ICS
ACT Inspector of Custodial Services

# REVIEW OF A CRITICAL INCIDENT

**by the**

# ACT CUSTODIAL INSPECTOR

*Suspected drug overdose, endangering life of a detained person at the Alexander Maconochie Centre 21 May 2024*

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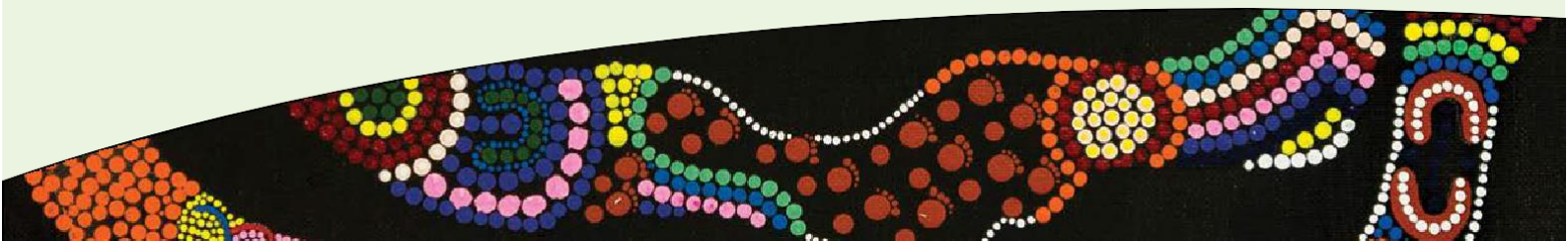

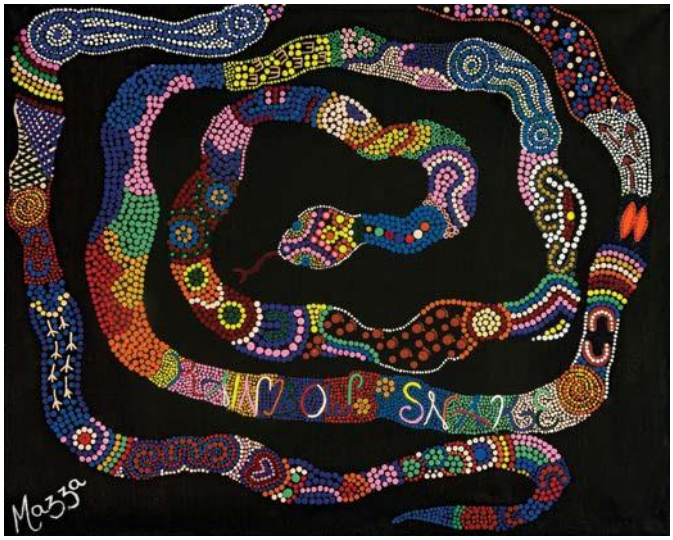

*Rainbow Serpent* (above and cover detail)
Marrilyn Kelly-Parkinson of the Yuin Tribe (2018)

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

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

**Content warning**

Readers should be aware that this report includes information related to the treatment and conditions of people in places of detention, including deaths in custody.

**About this report**

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ACT Custodial Inspector

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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# ACT CUSTODIAL INSPECTOR

*Suspected drug overdose, endangering life of a detained person at the Alexander Maconochie Centre 21 May 2024*

Rebecca Minty
ACT Inspector of Custodial Services
May 2025

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# Glossary

| Term | Meaning |
|---|---|
| ACTCS | Corrective Services |
| ACTP | ACT Policing (AFP) |
| AMC | Alexander Maconochie Centre (ACT adult prison) |
| CI Act | *Custodial Inspector Act 2017* (ACT) |
| CM Act | *Corrections Management Act 2007* (ACT) |
| CO | Corrections Officer |
| CORIS | ACTCS information management system |
| HHC | Hume Health Centre |
| Inspector | ACT Custodial Inspector |
| JHS | Justice Health Service |
| MCR | Master Control Room |
| OICS | Office of the Inspector of Custodial Services |
| TCH | The Canberra Hospital |
| WR1B | Women's Remand Cottage 1, B-pod |

# 1. Executive Summary

On 21 May 2024 after evening lock-in, a detained woman (Detained Person A) experienced what appears to have been a drug overdose from the opioid heroin. It occurred in Woman's Remand Cottage 1, B-Pod (WR1B) in the Women's Community Centre (WCC) precinct at the Alexander Maconochie Centre (AMC). The woman became unresponsive, and several detained women attempted to revive her including by providing Cardiopulmonary Resuscitation (CPR). Another detained woman attempted to alert Custodial Officers (COs) via phone to the Master Control Room (MCR), and by banging on the entrance door to the pod and entering the enclosed veranda area to attract attention of any staff in the closest officer's station, located in a nearby building. However, this station was unstaffed at the time. After some delay in connecting, the call reached the MCR operator who called a Code Blue (medical emergency). Custodial Officers and Justice Health Services (JHS) nurses responded. The COs waited for JHS nurses before entering the cottage and all arrived at the cottage five minutes after the call from the cottage connected to MCR. Approximately six minutes after an attempt to contact the MCR was first made by detained people, Justice Health Services staff rendered first aid including administering oxygen and Detained Person A regained consciousness shortly after. She was later taken by ambulance to The Canberra Hospital (TCH), but was not admitted, and returned to the AMC several hours later where she was accommodated in the Crisis Support Unit.

The Inspector may conduct a Critical Incident Review of certain events in a correctional centre or in the provision of correctional services, including where 'a person's life [is] endangered'. The Inspector formed the view that this incident met that threshold.

Subsequent to the incident, only one officer initially completed an incident report as he advised other officers involved that it was not necessary as his report would cover all issues. Notification of the incident was not made to supervisors as required by policy. The Inspector learnt of the incident from an Official Visitor. The Inspector consequently sought information from the Corrective Services (ACTCS) Acting Commissioner, who at that time was not aware of the incident. The Acting Commissioner commenced an Internal Review, with terms of reference that included ACTCS' response and why this incident was not reported at the time. The Inspector nevertheless determined that a review by her office was appropriate given the seriousness of the incident, the value of public reporting and the potential for any recommendations to contribute to prevention of similar incidents in future.

This Critical Incident review finds that the response by COs did not demonstrate the urgency that the situation demanded and is required by relevant policy and procedure. Several factors likely contributed to this, including AMC was below its optimum staffing level on night shift; and CCTV footage was likely not immediately monitored in the MCR to provide a contemporaneous understanding of the situation. After the incident, measures were not put in place to reduce the risk of any further overdose in the cottage such as conducting a search for drugs, or closer surveillance of the cottage overnight. Incident reporting and record keeping did not meet policy and procedural requirements, with no apparent consequences for the failure. Furthermore, the disciplinary process applied to the detained women accommodated in WR1B after the incident on 21 May 2024 did not comply with relevant legislation, policy or procedure.

The Inspector was pleased to see a rigorous internal review of the incident by ACTCS, which identified most of the issues outlined above and made several recommendations for improvement. Overall, this Critical Incident Review mostly complements the findings and recommendations made by the ACTCS Internal Review. Given that there have been few ACTCS internal reviews of incidents in recent years and formal internal reviews are not embedded in the ACTCS incident reporting framework, the Inspector has recommended that ACTCS embed an internal review process within

its incident review framework. The *Custodial Inspector Act* 2017 envisaged the Inspector's Critical Incident review function *complement* internal reviews, and furthermore the Inspectorate is not currently resourced to conduct significant numbers of critical incident reviews.

This review focuses on the ACTCS and JHS response to the incident, and does not consider how the drug or drugs that caused the likely overdose were in the possession of Detained Person A. The Inspector's next Healthy Prison Review (due to be tabled by the end of 2025) will consider drugs and harm minimisation as part of the whole of prison review.

