within 3 months of the tabling of this report, ACT Corrective Services review the interaction of CORIS with the Daily Brief. The review should focus on how to ensure systems for recording key information relating to risk, and safety and wellbeing of detained people are efficient, minimise gaps and are well understood by Corrections Officers.

2. Introduction

On 13 December 2023 a detained person (Detained Person A) at the AMC was seriously assaulted in his cell by another detained person (Detained Person B). Detained Person A was later admitted to The Canberra Hospital (TCH) with significant but non-life-threatening injuries. The admission to hospital triggered ACTCS to report this incident to OICS as a critical incident under section 17(2)(g) of the *Inspector of Correctional Services Act 2017* (ICS Act), being 'an assault or use of force that results in a person being admitted to hospital'.

The Inspector has discretion whether to review a critical incident, and OICS *Operating Procedure – Exercising discretion to review a critical incident*, sets out criterion and decision-making processes for determining whether or not the Inspector will commence a review. Applying this criterion, the Inspector decided to conduct a critical incident review noting particularly the seriousness of the incident, and the potential of any recommendations to contribute to prevention of similar incidents in future.

ACTCS reported this incident to ACT Policing (ACTP), who attended the AMC to conduct interviews with the detained people involved, collect evidence and undertake crime scene investigations. OICS understands that criminal charges remain ongoing at the time of writing.

In undertaking this review, OICS reviewed case notes on CORIS (ACTCS information management system), the 'Daily Brief' for the relevant unit, CCTV, Officer Incident Reports, Minutes from the post incident debrief (Hot Debrief) and liaised with ACTP regarding the incident. This report does not discuss specific details of the assault or the extent of Detained Person A's injuries. For these reasons, and so as not to interfere with the police investigation, OICS did not seek to interview the detained people involved or ACTCS staff.

The focus of this review is steps taken by ACTCS pre and post incident, incident reporting, and systems of information management and record keeping. OICS undertakes critical incident reviews with a view to identifying good practices and any areas for improvement.

3. Background

The incident occurred on 13 December 2023 in Special Care Centre North wing (SCC-N) at the AMC. SCC-N is the Assisted Care Unit (ACU), an accommodation unit within the AMC for male detained people with complex presentations and vulnerabilities because of mental health, disability or other needs.[1] Many of the detained people accommodated in SCC-N are on protection and may be considered particularly vulnerable in a custodial environment due to their complex needs.

At approximately 5:00PM, Detained Person A approached the officer's station in the SCC with blood on his face and clothing to notify COs that he had been stabbed in the neck, back and shoulder by another detained person in his cell. At this time Detained Person A did not identify the alleged perpetrator of the assault. A CO called a Code Blue (medical emergency) over the radio.

Detained Person B was seen by COs exiting Detained Person A's cell with what appeared to be a weapon in his hand and entering the cell next door. At this time COs identified Detained Person B as the alleged perpetrator of the assault. COs secured all remaining detained people in the wing in their cells. Detained Person B was then removed from his cell and escorted to the Admissions area, strip searched, and evidence seized. Justice Health Services (JHS) nursing staff were carrying out medication rounds in SCC when the incident occurred. Detained Person A was assessed immediately and escorted to the Hume Health Centre (HHC) within AMC for further assessment.

ACTP were notified of the incident and attended the AMC at approximately 5:55PM to conduct interviews with the detained people involved and commence crime scene investigations. Following an interview with ACTP, Detained Person A was escorted by ambulance to TCH and admitted.

Following ACTP investigations, Detained Person B was escorted to the Crisis Support Unit (CSU) at the AMC, where he stayed overnight for observations. The following day he was transferred to the Management Unit under Investigative Segregation pending further ACTP investigations.

On 15 December 2023 Detained Person A returned to the AMC from TCH and was accommodated in CSU. The ACTP investigation remained ongoing at the time of writing.

