



**ACT**  
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Justice and Community Safety

# Moss Review

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Annual Report, February 2018





**ACT**  
Government

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Justice and Community Safety

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## Executive Summary

The death of Steven Freeman on 27 May 2016 is a profound tragedy. We recognise the ongoing grief and sadness that Steven Freeman's family has experienced since that time and we also acknowledge the significant impact that his death continues to have on the Aboriginal and Torres Strait Islander community.

In the year since the Government released its response to the review by Mr Philip Moss AM, *"So Much Sadness in Our Lives": Independent Inquiry into the Treatment in Custody of Steven Freeman* (the Moss Review), the ACT Government has taken significant steps to improve the well-being and safety of people in the Alexander Maconochie Centre (AMC).

The Government response agreed to eight of the nine recommendations from the Moss Review. Recommendation 7 of the Moss Review related specifically to the ACT Health Services Commissioner, an independent statutory officer holder who has conducted an 'own motion investigation' into matters relating to delivery of health services within the AMC including the prescription of Methadone at the AMC. The ACT Government will consider any findings arising from the Health Services Commissioner's report in due course. In addition, the ACT Government will also consider any findings arising from the Coroner's Inquest in the death of Steven Freeman once these have been handed down.

The past year has seen significant progress being made against all recommendations, with an Independent Steering Committee confirming that three recommendations have now been fully satisfied. The recommendations satisfied relate to enhanced CCTV capability at the AMC; the investigation and subsequent prosecution of serious assaults that occur within the AMC.

The ACT Government remains committed to ensuring people held in custody receive health services equal to those that are available in the community and meet individual needs. ACT Health, along with ACT Corrective Services, is working collaboratively with Winnunga Nimmityjah Aboriginal Health and Community Services to deliver culturally specific and appropriate health services to people in custody, and has commenced trialling arrangements to improve health service options for detainees at AMC.

Many of the recommendations require on-going cooperation and improved information-sharing between key stakeholders, and I am pleased to see strong focus and leadership being applied by Directors-General and key stakeholders involved to achieve this. Work will remain ongoing in these areas.

The establishment of an Inspector of Correctional Services in 2018 along with supporting legislation will help promote the continuous improvement of correctional centres and correctional services. It will also ensure systematic review and scrutiny of the correctional centres and services, and provide independent and transparent reporting to ensure the highest levels of scrutiny and strong accountability. The commencement of this role will also provide on-going assurance around the implementation of the Moss Review recommendations.

I wish to acknowledge and thank Mr Russell Taylor AM as the Independent Chair of the Oversight Steering Committee for leading the implementation work with Directors-General and key Aboriginal and Torres Strait Islander community leaders. This work remains on-going, and as can be seen by this Annual Report, the Government is making substantive changes to improve the treatment and care of all persons held in custody.