This review makes 10 findings and 8 recommendations.

# 2. Findings & Recommendations

**Finding 1:**

The *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2020* does not contemplate Corrective Services conducting internal reviews, and over recent years there have been few internal reviews conducted into critical and serious incidents in custodial settings.

**Finding 2:**

It is a positive practice, and a leading approach in Australia, that Naloxone is available for use by JHS nurses and COs after hours at the AMC when there are no medical services onsite.

**Finding 3:**

There were insufficient Corrections Officers on shift on the night of 21 May 2024 to ensure the Women's Community Centre officer post was staffed in accordance with Corrective Services operational guidance.

**Finding 4:**

Staffing arrangements were such that male Corrections Officers responded to this incident, rather than female staff as per the expectations set out in Corrective Services policy and the *ACT Public Sector Correctional Officers Enterprise Agreement 2023-2026*.

**Finding 5:**

Master Control Room operators at the AMC would benefit from a checklist for emergency situations to guide the operators on the information they should seek from detained people in an emergency.

**Finding 6:**

There is a discrepancy between the time displayed on the digital clock in the Master Control Room, and the timestamps used on CCTV and audio recordings which makes accurate post incident review and analysis unnecessarily complex.

**Finding 7:**

On the night of this incident the requirement of two Custodial Officers stationed and available to perform required duties at Master Control Room post was not met.

### Finding 8:

During the incident, Corrective Services policies and procedures that require CCTV footage to be appropriately monitored by the Master Control Room operator do not appear to have been followed.

### Finding 9:

That a previous OICS recommendation made in 2022, and agreed to by government, "[t]hat Corrective Services review and document the roles, staffing, management and operation of the AMC Master Control Room and any special training requirement for staff rostered in the Master Control Room" has still not been implemented.

### Finding 10:

The disciplinary process applied to the detained women accommodated in WR1B after the incident on 21 May 2024 did not comply with relevant legislation, policy or procedure.

### Recommendation 1:

Within 3 months, Corrective Services ensure the policy framework and staffing capacity is in place to ensure critical reflection and timely review of incidents to embed a culture of continuous improvement. Relevant policy should provide for discretion to initiate internal reviews for at least any incident that meets the definition of both a Critical Incident under the *Custodial Inspector Act 2017* and a 'notifiable incident' under Corrective Services policy.

### Recommendation 2:

Within 3 months, Corrective Services consider providing detained people with direct access to Naloxone, as well as basic first aid training periodically including on cardiopulmonary resuscitation.

### Recommendation 3:

Corrective Services immediately confirm that the intercom from the Women's Community Centre cottages to the Master Control Room (MCR) is working correctly, including ensuring that any intercom calls to the local officer station are forwarded immediately to MCR if an officer station is unattended.

## Recommendation 4:

Starting within 3 months, Corrective Services (ACTCS) ensure that AMC night shift is sufficiently staffed overall to ensure that the Women's Community Centre (WCC) post is staffed by at least two Corrections Officers during night shift, and that wherever possible these are female staff. In the meantime, and whenever WCC is not staffed at night, ACTCS ensure that the Master Control Room monitors the WCC cottages CCTV at all times during night shift unless exceptional circumstances necessitate otherwise.

## Recommendation 5:

Within 3 months, Corrective Services permanently roster two staff to be stationed in the Master Control Room (MCR) at all times, including night shift, with at least one having significant experience as a Corrections Officer. All MCR officers should be provided specific training, including detailed information about what to ask detained people in the case of an emergency and guidance until help arrives.

## Recommendation 6:

As recommended in its internal review of this incident, Corrective Services (ACTCS) immediately ensure consequences for staff not complying with legislation and ACTCS policy.

## Recommendation 7:

Corrective Services immediately ensure that all operating procedures concerning discipline and searching for contraband using body scanning technology are compliant with relevant legislation and notified policies and procedures, including the *Human Rights Act 2004*.

## Recommendation 8:

Corrective Services ensures policies are followed to ensure detained people who test positive for illicit substances, refuse to be tested, or are involved in suspected drug-related incidents are referred to alcohol and other drug services.

# 3. Introduction

## 3.1 Authority for the review

The CI Act defines certain events in a correctional centre or in the provision of correctional services which are 'critical incidents' that the Inspector may review.

During this incident, Detained Person A became unresponsive and was reported to be turning blue. Custodial Officers and JHS nurses arrived at the WCC, and after JHS intervention, Detained Person A became responsive. She was taken to hospital but not admitted and returned to the AMC some hours later. Based on information considered in this review, it is probable that Detained Person A experienced an overdose (likely the opioid heroin). The Inspector therefore considers this incident to be a critical incident under the CI Act in that it amounts to 'a person's life being endangered'.

The Inspector has discretion whether to review a critical incident, guided by criterion in OICS *Operating Procedure – Exercising discretion to review a critical incident*. Applying this, the Inspector decided to conduct a critical incident review noting particularly the seriousness of the incident, the value of public reporting and the potential for any recommendations to contribute to prevention of similar incidents in future.

## 3.2 Methodology

The Inspector undertakes critical incident reviews with a view to identifying good practices and any areas for improvement at a systems level.

The Inspector initially learnt of this incident from an Official Visitor and sought clarification from the Acting Commissioner. It became apparent that ACTCS' incident reporting policy had not been followed which included failure to notify the Assistant Commissioner (Custodial Operations) and Acting Commissioner.[1] The Acting Commissioner directed that an internal review of the incident be conducted (Internal Review). Corrective Services provided a final draft of the Internal Review to OICS in December 2024. The Inspector waited until the Internal Review was undertaken before commencing OICS' review and had the benefit of seeing that review.

Material considered by OICS in this review included case notes on CORIS (the ACTCS custodial records management system), health records concerning Detained Person A's medical treatment arising from the incident, CCTV footage of the cottage where the incident occurred and the MCR, intercom recording, and relevant ACTCS policies and procedures. As the Internal Review included staff interviews, OICS did not seek to re-interview staff but considered the interview notes.

This review focuses on the system response (in particular, ACTCS and JHS) to the *potential* of a drug overdose in prison, including the immediate aftermath as well as incident reporting and record keeping. It does not consider the precise nature of drug consumed by Detained Person A, how drugs were accessed and consumed, or the nature of any drug use by detained people leading up to the incident. The issue of drug supply, demand and use, and harm minimisation will be considered as a spotlight topic in the 2025 Healthy Prison Review of the AMC.

[1] Under ACTCS policy, this was a 'notifiable incident' requiring the Duty Manager to notify both of these positions of the incident within 60 minutes of the event. A 'notifiable incident' includes where a cell door was unlocked after hours other than to provide medication.

# 4. Background

## 4.1 The Incident on 21 May 2024

A chronology is provided at Appendix 1.

On 21 May 2024 after evening lock in,[2] Detained Person A experienced a medical emergency, in what was likely a drug overdose. She was accommodated in WR1B at the WCC precinct in the AMC at the time. According to CCTV and audio from the cottage intercom (phone), it appears she became unresponsive while in a cell. She was dragged from that cell to the communal area by other detained women who commenced (or possibly continued) chest compressions on her.

Another detained person (Detained Person B) attempted to seek assistance by calling the MCR from an intercom (phone) in WR1B approximately 1 minute after Detained Person A was dragged into the common area. For reasons that are not entirely clear to OICS, there was a delay of approximately 90 seconds in the line connecting WR1B to the MCR (although it may have been due to the call going to the closest officer station, which was unattended, before diverting to MCR). While waiting to connect to the MCR, Detained Person B also sought to attract attention of COs by banging on the entrance door to the pod and entering the enclosed external veranda. However, possibly unknown to the detained women, the nearby WCC officer station was not staffed at the time.