[1] Model of Care – Supports and Interventions, *A Model of Care following the merger of ACT Corrective Services' Specialist Communities and Specialist Interventions teams.*

4. Positive practices

4.1 ACT Corrective Services initial response

Based on the information reviewed by OICS, it appears that ACTCS staff responded in a timely and appropriate manner. Once alerted to the incident a CO called a Code Blue (medical emergency) at SCC-N over the radio and followed up with a second call with further details of the assault and Detained Person A's injuries to communicate requirements for additional responders. Justice Health nursing staff present in SCC responded to Detained Person A's injuries immediately.

4.2 Evidence handling and crime scene management

Review of CCTV shows that detained people in SCC-N were promptly moved out of the area and secured in their cells to allow for COs to respond to the incident without interference and to maintain the integrity of evidence and the crime scene. A detained person who shared a cell with Detained Person A, was relocated to another cell while investigations were underway.

Documents reviewed by OICS indicate that evidence was collected and processed in accordance with *Corrections Management (Evidence Management) Operating Procedure 2022.*[2] Detained Person B's shoes were collected prior to him being escorted to Admissions, where he was strip searched and clothing collected and placed in separate, labelled brown paper bags. Officers also placed Detained Person B's hands in brown paper bags in case the collection of forensic evidence was required by ACTP. Detained Person A's clothing was collected and processed as evidence by COs.

During the review process, OICS liaised with ACTP who commended the response of COs in relation to crime scene management, noting they were helpful and effectively secured the crime scene which made investigators jobs straightforward.

This is positive to note, and an improvement from a previous critical incident review where OICS identified concerns with evidence handling and recommended COs undergo further training on Crime Scene and Evidence Preservation.[3] The government accepted that recommendation, noting in response [to the recommendation], refresher training on crime scene and evidence management was provided to staff. ACTCS notified their updated Crime Scene Management Operating Procedure and Evidence Management Operating Procedure on 23 December 2022. ACTCS is undertaking work to align its current training in crime scene and evidence collection to the national unit of competency, to be awarded to staff undertaking development opportunities to gain their certificate IV in Correctional Practice.[4]

ACTCS staff response to this incident demonstrates significant progress in crime scene and evidence management since previous critical incident reviews.

Finding 1:

That ACT Corrective Services staff secured and managed the crime scene and evidence according to policy and procedure.

[2] *Corrections Management (Evidence Management) Operating Procedure 2024.*
[3] ACT Inspector of Correctional Services (2023), Review of a critical incident: Alleged Sexual Assault of a Detained Person at the Alexander Maconochie Centre, Canberra
[4] Report of a Review of a Critical Incident by the ACT Inspector of Correctional Services – an Alleged Sexual Assault of a Detained Person at the Alexander Maconochie Centre, Government Response, April 2024, 4.

5. Matters arising from the incident

5.1 Incident reporting and record keeping

All staff involved in an incident response must complete an Incident Report Form as soon as practical following the conclusion of the incident. The *Corrections Management (Incident Reporting, Notifications and Debriefs) Operating Procedure 2020* details how incident reports must be completed. They must be clear, concise, and factual and follow the 5WH approach (when, where, who, what, why, how).

Some incident reports were comprehensive including incident specifics, the role of the report's author in relation to the incident, and the role of others. However, there is a considerable paucity of detail in some incident reports from staff members that played a key role in incident. Further, it would appear that not all officers 'involved, or who witnessed' the incident completed a report.

Only one incident report considers the 'why' (which is described in the Operating Procedure as the 'possible trigger for the event if known'). The one incident report that refers to a possible 'why', notes that the victim of the assault told him (after the incident) that he had an argument earlier in the day with the alleged perpetrator, and the victim had informed a CO of that argument.

From OICS other inquiries, it is understood that COs on the unit were aware of this argument and attempted to resolve issues between Detained Person A and Detained Person B by conducting an informal mediation between them earlier on the day of the incident. However, OICS was unable to identify any documentary recording of this attempted mediation.

It is noted that all other incident reports do not include any information about an argument earlier in the day between Detained Person A and Detained Person B, nor that Detained Person A reported it to staff, nor any action taken by staff in response. OICS has raised concerns about the adherence to polices concerning the management of evidence in previous reviews.