Shane Rattenbury MLA  
Minister for Corrections

## Moss Implementation Annual Report

### Recommendation 1

|  | Government Position | Lead  | Executive Sponsor | Status          |
|--|---------------------|-------|-------------------|-----------------|
| That ACTCS conduct a survey of electronic surveillance at the AMC to ensure best practice protection for, and the security of, detainees including:<br>training for AMC custodial officers operating CCTV cameras;<br>and developing protocols relating to camera settings, movement and recording   | AGREED              | ACTCS | ACTCS             | <b>COMPLETE</b> |
| <p><u>Associated Conclusions:</u></p> <p><i>Changes have been made since Steven Freeman's assault. In particular, three new cameras have been installed in Sentenced Unit 1, facing towards the cell doors. Had these cameras been in place at the time of Steven Freeman's assault, there would have been additional evidence available to ACT Policing and ACTCS about which detainees entered Steven Freeman's cell. The Inquiry concludes that, had these measures and processes been in place when Steven Freeman was admitted to the AMC, the likelihood of his being assaulted would have been significantly reduced.</i></p> <p><i>The Inquiry understands that the CCTV cameras in operation at the time of Steven Freeman's assault had the capability to "sweep", although they were not used in this way. The Inquiry notes that one of the cameras could be moved to observe Steven Freeman's cell door, as occurred when the Code Pink was called. The Inquiry concludes that ACTCS consider increased use of sweeping CCTV cameras regularly.</i></p> <p><i>The Inquiry concludes that ACTCS should log all movements of CCTV cameras consistently with the requirements of the Australian Standard.</i></p> <p><i>The Inquiry concludes that training consistent with the Australian Standard is not given to CCTV Operators at the AMC.</i></p> <p><i>The Inquiry concludes that the security of the AMC is lessened by the incorrect time being displayed on CCTV footage, which makes it unnecessarily difficult to determine the time of incidents within the AMC.</i></p> |                     |       |                   |                 |
| <p><u>ACT Government Action</u></p> <ul style="list-style-type: none"> <li>• Supporting infrastructure related to this recommendation has been implemented. This has included the installation of additional CCTV cameras and the improvement to the quality of images that are provided by the CCTV System.</li> <li>• The Steering Committee attended the AMC on 27 July 2017 to view the CCTV system in order to better understand the capability of the system.</li> <li>• ACTCS implemented a training package to support the operation of the CCTV system which has been included in the ongoing training of all correctional officers.</li> <li>• The policies and procedures related to this recommendation have also been notified, and are being implemented by ACTCS</li> <li>• On 22 November 2017, the Steering Committee found this recommendation to be satisfied.</li> </ul>   |                     |       |                   |                 |

## Moss Implementation Annual Report

### Recommendation 2

|   | Government Position | Lead                | Executive Sponsor       | Status          |
|---|---------------------|---------------------|-------------------------|-----------------|
| <b>That ACT Policing accord a higher priority to the investigation of any assault at the AMC</b>  | AGREED IN PRINCIPLE | ACTCS /ACT Policing | ACTCS/ DPP/ACT Policing | <b>COMPLETE</b> |
| <p><u>Associated Conclusions:</u></p> <p><i>The Inquiry concludes also that the investigations of serious assaults at the AMC should be given a higher priority by ACT Policing. The Inquiry notes that during Steven Freeman's bail hearings, ACT Policing gave evidence that they were not treating his assault as an attempted murder investigation.</i></p> <p><i>The Inquiry concludes that the current system of notification regarding deaths in custody by ACT Policing is inappropriate, particularly for Aboriginal and Torres Strait Islander peoples. The Inquiry notes that ACT Policing treat all deaths in custody as a criminal investigation, and so must be involved in notification to the family.</i></p> <p><i>The Inquiry concludes that ACTCS should attempt to attend with ACT Policing when they notify the detainees' family, preferably an ACTCS Indigenous Liaison Officer.</i></p> <p><i>The Inquiry concludes that ACTCS should not undertake cultural activities without consulting with the relevant family (following a death in custody). If the family cannot be contacted, ACTCS should consult with the Aboriginal organisation supporting the family.</i></p> <p><i>The Inquiry concludes that ACTCS and ACT Policing should update their MOU to reflect changes made in August 2015 when ACT Policing began providing ACTCS with: the statement of facts for current charges, a list of all victims, a list of known associates, and a list of alerts on ACT Policing which records those who are relevant to the safety of the detainee or other detainees at the AMC, any victims, the AMC or the Community.</i></p> <p><u>ACT Government Action</u></p> <ul style="list-style-type: none"> <li>• Following consultations which commenced in early January 2017, the Memorandum Of Understanding (MOU) between ACTCS and ACT Policing was reviewed and updated to reflect the issues raised in the Moss Report. The amended MOU was agreed by both agencies and signed on 28 April 2017. It sets out the arrangement between ACT Policing and ACTCS, including information-sharing, cooperative management arrangements relating to serious incidents and operations, and the nature of incidents to be reported to and responded by ACT Policing. The amended MOU includes arrangements for reporting serious assaults to Deputy Chief Police Officer level within ACT Policing to ensure investigations are appropriately prioritised and have appropriate oversight.</li> <li>• In relation to next of kin notifications, the MOU provides that where appropriate, a designated Aboriginal or Torres Strait Islander representative from ACTCS may accompany ACT Policing and/or representatives of the ACT Coroner's Court when notifying the next of kin to provide cultural support. ACTCS will provide a nominated senior officer to attend notifications of next of kin in support of ACT Policing or the Coroner's representative at their request This approach is in the spirit of Recommendation 19 of the Royal Commission into Aboriginal Deaths in Custody around notifications to next of kin.</li> <li>• The MOU between ACTCS and ACT Policing provides for a Management Committee to oversee and manage the relationship between the two agencies with a specific focus on the arrangements of the MOU and other operational and policy issues. The ACTS/ACT Policing Management Committee forum met for the first time on 10 August 2017 and is scheduled to meet again in early 2018.</li> <li>• The Steering Committee sought advice from ACT Policing on 26 July 2017 and 22 November 2017 to understand how this recommendation was being met.</li> <li>• On 12 December 2017, the Moss Implementation Steering Committee agreed this recommendation has been satisfied, and received detailed briefings on the investigation and prosecution decision processes.</li> </ul> |                     |                     |                         |                 |