When the intercom (phone) connected to the MCR, Detained Person B stated that Detained Person A had "passed out". In response, the MCR immediately called a Code Blue (medical emergency) and COs and JHS nurses responded. The night shift supervisor and another CO were in MCR at the time (in addition to a CO who was posted as MCR operator). When the Code Blue was called, two COs left the MCR in the gatehouse to attend WCC, which was a short distance away but required traversing several gates. This left the one CO posted to MCR responsible for all MCR duties. The other CO assigned to the MCR/X-ray post was performing other duties in the gatehouse.

In a subsequent call to the MCR, Detained Person B and another detained person (Detained Person C) advised that Detainee Person A was turning blue. The MCR officer asked if Detained Person A had "taken anything", to which Detained Person C replied: "I really don't know". Throughout the incident, CCTV footages demonstrate that detained people in WCC were continuously performing CPR and circling the common area in an agitated state while frequently looking outside to determine if staff were approaching. At one point on the audio recording, a detained person in the background can be heard saying "I can't keep going", likely a reaction to having attempted CPR for several minutes.

The audio recording from the intercom (phone) between WR1B and the MCR indicates urgency and agitation in the tone of Detained Person B's voice. It does not appear that the MCR brought up the relevant CCTV camera from WR1B to one of their viewing screens until five minutes after the first attempt was made to contact the MCR. Had the MCR operator done so sooner, that officer may have sought to communicate the apparent urgency of the situation via radio to the responding COs and JHS nurses. For example, that footage would have showed detained people attempting CPR and otherwise acting in an urgent manner. It is noted that during this period the MCR operator had to respond to other matters in addition to this incident, such as intercom calls from other detained people and a smoke alarm being activated elsewhere in the AMC.

The first two responding COs waited at the WCC precinct for JHS nurses to arrive for approximately a minute before entering WR1B, where assistance was rendered immediately by the JHS nurses.

[2] Evening head count is at 7:00pm and lock in occurs immediately after. For cottage accommodation at the AMC, the door to the cottage is locked at this time but detained people can still move between their cells and communal areas of the cottage (kitchen, lounge area, bathroom).

It took approximately 6 minutes between detained people attempting to contact the MCR and the COs and JHS nurses arriving on the scene (5 minutes after the intercom call first connected).

Fortunately, Detained Person A became responsive shortly after being attended to by JHS nurses. She was taken to TCH and subsequently returned to AMC in the early morning of 22 May 2024, where she was accommodated in the Crisis Support Unit until 25 May 2024.

The ACTCS Internal Review found that the cause of the medical event Detained Person A suffered was unknown, but assumed it was a drug overdose. Taking into account all of the circumstances and evidence gathered, some of which is sensitive and confidential and was not available to the ACTCS Internal Review, the Inspector concludes that an overdose (likely to the opioid heroin) probably caused the incident on 21 May 2024.

After the incident, there was no comprehensive search of WR1B (full area sweep) that night (21 May 2024), however this review makes no formal findings on whether that was feasible with available staffing resources and competing priorities. Manual and electronic search records indicate that searches were conducted in all WCC cells on 22 and 24 May 2024, and a K9 (drug detection dog) search of WCC was conducted on 23 May 2024. Nothing was found but the K9 team showed interest in two particular areas of WR1B. Four of the five detained people in WR1B underwent a body scan, with two indicating an anomaly leading to them being placed in segregation and losing privileges. Four of the five detained people who had been in WR1B were drug tested between 23 and 27 May, with three testing positive for various substances although this may not be from taking illicit substances in the AMC given that detained people may be prescribed certain substances through Justice Health Services (e.g. Buprenorphine which is an opioid) or may have ingested substances pre-admission that are still present in their system upon testing. As noted by the Internal Review, none of the test result records or case notes indicated how the drug test results should be interpreted. The Inspector concurs with ACTCS Internal Review comment that it is important for records to be as detailed as possible to inform ACTCS' understanding of drug use patterns across AMC and to inform future actions that may need to be taken based on those results.

As a further general reflection, OICS notes that a system of testing wastewater at the AMC would provide ACTCS with useful information indicating the type and prevalence of drugs in the prison and is worthy of consideration as part of a broader drug strategy.

In relation to reporting, the night shift supervisor completed an incident report and uploaded it at around 1am on 23 May (a case note was made on 22 May stated that the note was a 'late entry due to system fail').

### 4.2 Conducting an internal review of this incident was positive practice

On 24 July 2024, the ACTCS Acting Commissioner requested that the ACTCS Quality Assurance and Risk team undertake a review of the incident (Internal Review), with a terms of reference to:

- examine ACTCS' response to the incident with a focus on what drew attention to the incident and the time taken to respond to the incident;
- explain why this incident was not reported at the time;
- identify what supports were provided at the time for those detainees who witnessed the event; and
- identify any other relevant matters arising during the Review.

The Internal Review met with relevant current staff involved in the incident except for 2 staff (the MCR operator and a JHS nurse) who were no longer employed with their respective employers. It also reviewed relevant CCTV, audio, documents and conducted a site visit. The internal review was

thorough and made 9 findings and 3 recommendations. It is a positive feature of this review that it considered systemic issues relevant to the specific issues raised by the incident.

The internal review recommended:

| |
|---|
| *Recommendation 1 —* ACTCS clarify the scope of responsibilities and decision-making of night shift supervisors and distinguish that role from the role of the duty manager. |
| *Recommendation 2 —* ACTCS retire the *Local operating procedure for items identified on Body Scanner* and communicate legislatively compliant guidance to staff regarding managing anomalies. |
| *Recommendation 3 —* ACTCS ensure consequences for non-compliance with legislation and ACTCS policy are clearly identified and followed through on in every instance. |

Corrective Services policy contemplates debriefs but not reviews. The *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2020* refers to two types of post incident reflective practice 'hot debriefs' and 'formal debriefs'. A hot debrief occurs almost immediately post incident and is an opportunity to check on any immediate issues, concerns and welfare. According to ACTCS policy, a formal debrief is a structured process that is intended to offer staff the opportunity to work through the incident chronologically, identify key issues for learnings to mitigate recurrence and to assist in addressing operational or staff wellbeing concerns (see further, Appendix 3).

It is suggested that in contrast, a review involves more comprehensive information gathering such as reviewing records and talking to interested parties. Further, it provides the opportunity for critical analysis and reflective practice including findings and recommendations including potentially considering systemic matters. The Internal Review undertaken by ACTCS is a positive practice. The Inspector notes that there have been relatively few internal reviews conducted by ACTCS in recent years.[3]

This review recommends that ACTCS embed an internal review framework in policy and practice. This would not duplicate OICS' function of independently conducting select critical reviews that are made public. The Explanatory Statement to the CI Act notes the Inspector's critical incident review function was intended to sit alongside ACTCS internal review function:

> The definition of a 'critical incident' establishes a high threshold for incidents that occur in a custodial environment. This definition aims to ensure accountability and public transparency of events that may cause significant impact or harm in a custodial setting. It also reflects that there are appropriate existing internal review mechanisms within correctional centres for the oversight of events or incidents which do not cause significant harm.[4]

[3] The Inspector is aware of less than 5 since 2018, in a period where the Inspector received approximately 37 notifications of Critical Incidents and reviewed 16 of these.
[4] When OICS was established, it appears to have been anticipated (and funded for) reviewing 1 critical incident per year. The Inspector is also only funded presently to conduct 1 critical incident review per year, although has generally undertaken more than this since the office was established.

**Finding 1:**

The *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2020* does not contemplate Corrective Services conducting internal reviews, and over recent years there have been few internal reviews conducted into critical and serious incidents in custodial settings.