The benefits of appropriately detailed Incident Reports include:

- Assisting later assessment and understanding of what happened,
- Evaluating potential lessons that may be learnt to prevent a repeat; and
- Forming a more solid evidence basis to assist in any subsequent legal matter (which may obviate the need for a statement to be provided to the police or lawyers or may assist if a CO is required to give evidence).

OICS further notes that the *Corrections Management (Incident Reporting, Notifications Debriefs) Policy 2020* and associated Operating Procedure predate the implementation of CORIS, and so there is no specific Policy or Procedure to guide ACTCS staff on incident reporting on CORIS. OICS notes both the policy and Operating Procedure are currently under review and hope to see this issue addressed in the revised versions.

Finding 2:

That not all Incident Reports contained satisfactory level of detail for record keeping of a custodial incident, particularly relating to possible reasons why the incident may have occurred.

5.2 Recording information relating to potential safety risks

Given it is possible that some COs may have been aware of a conflict between the victim and the alleged perpetrator prior to the assault occurring, OICS considered whether any relevant information about risk of violence between the victim and the alleged perpetrator was recorded anywhere, and if any responses or follow up actions in relation to risk were recorded. In particular, information about an argument may have been relevant to a consideration of a violence risk or reconsideration of accommodation placement.

Further, the review considered more broadly the current systems utilised on this unit for recording risk.

5.2.1 Relevant Policies

The *Corrections Management (Risk Alerts) Policy 2019* [5] guides staff in managing and recording risks related to the welfare, safety and security of detained people. When a staff member becomes aware of a violence risk (imminent risk of violence to another person) relating to a detained person they must notify the Head of Security or above who is required to carry out an assessment and record the outcome of the assessment on the detained person's electronic file (which should presumably now be CORIS).

The *Corrections Management (Placement and Shared Cell) Operating Procedure 2023*[6] guides COs that become aware of a change of a detained person's circumstances which may impact the risk to, or from that detained person in their accommodation area. If a CO becomes aware of a risk to or from a detained person, they must notify their Area Supervisor (CO2), and record the information they have received on the detained person's electronic file (CORIS). The Area Supervisor is then required to review the detained person's electronic file and consider the risk and the requirement for an accommodation placement review.

OICS reviewed 'notes' and 'risk alerts' in CORIS as well as the SCC Unit 'Daily Brief' document. No information was recorded electronically in either system on the day, or in the days preceding the incident, relating to risk of Detained Person B assaulting Detained Person A.

In response to a draft copy of this report, ACTCS noted that 'minor arguments are not an uncommon occurrence at AMC and the vast majority of these do not result in physical altercations or assaults.

Finding 3:

Detained Person A reportedly notified a Corrections Officer about an argument he had with the alleged perpetrator prior to the assault, but there is no record of these concerns being recorded on any information management system.

5.2.2 CORIS – Information Management System

In reviewing this incident OICS considered the way information relating to risk was recorded on CORIS.

Significant investment has been made in CORIS as an Offender Management System to provide a more modern comprehensive management of corrections processes and improve data capture and management. As of June 2022, ACTCS had spent $7.606 million on the development and roll-out of CORIS,[7] which 'went live' on 27 June 2022. ACTCS notes that a significant benefit of CORIS compared to ACTCS' previous Custodial Information System (CIS) is CORIS' capability to provide

[5] *Corrections Management (Risk Alerts) Policy 2019*. This has not been updated since CORIS 'went live' mid 2022.

[6] *Corrections Management (Placement and Shared Cell) Operating Procedure 2023*

[7] Mick Gentleman MLA, Response to Question on Notice No 813, ACT Corrective Services—Corrections Information System (Question No 813), Hansard Page 2519 Week 07 Monday 15 August 2022.

real time and better-quality information to ACTCS staff relating to detained people at the AMC.[8]

CORIS is modular in design which means different functionality can be added on and customised. Current features relevant to this incident include:

- an *Incident Module* which is designed to capture all relevant information relating to an incident including collating CO Incident Report Forms and Incident Summary Reports. All staff members involved in an incident are required to complete an incident report following an incident.[9]
- *Notes* relevant to an individual detained person. These can include record of attendance or refusal to attend appointments, programs, employment, visits, case notes, health information, general comments etc.
- *Alerts* such as security classification, escape or violence risk, Incentive and Earned Privilege (IEP) level, non-associations, health alerts, information relating to court orders etc.