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### Recommendation 3

|   | Government Position | Lead  | Executive Sponsor | Status          |
|---|---------------------|-------|-------------------|-----------------|
| <b>That ACT Policing, ACTCS and ACT DPP develop and adopt pro-charge and pro-prosecution policies in relation to assaults at the AMC</b>  | AGREED IN PRINCIPLE | ACTCS | ACTCS             | <b>COMPLETE</b> |
| <p><u>Associated Conclusions:</u></p> <p><i>The Inquiry understand that ACT Policing already has a pro-arrest policy in relation to family violence matters. The Inquiry concludes that a similar pro-charge policy is required for violent incidents at the AMC.</i></p> <p><i>The Inquiry concludes that consideration should be given to how ACTCS and ACT Policing can work together in the context of investigations to achieve a coordinated, rather than serial and separate approach, to matters at the AMC.</i></p> <p><i>The Inquiry concludes also that ACTCS and ACT Policing should determine how joint investigation would enhance the response to any incident of assault at the AMC.</i></p>  |                     |       |                   |                 |
| <p><u>ACT Government Action</u></p> <ul style="list-style-type: none"> <li>• The Director of Public Prosecutions (DPP) has a Prosecution Policy that fully supports the intent of this recommendation.</li> <li>• The Prosecution Policy can be found on the DPP's website (<a href="http://www.dpp.act.gov.au">www.dpp.act.gov.au</a>).</li> <li>• As an independent statutory officer responsible for prosecution decisions, the DPP has advised that if a report is made of an assault in the AMC and there is sufficient admissible evidence to support a prosecution, the matter will be treated in the same way as assaults in the community.</li> <li>• The views of ACT Policing and the DPP that there is a 'pro-charge' approach when there is sufficient evidence is accepted by the Steering Committee. The Steering Committee came to the view that while the intent of Recommendation 3 was clear, the way it was written may have been misguided.</li> <li>• In October 2016, ACTCS adopted a proactive policy position for reporting violent incidents within the AMC and revised its incident reporting process to better capture information in relation to significant incidents at the AMC, including assaults and serious assaults. In addition to an increased focus on incident reporting at the time of any incident within the AMC, the revised process will review, categorise and compliance check all incidents to identify information gaps and remediate any operational issues.</li> <li>• Following consultations which commenced in early January 2017, the MOU between ACTCS and ACT Policing was reviewed and updated to reflect the issues raised in the Moss Report. The amended MOU was agreed by both agencies and signed on 28 April 2017. The amended MOU includes arrangements for enhanced collaboration between ACTCS and ACT Policing to the investigation of incidents (including assaults) at the AMC. Also refer to Recommendation 2.</li> <li>• General information sharing capability was enhanced in the updated MOU to enable the provision of a statement of facts for current charges, a list of victims, a list of known associates and a list of alerts which records those who are relevant to the safety of the detainee and others.</li> <li>• The Steering Committee considered the investigation into the assault of Mr Freeman and sought further information about the investigation and prosecution decision making process by ACT Policing. The Deputy Chief Police Officer (Crime) provided a written response to the Steering Committee outlining the position of ACT Policing on this issue. ACT Policing and the DPP Deputy Director both met with the Steering Committee to discuss and clarify the roles and responsibilities of both agencies in investigating and prosecuting alleged assaults.</li> <li>• ACT Policing provided advice about other assault incidents that have occurred in the AMC since the new MOU was signed to demonstrate how the intent of this recommendation is being met.</li> <li>• On 12 December 2017, the Steering Committee agreed that the work achieved with these improvements is in the spirit of what Mr Moss intended in his review. The Committee agreed that this recommendation had been satisfied.</li> </ul> |                     |       |                   |                 |