**Recommendation 1:**

Withing 3 months, Corrective Services ensure the policy framework and staffing capacity is in place to ensure critical reflection and timely review of incidents to embed a culture of continuous improvement. Relevant policy should provide for the discretion to initiate internal reviews for at least any incident that meets the definition of both a Critical Incident under the *Custodial Inspector Act 2017* and a 'notifiable incident' under Corrective Services Policy.

# 5. Matters arising from the incident

Corrective Services policies and procedures relevant to this incident are discussed further Appendix 3.

Given the presence of illicit drugs in AMC (see callout box), ACTCS must prioritise a drug strategy that encompasses reducing both supply and demand for illicit substances, measures to minimise harm caused by drugs, and comprehensive supports for those using drugs (ie Alcohol and Other Drug treatment, counselling and psycho-social support). This review acknowledges that various programs and initiatives are in place but these should be brought together and given appropriate priority through a strategy.

In the case of opioid overdose, an important harm minimisation measure is the availability of Naloxone, a drug that reverses the effect of opioid overdose. The AMC has Naloxone available for use by JHS nurses and COs after hours when there are no medical services onsite[5]. This is excellent practice, and a leading approach in Australia.

### Risk of drug overdoses in jail

The prevalence of drugs in custodial settings is widely documented. Illicit drugs may enter a custodial environment in a range of ways including being brought in by detained people, visitors, staff, contractors, deliveries, or thrown or dropped (e.g. via drone) over the perimeter fence. Detained people may also stockpile or trade in prescription medication obtained within the prison, although not all medications that are available in the community can be prescribed in a custodial setting.

As part of OICS 2025 (not yet published) Healthy Prison Review, we surveyed detained people at the AMC. Fifty-six per cent of detained people who answered the question agreed with the statement 'It is easy to get illicit drugs in the AMC)' (n=100).

Overdose in a custodial setting poses a serious risk to life. Since 2016 there have been 2 deaths in the AMC that a coroner has found attributable to drug use / overdose. Coronial inquests into those deaths made several recommendations about minimising both the supply of and demand for illicit substances at the AMC, that are beyond the focus of this review. It should be noted that there have been a further 5 deaths in the AMC that are still before the coroner with cause of death not yet published.

In a previous inquest, the ACT Coroner has acknowledged the efforts of Corrections Officers entering cells to commence CPR within seconds of responding to a suspected drug overdose.

Nationally, since 2016, there have been 14 deaths in custody attributed to drug overdose in prison. (See University of Queensland's *The Deaths in Custody Project* at https://www.deaths-in-custody.project.uq.edu.au/)

[5] This is an implemented recommendation of the 2019 OICS Healthy Prison Review. In 2020 ACTCS introduced Naloxone into first aid kits in units and trained COs in its use so that in the event of a suspected overdose after hours, staff could administer it until further medical assistance arrived. It also follows a 2018 recommendation by the ACT Human Rights Commission (Health Services Commissioner), *Review of the Opioid Replacement Treatment Program at the Alexander Maconochie Centre* (Report, March 2018).

**Finding 2:**

It is a positive practice, and a leading approach in Australia, that Naloxone is available for use by JHS nurses and COs after hours at the AMC when there are no medical services onsite.

### 5.1 Sound policies and procedures for afterhours response to suspected overdose, but response lacked requisite urgency

The *Corrections Management (Code Blue – Medical Emergency) Operating Procedure 2024* provides that all officers have a duty of care to provide first aid except where providing such aid places anyone at risk of harm, for example where one or more detained people are offering physical resistance.[6]

Policy and training requires that in a situation of 'immediate need' (for example, an unresponsive detained person), ACTCS staff must not wait for JHS staff, but instead must consider what emergency medical assistance they can provide, including dispensing Naloxone, until further medical assistance arrives. Corrective Services advised that information about the administration of Naloxone to detained people in cases of suspected overdose is emailed to staff 'periodically'. Naloxone specific training is not mandatory as training is not required to use the nasal administered product, Nyxoid. Nonetheless, in August 2022, Naloxone training (including information and practical use of Nyxoid) was added to the first aid course delivered to staff.

Corrective Services sent a reminder to staff in August 2024 about the availability and use of Naloxone Nasal Spray, which stresses the importance of Naloxone being available and dispensed before health staff arrive:

> Naloxone is not harmful to people if administered to someone who is not overdosing, and you cannot overdose on Naloxone. Where you suspect a detainee has overdosed it will simply reverse the effect of the drugs and prevent death.
>
> Intranasal Naloxone will be available for use during critical incidents along with emergency medical treatment where it is possible that a person may be suffering from an overdose. Should a person be found unresponsive, with signs of breathing problems, severe sleepiness, blue lips, pinpoint pupils, *Naloxone can be used to resuscitate whilst waiting for Justice Health code pink [sic] response or an ambulance after hours* [emphasis added].

This was good practice and ongoing vigilance and attention to these matters is required.

Corrective Services policy, procedure and training material appears appropriate and evidence-based including in relation to the provision of assistance to detained people in medical emergencies (however, 'code pink' is no longer a recognised code under ACTCS' emergency management procedures and the discrepancy with other notified policy and procedure should be addressed immediately).

In this incident response, although a timely 'Code Blue' (medical emergency) was called by the MCR operator and staff responded to that code, staff delayed entering the pod until JHS staff and additional COs arrived in the WCC precinct (a delay of approximately 1 minute), an approach which is inconsistent with policy direction to enter a unit and render immediate assistance in case of emergency. It is worth noting that there was no evidence of 'a significant threat or risk to staff

[6] The AMC *Duties of First Responding Officer – Training Manual* (October 2023) states the same.

members' that would provide an alternative approach under the relevant policy. One minute may seem like a relatively small delay, however, seconds may be vital in emergency response situations.

The lack of utmost urgency in response may have been caused by staff not receiving any supplementary radio calls that could have clarified the urgency of the situation. The role of the MCR post in an emergency is discussed later in the report.

It is crucial that COs respond to medical emergencies where a detained person is unresponsive with requisite urgency and in line with policy and procedure. Every additional minute of delay can be critical to the outcome.

### 5.2 Additional harm minimisation measures focusing on detained people should be considered

Corrections Officers and JHS staff are often called on to provide emergency lifesaving responses as part of their work, a part of their function that may not be fully appreciated or acknowledged publicly.

In this incident, efforts of the detained people involved in the incident on 21 May 2024 must also be acknowledged. Several of them performed CPR until further assistance was provided. It may be that those efforts were critical to Detained Person A's recovery. Their efforts, and decision to alert ACTCS staff to an unresponsive detained person, which risked scrutiny of drug taking behaviour and potential disciplinary action, were noteworthy.

After evening lock in, detained people are likely to be first responders to an overdose by a cellmate or someone in their cottage. In this context, the availability of harm minimisation measures may be life saving.

While the focus of ACTCS must be on a rapid, appropriate response from COs in the first instance, there is also value in considering what further skills and tools detained people can be provided with in cases of suspected drug overdose. In such circumstances, provided they are given the appropriate guidance, OICS suggests there is value in considering if detained people should be provided access to Naloxone so they dispense it in emergency situations, noting evidence from California indicating positive outcomes (see Appendix 2). This approach may have some complexity, for example, ensuring the best possible follow up care and support if detained people administer Naloxone to their peers, and managing ACTCS' duty of care in relation to drugs circulating in the prison. However, it may save a life.

Separately, there would be value in providing basic first aid training to detained people that covers CPR. Beyond the immediate detention setting, this would have benefit as a general life skill.

**Recommendation 2:**

Within 3 months, Corrective Services consider providing detained people with direct access to Naloxone, as well as basic first aid training periodically including on cardiopulmonary resuscitation.

### 5.3 Availability of staffing on the night contributed to a slower response

The AMC has a 'Regime Management Plan' (RMP) that sets out required staffing levels for day and

night, and guides distribution of staff across various 'posts' within the jail.[7] Regime Management Plan requirements were not met on the night of 21 May 2024. There is also a form for Night Shift Managers to complete which requires the Night Shift Manager to ensure there are two officers for certain specified teams.