The *notes* and *alerts* are important features of CORIS as they provide vital information to support COs ability to effectively manage risk. However, this information is linked to an individual detained person's electronic file on CORIS. Currently the functionality of CORIS that enables COs managing units to view relevant information specific to that unit at a glance, is not being utilised.

5.2.3 Daily Brief – accommodation information log

Alongside CORIS, the AMC utilises Microsoft Word Documents saved on the AMC computer network drive known as the Daily Brief. The Daily Brief is specific to accommodation units. The Daily Brief pre-dates the introduction of CORIS, dating back to at least 2014 and possibly earlier. It does not appear to be cross referenced or linked to CORIS, nor referenced in any AMC policy or procedure. OICS is aware that this document is usually completed at the end of a shift by the CO2 Area Supervisor and that COs will often read the Daily Brief at the start of their shift to familiarise themselves with what has been happening in the unit since their last shift on that unit.

The Daily Brief seen for the relevant period for this review contains practical / administrative information relating to the unit (such as movements of detained people between cells, linen change schedule, use of TV remotes etc). It also contains information relating to operational environment and risk, eg.

> *[detained person] was making threats to [detained person], any more threats he has been told by Management that he be moved to Segro if it persists.*

As well as information relating to individual detained people that would normally be seen in a case note, eg:

> *[detained person] has had the Placement Assessment completed, waiting on [staff member] to complete referral to go into SCC North.*

In this instance, the two comments above were not also recorded on CORIS. It is unclear if this sort of information is routinely also recorded in a detained person's 'notes' on CORIS in addition to Daily Brief.

For the relevant period reviewed, it was apparent the Daily Brief was utilised in an ad hoc way to record a wide range of information – some of it mundane and procedural, but some of it pertinent to safety and risk in the unit environment. Concerningly, it appeared that the latter types of

[8] ACT Corrective Services Sharepoint Site for CORIS.

[9] See *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2020*. This policy, and the Incident Reporting, Notifications Debriefs Operating Procedure 2020 predate the implementation of CORIS, resulting in a lack of specific guidance for ACTCS staff on requirements of reporting incidents in CORIS. OICS notes both documents are currently under review and hope to see this issue addressed in the revised versions.

information may not be consistently recorded in CORIS.

5.2.4 Multiple systems

It is of significant concern that the AMC operates with multiple information systems recording unit-based operational risk (CORIS, plus Daily Briefs for various units) with no clear guidance on intended use of the Daily Brief nor how it is to interact with CORIS. Clarity around information systems is particularly important when recording safety and security alerts or significant interactions between detained people, for the purpose of sharing information with other staff working in the accommodation unit and across the jail. Multiple manual points of information recording is inefficient, potentially duplicates efforts, and increases the risk of an error occurring. It reduces likelihood of the right information being available to the right person at the right time. Staff may have differing understandings of the use of each system, or there may be confusion about what information is recorded where.

ACTCS have put considerable financial and human resources into the design and delivery of CORIS including significant staff training. There is a need to review the use of the Daily Brief to assess what information is currently recorded in this document, and if and how it should be recorded in CORIS. The objective of such a review should be to ensure efficient processes that ensure key information relating to the management of risk and related to wellbeing of detained people being accessible to the right people at the right time.

Recommendation 1:

That within 3 months of the tabling of this report, ACT Corrective Services review the interaction of CORIS with the Daily Brief. The review should focus on how to ensure systems for recording key information relating to risk, and safety and wellbeing of detained people are efficient, minimise gaps and are well understood by Corrections Officers.

It does not appear that the existence of multiple systems played a part in this incident (as it appears no information was recorded on any system that could have prevented it occurring). However, having dual systems introduces unnecessary and unacceptable risk in custodial operations and needs to be addressed, and may potentially create confusion among staff about where such information should be recorded.

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