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### Recommendation 4

|  | Government Position | Lead                 | Executive Sponsor    | Status          |
|--|---------------------|----------------------|----------------------|-----------------|
| <b>That the arrangements for the provision of health care at the AMC be established, under contract or MOU, to reflect the respective responsibilities of ACTCS and Justice Health Services</b>  | Supported           | ACT Health and ACTCS | ACT Health and ACTCS | <b>COMPLETE</b> |
| <p><u>Associated Conclusions:</u></p> <p><i>The Inquiry concludes there is need to reform the AMC (ACTCS)/Justice Health Services (ACT Health) relationship under contract or MOU to improve information sharing and to reflect the AMC responsibility and accountability for the management of detainees' safety and wellbeing. This MOU should reflect that Justice Health Services must meet professional health standards and protect patient privacy and confidentiality.</i></p> <p><i>The Inquiry notes that there will need to be a mechanism to ensure that the arrangements established under contract or MOU are workable at the operational level and that issues of concern can be resolved as they arise. Accordingly, the Inquiry concludes that a coordinating committee needs to be established. The committee would comprise representatives of the AMC, Justice Health Services and Winnunga Nimmityjah Aboriginal Health Service.</i></p>  |                     |                      |                      |                 |
| <p><u>ACT Government Action</u></p> <ul style="list-style-type: none"> <li>• The initial timeframe of 30 June 2017 was unable to be met.</li> <li>• In June 2017, an external consultant was engaged to assist to develop a contract or MOU.</li> <li>• Following the work of the consultant, a high-level 'Arrangement' for the provision of health services for detainees was agreed and signed by Directors-General JACS and ACT Health on 15 August 2017.</li> <li>• The Arrangement provides strategic direction and authority to staff and contains the following key elements: <ul style="list-style-type: none"> <li>• Statement of Intent</li> <li>• Guiding Principles</li> <li>• Service Arrangements and Responsibilities</li> <li>• Resources and Governance</li> <li>• Incident reporting and dispute resolution</li> <li>• Relationships and media</li> <li>• Review</li> </ul> </li> <li>• ACTCS and ACT Health jointly briefed staff on the new Arrangement on 16 August 2017.</li> <li>• In support of the Arrangement, a number of supporting schedules are to be developed. The first schedule, on Information Sharing, was signed on 20 November 2017 by the Executive Directors of ACT Health and ACTCS. Further schedules will be developed throughout 2018 to support the collaborative working arrangements between ACT Health and ACTCS.</li> <li>• A joint working group of ACTCS and ACT Health staff is progressing a range of matters associated with Mental Health Services at the AMC. This work further supports this recommendation by strengthening roles and responsibilities between the two Directorates.</li> <li>• On 24 January 2018, the Steering Committee found that the development of the Arrangement and supporting schedules satisfied this recommendation.</li> </ul> |                     |                      |                      |                 |