The RMP states that, where possible, ACTCS will ensure the availability of female COs where there are women in custody, a principle also reflected in the ACT Public Sector Correctional Officers Enterprise Agreement 2023-2026 (Enterprise Agreement).[8] The WCC post was not staffed at the relevant time, and only male COs were available to attend the WCC post when the incident occurred.

If the WCC post was staffed at the time, there would have been a more rapid response to the incident – not only might staff have heard the detained person banging on the door of the pod, but the WCC officer station is just meters away from the WR1 cottage with no gates to pass through when the Code Blue was called.

Corrective Services policy states that cell doors must not be unsecured without a minimum of three officers present unless an immediate risk to the preservation of life is identified.[9] In the present incident, considering all the information available, there was an immediate risk to the preservation of Detained Person A's life, albeit in circumstances where the responding officers did not have full access to all relevant information. Nonetheless, the Inspector considers that in these circumstances, it was not necessary for a minimum of 3 staff to be present before unlocking the pod door.

The Inspector understands that in practice there may be some reticence to open a cell/cottage door after hours unless there are three staff present, presumably due to risks of assault by detained people.

The number of staff on duty after hours is also critically important. If more than one emergency situation were to occur at the same time, as almost occurred on 21 May 2024 when a fire alarm sounded, there will be further challenges in sufficient staff attending both incidents in a timely way if night rostering is below optimum levels.

In response to a draft of this report, ACTCS agreed that officers should have entered before JHS staff but disagree that there is sufficient evidence that responding officers were aware that an immediate risk to the preservation of life had been identified. Corrective Services submit that there was a Code Blue and first responding officers were aware that a detainee had 'passed out'. No further communication had been provided to them. Corrective Services further notes that in the absence of any additional information or updates on the situation, officers made a reasonable decision to wait for additional staff given they were entering a cottage (rather than a cell) where up to 5 detainees were housed.

**Finding 3:**

There were insufficient Corrections Officers on shift on the night of 21 May 2024 to ensure the Women's Community Centre officer post was staffed in accordance with Corrective Services operational guidance.

[7] *Alexander Maconochie Centre – Regime Management Plan* suggests it is made under the *Regime Planning Policy,* but that policy has been repealed and replaced by the *Corrections Management (Core Day) Policy 2023.*
[8] *ACT Public Sector Correctional Officers Enterprise Agreement 2023-2026 Clause 01.*
[9] *Corrections Management (Night Shift) Operating Procedure 2019* (Restricted).

**Finding 4:**

Staffing arrangements were such that male Corrections Officers responded to this incident, rather than female staff as per the expectations set out in Corrective Services policy and the *ACT Public Sector Correctional Officers Enterprise Agreement 2023-2026*.

**Recommendation 3:**

Corrective Services immediately confirm that the intercom from the Women's Community Centre cottages to the Master Control Room (MCR) is working correctly, including ensuring that any intercom calls to the local officer station are forwarded immediately to MCR if an officer station is unattended.

**Recommendation 4:**

Starting within 3 months, Corrective Services (ACTCS) ensure that AMC night shift is sufficiently staffed overall to ensure that the Women's Community Centre (WCC) post is staffed by at least two Corrections Officers during night shift, and that wherever possible these are female staff. In the meantime, and whenever WCC is not staffed at night, ACTCS ensure that the Master Control Room monitors the WCC cottages CCTV at all times during night shift unless exceptional circumstances necessitate otherwise.

### 5.4 Master control room was understaffed and key incident response functions were not adequately fulfilled

The MCR is the 'nerve centre' of the AMC and has a central role at night when detained people are locked-in and the centre runs on night shift staffing. Staff in the MCR are responsible for a range of functions including movement control (opening gates etc), monitoring CCTV and alarms, radio traffic control, cell intercom responses, and incident control. It can be a particularly challenging post due to multiple demands, particularly when there is an incident(s).

In case of an incident such as this, MCR must:

- Monitor cameras and intercoms and respond to detainee intercom calls as required.
- Control movement through doors and gates.
- Arrange a CO to investigate and check the relevant CCTV.
- On the notification of an incident code, log the incident in the MCR logbook.
- Adjust the cameras as required to ensure best possible coverage of the location for the duration of an incident.
- Notify emergency services and ensure their access to the centre.
- If the MCR officer observes anything of further concern, notifying the Forward Commander, who in this case was the night shift supervisor.

The RMP and Night Shift Operating Procedure require two staff be assigned to MCR post (and presumably, to be available to perform the relevant duties of that post at any time required). On the night of this incident there were two staff assigned to the combined MCR and x-ray post, but one

officer was performing duties outside the MCR and was instructed to stay there after the incident to manage ingress for emergency services.

There are too many responsibilities in MCR for a single staff member during night shift, particularly if an incident occurs, or multiple incidents occur concurrently.

During the incident, it appears that the MCR officer logged the incident in the MCR logbook as required and called a Code Blue in a timely way. It appears highly likely based on CCTV footage of the MCR, that the MCR officer did not bring up WR1B cameras until 19:52, some 5 minutes after the intercom from WR1B connected, contrary to incident response requirement.[10] From the CCTV, it is clear from 19:46 onwards that the detained people in the WR1B were very concerned for the welfare of Detained Person A. The attempts by detained people to resuscitate Detained Person A can be clearly seen on the camera from 19:47. Had MCR had vision of WR1B, it may have changed the way ACTCS staff responded to the incident (for example, a supplementary radio call could have been made updating responding staff about the urgency of the situation).

It should be noted that at the time the incident was unfolding in WR1B, the MCR operator also had to deal with intercom calls from elsewhere in AMC, and a fire alarm that was ultimately shown to be a false alarm but regardless, necessitated the MCR operator coordinating attendance of ACT Fire and Rescue.

In a 2021 Critical Incident Review of an escape from secure custody,[11] The Inspector highlighted the importance of MCR post being sufficiently staffed by COs who have received appropriate training for the demands of the post. That review recommended:

> **Recommendation 3:**
>
> That Corrective Services review and document the roles, staffing, management and operation of the AMC Master Control Room and any special training requirement for staff rostered in the Master Control Room.

The government 'Agreed' to that recommendation, and the response noted:

> The Master Control Room operating procedures will be reviewed, and any consequential training will be identified and delivered within the custodial training schedule.

This recommendation has still not been implemented. The government response committed to do this by 31 December 2022, however the timeframe for completion has been extended to 30 June 2025. Corrective Services has advised that MCR Operating Procedures are scheduled for review as a priority in 2025. This is a crucial piece of work that is long overdue.

In response to this draft report, ACTCS noted that mentoring / training has been undertaken by an experienced officer for MCR operations since June 2024. Nineteen officers have completed this mentoring / training, which has been developed in consultation with the Organisational Capability Unit and uses a competency checklist to ensure relevant topics are consistently covered and understood by officers. The Inspector welcomes this approach but does not consider it fully addresses the recommendation.

In the present case, it is observed that in addition to reviewing CCTV footage earlier, the MCR operator could have attempted to gather further information about the situation on the call and potentially offered relevant instructions until help arrived (for example, check Detained Person A's

[10] Including the *Master Control Room – Incident Response Operating Procedure* and *Master Control Room – Night Shift Operating Procedure.*
[11] OICS, *Escape of a detainee from a secure escort on 9 July 2021* (Report, 2021) 15.

airway). A checklist for emergency medical situations may assist guiding an MCR operator until further assistance was available.

The Inspector suggests that as part of the review of MCR procedures, there is considerable merit in ACTCS working with key stakeholders such as Justice Health Services, ACT Ambulance Services and ACT Fire and Rescue to develop a script or checklist to assist MCR operators when a detained person calls in an emergency situation (e.g. medical emergency, fire etc.).