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### Recommendation 5

|  | Government Position | Lead       | Executive Sponsor    | Status          |
|--|---------------------|------------|----------------------|-----------------|
| <b>That Winnunga Nimmityjah Aboriginal Health Service be integrated into the provision of health care at the AMC in order to introduce its holistic model of care to Indigenous detainees</b>  | AGREED              | ACT Health | ACT Health and ACTCS | <b>ON-GOING</b> |
| <p><u>Associated Conclusions:</u></p> <p><i>Recognising the significant proportion of Indigenous detainees at the AMC, the Inquiry concludes there is a need to introduce Winnunga Nimmityjah Aboriginal Health Service to provide its holistic approach to health care for Indigenous detainees at the AMC.</i></p> <p><i>The Inquiry concludes that the involvement of Winnunga Nimmityjah's holistic model of health care would enhance the provision of mental health and counselling services at the AMC.</i></p> <p><i>The Inquiry concludes that there would be considerable benefit for Aboriginal and Torres Strait Islander detainees if Winnunga Nimmityjah Aboriginal Health Service's holistic approach was integrated into the health care which Justice Health Services provides.</i></p> <p><i>The Inquiry concludes also that a significant role for Winnunga Nimmityjah Aboriginal Health Service is necessary, given the need to enhance the care available to Indigenous detainees in the AMC. The present limited involvement of Aboriginal-led health services in an institution with a detainee population of 25% Aboriginal and Torres Strait Islander peoples is not acceptable.</i></p> <p><i>In light of the RCIADIC recommendations, the Inquiry concludes further that ACTCS and ACT Health work with Winnunga Nimmityjah Aboriginal Health Service to fund and embed its holistic health model for Aboriginal and Torres Strait Islander clients. There are several benefits to this approach, including enhanced Throughcare for detainees leaving the AMC.</i></p> <p><i>The Inquiry concludes that the AMC requires resources for the enhanced role for Winnunga Nimmityjah Aboriginal Health Service</i></p> <p><i>Noting the role the Inquiry proposed for the Winnunga Nimmityjah Aboriginal Health Service at the AMC (to introduce its holistic approach to health care) the Inquiry concludes also that it would be desirable for Winnunga Nimmityjah to be included in this forum.</i></p> <p><u>ACT Government Action</u></p> <ul style="list-style-type: none"> <li>• ACTCS and ACT Health have held facilitated discussions with Winnunga Nimmityjah Health Service to discuss the model of Aboriginal and Torres Strait Islander Health Service delivery in the AMC.</li> <li>• The workshops have achieved significant progress in developing agreed principles and shaping the proposed model of care.</li> <li>• On 28 November 2017, in a new partnership approach, Winnunga increased their support at the AMC initially focused on female detainees as they transitioned to a different accommodation unit. This new partnership approach forges the early implementation of this recommendation by piloting arrangements to support the integration of the Winnunga model of care into the delivery of health and well-being services to be provided in the AMC.</li> <li>• Winnunga's support of female detainees will expand to full integration over time to include males, to incorporate its model of care within the AMC alongside ACT Health services.</li> <li>• ACTCS, ACT Health and Winnunga commenced a series of workshops in January 2018 to work through operational details to support the full integration of the Winnunga model of care into the AMC. This model has key focus areas including information sharing, clinical handover, pharmacy/pathology processes and case management.</li> </ul> |                     |            |                      |                 |