On a separate matter, reviewing this incident it was apparent that the timestamps on the CCTV differ from the clock displayed in the MCR, which was presumably used by the MCR operator to log significant developments in the incident. This causes confusion as the MCR wall clock may be referred to for recording information in registers and logs etc. It should be calibrated and checked regularly.

**Finding 5:**

Master Control Room operators at the AMC would benefit from a checklist for emergency situations to guide the operators on the information they should seek from detained people in an emergency.

**Finding 6:**

There is a discrepancy between the time displayed on the digital clock in the Master Control Room, and the timestamps used on CCTV and audio recordings which makes accurate post incident review and analysis unnecessarily complex.

**Finding 7:**

On the night of this incident the requirement of two Custodial Officers stationed and available to perform required duties at Master Control Room post was not met.

**Finding 8:**

During the incident, Corrective Services policies and procedures that require CCTV footage to be appropriately monitored by the Master Control Room operator do not appear to have been followed.

**Finding 9:**

That a previous OICS recommendation made in 2022 and agreed to by ACT Government, "[t]hat Corrective Services review and document the roles, staffing, management and operation of the AMC Master Control Room and any special training requirement for staff rostered in the Master Control Room" has still not been implemented.

**Recommendation 5:**

Within 3 months, Corrective Services permanently roster two staff to be stationed in the Master Control Room (MCR) at all times, including night shift, with at least one having significant experience as a Corrections Officer. All MCR officers should be provided specific training, including detailed information about what to ask detained people in the case of an emergency and guidance until help arrives.

### 5.5 Poor reporting and record keeping must be addressed at each level of operations

The ACTCS Internal Review included a robust consideration of incident reporting and record keeping, including a recommendation on the subject, which OICS endorses and repeats below.

Corrective Services policy acknowledges the imperative to report incidents transparently, to the appropriate authority and in a timely manner to ensure that confidence is maintained in ACTCS. In an incident of this type the Duty Manager must notify both the Assistant Commissioner (Custodial Operations) and the Commissioner within 60 minutes of the conclusion of the incident, or as soon as is practicable in the event of an ongoing incident. This did not occur within the timeframe, or at all.

An incident summary and the associated incident reports must be provided to AMC Executive Support by the next business day, who must then provide the relevant material to ACTCS Operational Compliance within 2 days of the incident occurring in the case of notifiable incidents. This did not occur.

The night shift supervisor completed an incident report which was uploaded to the CORIS database around 1 a.m. on 23 May 2024 (just over 24 hours post incident). Policy requires all those involved in an incident complete an incident report. The Inspector understands that the night shift supervisor instructed the other officers involved in the incident not to complete individual incident reports because in his view his report would cover all material aspects. Further, OICS understands that the night shift supervisor characterised this incident as one not involving a serious injury or threat to life and on that basis he did not contact the Duty Manager, or consider it a 'notifiable incident'. The Inspector was not informed of any feedback, guidance, supervision or support being provided to this officer from his supervisors in relation to his non-compliance with policy, something that should be standard in cases of significant departure from required operational policy and procedure.

The remaining officers did not upload additional incident reports to the CORIS database until more than 5 weeks after the incident between 5 to 12 July 2024 (following OICS notification of this incident to the Acting Commissioner). As of March 2025, the night supervisor's report and the incident reports of the other six officers remain 'pending level 1 review' on the CORIS database and so have not been finalised. This means they could still be edited and changed. Corrective Services processes require a more senior staff member to finalise such reports.

The officer rostered in the MCR on the evening of 21 May 2024 did not complete an incident report at all and left their employment with ACTCS without doing so.

In summary, several critical aspects of ACTCS incident reporting and recording were not followed:

- All officers involved did not prepare contemporaneous incident reports;
- Officer reports were not checked by more senior officers and 'locked' for editing;
- No incident records were created within the timeframes set out in policy;
- The Duty Manager was not notified of the incident;

- The Assistant Commissioner was not notified about the incident;
- The Commissioner was not notified about the incident;
- The Custodial Inspector was not notified about the incident.

Previous OICS Critical Incident reviews have raised concerns about poor reporting practices, including where not all the officers 'involved, or who witnessed' the incident complete a report. The Inspector is concerned that not only are some COs not appropriately completing incident reports, but that more senior officers are not discharging their obligations to ensure reports are properly completed and approved in a timely fashion. It is particularly concerning to see such failures in reporting serious incidents when it is assumed staff would expect more senior ACTCS management and external bodies, such as OICS, to be reviewing such material. If appropriate record keeping obligations are not being met for such serious incidents, it raises serious questions about how more routine incidents are being recorded.

While it is important to have effective, evidence-based policies and procedures, these documents are only useful if they are put into practice, senior staff take responsibility for compliance and quality control, and themselves role model compliance. The Inspector restates the recommendation made by the Internal Review.

**Recommendation 6:**

As recommended in its Internal Review of this incident, Corrective Services (ACTCS) immediately ensure consequences for staff not complying with legislation and ACTCS policy.

### 5.6 What support was provided post-event?

The ACTCS Incident Reporting policy requires that Divisional Executives ensure appropriate supports for staff and detained people after serious incidents as required. Corrective Services has made significant improvements in recent years in the important matter of ensuring staff have access to appropriate, timely support such as Employee Assistance Programs, peer support, and post incident support. This recognises that the role of Corrections Office includes stressful situations and exposure to both direct and vicarious trauma.

It is positive that the ACTCS Internal Review considered the post-event support, including to detained people, noting that this incident may have significantly impacted them. While Detained Person A received medical care from JHS nurses and support from the Case Management and Supports and Interventions Unit teams in the period following the incident, it does not appear that counselling or other supports were offered to the other detained people involved.

It is apparent from the evidence, particularly the CCTV and audio recordings, that the detained people spent considerable time and energy trying to revive Detained Person A and appeared at times extremely anxious and stressed during the incident. Case notes indicate that after the incident several detained people reported disrupted sleep, asked to be placed in segregation and showed physical signs of distress such as shaking. One detained person was placed in the Crisis Support Unit after acting 'in a highly distressed state' at 1:35am two days after the incident.

Corrective Services provides limited advice to staff about how to manage the recovery for detained people following an incident, including welfare management. Proactive and prosocial engagement between staff and detained people helps to identify where detained people may need assistance. Justice Primary Health Services (Primary Health), Custodial Mental Health Services (CMHS), Winnunga Aboriginal Health Services (Winnunga) and the AMC Supports and Interventions Unit

provide health and wellbeing services to detained people at the AMC. However, it does not appear any referral was made to these services to reach out to the detained people in WCC after the incident. Access to appropriate support should have been offered to the other women detained in WR1B. Although beyond the scope of this review the chronic lack of supports and services for detained people with mild to moderate mental health conditions and psychosocial disability was raised in the Inspector's 2022 Healthy Prison Review, and the Auditor General's 2022 review of the *Management of Detainee Mental Health Services in the Alexander Maconochie Centre*. The latter also recommended that COs receive training and ACTCS provide guidance material to improve the timely identification of mental health issues in detained people.

### 5.7 Disciplinary procedures and searching

Over the days following the incident ACTCS conducted searches of the women's cottages and cells including using the K9 team (drug detection dogs). No drugs or drug paraphernalia was found during these searches.

However, the first of these searches did not take place until 22 May 2024, the day after the incident. The immediate risk arising from this was that there may have been more drugs in the pod on the 21 May 2024 carrying a risk of further overdoses. This risk could have been mitigated in various ways such as conducting a full sweep, utilising K9s sooner, or having (female) staff stationed in that cottage to conduct observations. These options may have necessitated calling additional staff in to work.

Following the incident, four of the 5 women on WR1B were required to undergo body scans and drug tests. Due to anomalies indicated on body scans, some detained people were subjected to disciplinary punishment including a significant period of loss of privileges (180 days). This was imposed applying a local operating procedure adopted at AMC for responding to anomalies on body scans. This document is inconsistent with the requirements set out in the *Corrections Management Act 2007* and ACTCS notified policies and procedures. In particular the local procedure:

- lays disciplinary charges with prescribed penalties without regard to whether that penalty is appropriate, consistent and proportionate to that specific incident;
- imposes the maximum penalty under the *Corrections Management (Detainee Discipline) Policy 2023*;
- alters a detained person's Incentives and Enhanced Privileges (IEP) status based on a single event instead of a pattern of behaviour; and
- mandates a strip search (compliant or non-compliant) if a detained person records a 'positive scan' (e.g. an anomaly is detected) and does not provide a contraband item.

The standard of proof applied in a disciplinary hearing is whether a disciplinary breach charge has been proven on the balance of probabilities. In situations where the scan is inconclusive as to whether an anomaly is contraband, it is questionable as to whether, on the balance of probabilities, it can be concluded that the person has drugs or other prohibited thing concealed in their body.

The Inspector, along with other oversight bodies,[12] had raised concerns about this local operating procedure in the months prior to this incident, and subsequently. A loss of privileges for a prolonged period has a significant impact and may result in:

- only 1 phone call a week and 1 virtual video visit per week;

[12] Human Rights Commission, Ombudsman and Official Visitors.

- prohibition of money being deposited into their account by family and friends (e.g. for use on phone calls, food buy-ups or activity buy-ups);
- prohibition of access to the gym, education and other activities; and
- limits on the ability to make purchases such as toiletries.[13]

Corrective Services advised OICS that it has now altered this local operating procedure to address these inconsistencies. However, OICS is concerned that a punitive, unreasonable and potentially unlawful local procedure was in place, evincing a lapse in appropriate governance in its development.

**Finding 10:**

The disciplinary process applied to the detained women accommodated in WR1B pod after the incident on 21 May 2024 did not comply with relevant legislation, policy or procedure.

**Recommendation 7:**

Corrective Services immediately ensure that all operating procedures concerning discipline and searching for contraband using body scanning technology are compliant with relevant legislation and notified policies and procedures, including the *Human Rights Act 2004*.

Beyond the immediate operational response to a suspected drug overdose and detained people testing positive to prohibited drugs, there should be consideration of, and referrals to, appropriate alcohol and other drug supports. This may include medication assisted treatment and counselling.

The AMC *Drug and Alcohol Testing in Correctional Centres Policy* and *Corrections Management (Drug Testing (Urine)) Operating Procedure 2022* state that detained people with a confirmed positive result must be referred to the Alcohol and Other Drug Treatment Team for assessment, evaluation, and access to supports/treatments. AMC's policy was not followed as no referrals were made in this instance.

**Recommendation 8:**

Corrective Services ensures policies are followed to ensure detained people who test positive for illicit substances, refuse to be tested, or are involved in suspected drug-related incidents are referred to alcohol and other drug services.

[13] Privileges are defined in the *Corrections Management (Detainee Discipline – Penalties) Operating Procedure 2023*

# Appendix 1: Chronology of Incident

The Inspector has attempted to develop a chronology of the incident, but this has proved difficult to confirm because there is a lack of detailed incident reports from officers and witnesses, as discussed in this review. The estimated times in this chronology are based on the CCTV footage of the common area of the Women Community Centre (WCC) cottage WR1B, the Master Control Room (MCR) and various walkways around the AMC.[14]

19:46:00 - a detained person can be seen on CCTV dragging Detained Person A into the common area of the cottage, with the assistance of another detained person. Detained Person A appears unresponsive. It is apparent from the CCTV footage that detained people in the vicinity are concerned for Detained Person A's wellbeing.

19:47:16 - another detained person (Detained Person B) lifts the intercom (phone) to attempt to make a call to the MCR. Audio recording is not available for this call, and the CCTV recording of the MCR does not provide sufficient detail to ascertain if the call was successful. The Inspector assumes the call is not connected.

19:47:49 - Detained Person B begins banging on the entrance door to the pod presumably to alert staff after not being connected to the MCR. She can be seen continuing to hold the phone and at times lifting it to her face.

19:48:14 - Detained Person B leaves the phone but does not return the phone to the hook, instead leaving it hanging via its cord, to enter the enclosed cottage veranda (presumably to call out for help). Detained people commence/continue chest compressions of Detained Person A and these are continued throughout the incident. Based on earlier obscured vision of Detained Person A, it is likely that attempts at cardiopulmonary resuscitation (CPR) were attempted even earlier, while Detained Person A was still in the cell.

19:48:18 - The audio recording of calls between WR1B Pod and the MCR commences with the MCR staff member saying "control room". The phone has been off the hook in WR1B since 19:47:16, so it is unclear why the call is connected at this time. While no detained person is present to respond, background noise on the recording indicates that several detained people are concerned about something. They can be heard repeatedly calling out Detained Person A's name and there are references to someone not answering. It is unclear if this is a reference to Detained Person A not responding or difficulty speaking to the MCR. The MCR would have heard this.

19:48:38 - Detained Person B returns to the phone from the enclosed veranda and finally speaks to the MCR, stating "hello, something, we need somebody to come down, [Detained Person A] has passed out". At this time, there is only one of the two assigned COs in the MCR, although two other officers are present as part of their broader duties including the night supervisor. The MCR officer replies to the detained person ''No worries, we'll get someone to go down there now". Detained Person B urges staff to "hurry up". MCR staff member replies "yeah, we're coming now."

19:48:52 - Detained Person B apparently ends the call but leaves the phone receiver off the cradle. Between calls she walks out of the communal area via a sliding door into the enclosed veranda area, presumably to look out for staff approaching the cottage.

At 19:48:53 - the night shift supervisor calls a 'Code Blue' medical emergency and leaves the MCR with another CO to respond to the incident, resulting in the MCR being staffed by one officer. The MCR officer

[14] The CCTV timestamp is approximately 1 minute 10 seconds ahead of the clock displayed on the wall of MCR (and visible on the CCTV footage of the MCR).

then alerts additional COs and Justice Health Services (JHS) staff to the need for response to the medical emergency. This results in two additional COs making their way to WCC from sentenced unit, and two JHS staff making their way from the AMC's Health Centre to WCC. At this time, the CCTV footage shows the officer in the MCR monitoring the gates and making entries in the logbook.

19:49:35 - Detained Person B again returns to the phone and listens briefly to the receiver before returning the phone to its cradle. She then immediately picks up the receiver again. However, based on the audio recording timestamp, it appears she isn't connected to the MCR until 19:50:38.

19:50:00 to 19:50:38 - the MCR officer can be seen monitoring the movements of officers around the AMC, some apparently unrelated to the incident. Footage of WR1B is not clearly identifiable on any screen in the MCR.

19:50:38 - Detained Person B is connected to the MCR and urges staff to "hurry up". The MCR staff member replies "nurses are coming right now and so are staff". Detained people can be heard in the background calling "we need help", "hurry up" and "she is turning blue". The MCR staff member asks if Detained Person is awake, but as the detained person leaves the phone at 19:50:44, it is unlikely she heard the question, she returns the receiver to its cradle but the audio recording continues.

At 19:51:53 - another detained person (Detained Person C) picks up the phone and states "hello". The MCR officer responds to say nurses are in the area. The detained person states that "a girl is blue". The MCR staff member asks if Detained Person A is breathing. Detained Person C replies that she can feel a pulse, but she can't see much, and "her face is all blue…I've told her to squeeze my hand but she isn't responding at all". The MCR asks if Detained Person A has "taken anything". Detained Person C replies "I really don't know". MCR advises that she has just let staff "through the gate".

Detained Person C leaves the call and advises the other detained people that she has been told the staff have arrived. This call finishes at 19:52:26 and the detained person can be seen returning the phone to its cradle. However, the call apparently did not terminate as background noise from the cottage is captured for several minutes including the arrival of staff.

19:52:17 – The first responding officers pass through the gate to WCC precinct. It is at this time that CCTV from the MCR show the MCR officer accessing live CCTV footage from WR1B for the first time.

19:53:02 - JHS staff pass through the gate to WCC precinct.

19:53:39 - The first responding COs enter WR1B at the same time as JHS staff. Detained people cease chest compressions. Corrections Officers direct detained people to go to their cells. All ACTCS officers in attendance are male.

19:54:00 - JHS staff begin examining and treating Detained Person A at, approximately 7 minutes after the first attempted call by detained people to alert staff. JHS staff advised ACTCS staff that an ambulance is required.

At 19:58:00 - After JHS staff provide oxygen via a mask, Detained Person A begins speaking to JHS staff.

20:01:30 - Detained Person A can be seen on CCTV to lift her head from the floor, before sitting up and communicating with JHS and ACTCS staff.

20:04:24 – Detained Person A stands up and begins walking.

20:07:00 - First ACT Ambulance Service emergency vehicle arrives at AMC

20:09:51 - The first ACT Ambulance Service staff member enters the pod.

20:11:00 - Second ACT Ambulance Service vehicle (ambulance) arrives at the AMC.

20:14:07 - Further ACT Ambulance Service staff enter the pod.

20:27:13 - Detained Person A can be seen leaving the pod with emergency services team to attend TCH via ambulance.

In the early morning of 22 May 2025, Detained Person A returned to the AMC from TCH and was accommodated in the Crisis Support Unit until 25 May 2025.

# Appendix 2: Provision of Naloxone to detained people

The California Department of Corrections and Rehabilitation (CDCR) has found the distribution of Naloxone to detained people to be successful:

> As of February 2024, all CDCR incarcerated persons are offered an intranasal naloxone kit by nursing as part of the reception center process [sic], and individuals are allowed to keep the naloxone on their person if they transfer from one housing location to another. This allows incarcerated individuals to easily access naloxone if needed without the fear of retaliation or adverse consequences by revealing illicit drug use to custody staff.[15]

The CDCR found that as of February 2024, there had been 57 documented Naloxone events with administration by an incarcerated person to another incarcerated person experiencing an overdose. However, the Departments suggest the true number of naloxone administrations by an incarcerated person is likely much higher, but many overdoses are not reported and thus remain undocumented.

In Los Angeles in 2021, the lives of two detained people were saved when Naloxone was administered by fellow detained people.[16]

[15] The California Department of Corrections and Rehabilitation & California Correctional Health Care Services, *Impact of Naloxone Availability and Distribution within the California Department of Corrections and Rehabilitation* (Report, May 2024) 11.

[16] Los Angeles County Sheriff's Department (USA), 'Sheriff's Naloxone Custody Pilot Project Saves Inmates from Overdose' (27 May 2021) https://lasd.org/sheriffs-naloxone-custody-pilot-project-saves-inmates-from-overdose/#grve-about-author

# Appendix 3: Relevant Policies and Procedures

Several ACTCS policies, procedures and related documents are relevant to this incident, including those with relevant aspects summarised below.

The *Corrections Management (Code Blue – Medical Emergency) Operating Procedure 2024* provides that all officers have a duty of care to provide first aid except where providing such aid places anyone at risk of harm, for example where one or more detained people are offering physical resistance. Further, if the MCR officer is alerted to a possible Code Blue by a detained person over the intercom (phone) system, the MCR officer should contact an officer to investigate and check the relevant CCTV including monitoring it as per the Incident Response Operating Procedure. The MCR officer must ensure that CCTV is focused on the incident. If the MCR officer observes anything of further concern, the MCR officer must notify the Forward Commander (FC).

The Code Blue Operating Procedure further requires that all staff involved in or witnessing an incident must submit the required reports under the *Incident Reporting, Notifications and Debriefs Policy* as soon as possible following an incident. At the latest, these reports must be completed prior to the end of the shift (unless circumstances do not allow in which case the FC may allow the officer to complete the report as soon as practicable).

The *Corrections Management (Master Control Room – Incident Response) Operating Procedure 2019* requires that on the notification of an incident code, such as a Code Blue, the MCR staff must log the incident in the MCR logbook. The operating procedure also requires that MCR staff adjust the cameras as required to ensure best possible coverage of the location for the duration of the incident.

The *Alexander Maconochie Centre – Regime Management Plan* (RMP) establishes the services and activities to be delivered, and the associated staffing resources required at the AMC. The RMP prioritizes safety, security and reintegration and has been developed in consultation with the Community Public Sector Union. The RMP has been developed in a way to afford the highest level of flexibility to the Area Managers on a daily basis to ensure the obligations of the Corrections Management Act are met, while ensuring that health, safety and security obligations are prioritized.

The RMP states that, where possible, ACTCS will ensure the availability of female Correctional Officers where there are female detainees in custody.

The AMC's *Duties of First Responding Officer – Training Manual* (October 2023) states that "all Corrections Officers have a duty of care to provide first aid except where providing first aid puts any person at risk of harm".

**Incident Reporting Obligations**

The *Corrections Management Incident Reporting, Notifications and Debriefs Policy 2020* establishes guidelines and obligations for the reporting of incidents and associated notifications. An incident is defined as an event that may cause threat to the personal safety of staff, clients or others. The Policy acknowledges that it is imperative that incidents are reported transparently to the appropriate authority and in a timely manner to ensure that confidence is maintained in ACTCS.

The Policy requires that all incidents should be brought to the immediate attention of the Duty Manager for their consideration and in the case of 'notifiable incidents', that the Deputy Commissioner (Custodial Operations) (position title has been replaced with Assistant Commissioner Custodial Operations) and ultimately the Commissioner must be notified. The incident which occurred on 21 May 2024 falls into several types of 'notifiable incident' including

- Where a cell is unlocked after hours other than to provide medication; or
- Any other incident that should be reported due to the nature of the event, the potential

for adverse publicity or attention or poses a significant threat to the security and safety of the community and/or any staff member.

In such cases, the Commissioner must be notified of the incident by the Duty Manager withing 60 minutes of the conclusion of the incident, or as soon as is practicable in the event of an ongoing incident.

The Policy further requires that all staff who were involved in, or witnesses an incident, complete an incident report form as soon as practicable. Incident reports must be reviewed and quality assured by the Duty Manager by close of business on the same day. It is the obligation of the Duty Manager to ensure that all required reports have been received.

A post incident debrief is a structured discussion or review of an incident to identify any learnings and check on the welfare of those involved. The Policy states that debriefing will be required for most incidents and can include both hot debriefs and formal debrief. The Policy requires a hot debrief to occur following:

a. a physical injury to a staff member in a custodial or community corrections setting;

b. suicide attempt or death in custody;

c. detainee assault on staff;

d. detainee on detainee assault;

e. any event that would reasonably be expected to traumatise or adversely impact staff wellbeing; and

f. any event that presents a significant threat or risk to staff members.

A formal debrief is a structured process following an incident that is intended to offer staff the opportunity to work through the incident chronologically, identify key issues for learnings to mitigate recurrence and to assist in addressing operational or staff wellbeing concerns. The Policy does not require a formal debrief in the case of a medical emergency involving a detained person.

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).

When finalized, an incident summary and the associated incident reports must be provided to AMC Executive Support by the next business day, who must then provide the relevant material to ACTCS Operational Compliance within 2 days of the incident occurring in the case of notifiable incidents.