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### Recommendation 6

|  | Government Position | Lead  | Executive Sponsor | Status          |
|--|---------------------|-------|-------------------|-----------------|
| <b>That the ACTCS establish a separate remand prison within the AMC to ensure that remand detainees are segregated from sentenced detainees</b>  | AGREED IN PRINCIPLE | ACTCS | ACTCS             | <b>ON-GOING</b> |
| <p><u>Associated Conclusions:</u></p> <p><i>The Inquiry concludes that AMC should segregate remanded and sentenced detainees, by establishing at the AMC a separate remand facility, and thereby achieve greater human rights compliance.</i></p> <p><i>The Inquiry concludes that, at the AMC, the need to accommodate increasing numbers of detainees, with a wide range of categories and classifications, has been a factor in undermining the original aim of a human rights compliant prison with a focus on rehabilitation.</i></p> <p><i>The Inquiry concludes that if a separate remand prison were established at AMC, there would be improvements in a number of areas, including rehabilitation services, human rights compliance and personal safety of remanded detainees.</i></p> <p><i>The Inquiry concludes that it is inappropriate for the AMC to have to rely on "exceptional circumstances" to breach the human right of a remanded detainee to be segregated. In reaching this conclusion, the Inquiry acknowledges that, as a one institution corrective services system with limited accommodation options, the AMC management regards the personal safety of detainees as its highest priority.</i></p> <p><i>The Inquiry concludes that AMC management needs to be able to achieve both obligations of detainee safety and human rights.</i></p> <p><i>The Inquiry concludes that the claim so commonly made about the AMC being human rights compliant cannot be made in good faith. Until such time as male and female detainees are in separate facilities, and remanded detainees are segregated from sentenced detainees, the AMC cannot be said to be a human rights compliant correctional facility. In reaching this conclusion the Inquiry acknowledges that, as a one institution corrective services system with limited accommodation options, the AMC regards the personal safety of detainees as its highest priority.</i></p> <p><u>ACT Government Action</u></p> <ul style="list-style-type: none"> <li>• This recommendation was agreed in principle as it centres on the development of an additional facility within the AMC to allow for the separation of remand and sentenced detainees. Full implementation of this recommendation will require future decisions of government.</li> <li>• In order to address the intent of the recommendation, the Government has funded a Feasibility Study, which is currently being undertaken to consider infrastructure needs for the AMC for the next 5-20 years. A key consideration in the development of any future infrastructure will be the operating model of the centre, referred to in the report as the 'AMC Centre Logic', ensuring that this facility remains fit for purpose and meets future needs and demands.</li> <li>• Following Steven Freeman's assault, a new detainee induction process was quickly implemented for all new admissions to the AMC. This new process is vital to ensuring the safety and appropriate placement of detainees. Under this new process, all new admissions are located in a separate section of a cell block at the AMC for a period of 5-7 days, during which time they are placed on an observations regime, assessed and further intelligence checks are undertaken with ACT Policing. This new assessment process ensures that the safety and care needs of the detainees are appropriately assessed prior to placing into mixed populations.</li> <li>• The appointment of a new Inspector of Custodial Services will also help inform future decisions around the intent of this recommendation.</li> </ul> |                     |       |                   |                 |

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### Recommendation 7

|   | Government Position | Lead                         | Executive Sponsor | Status          |
|---|---------------------|------------------------------|-------------------|-----------------|
| <b>That the Health Services Commissioner (of the ACT Human Rights Commission) conduct an own motion initiative investigation into the prescription of methadone to detainees at the AMC.</b>  | NOTED               | Health Services Commissioner | Not applicable    | <b>ON-GOING</b> |
| <p><u>Health Services Commissioner's Action</u></p> <ul style="list-style-type: none"> <li>• This recommendation relates to the Health Services Commissioner, who is an independent statutory office holder within the ACT Human Rights Commission. Accordingly, the implementation of this recommendation is wholly a matter for the Health Services Commissioner.</li> <li>• The Health Services Commissioner has initiated an 'own motion investigation' into matters relating to the delivery of health services in the AMC, including matters associated with methadone prescription.</li> <li>• The Health Services Commissioner has advised that the investigation report is in the process of being finalised, and pursuant to the <i>Human Rights Commission Act</i> a draft of the report was provided to key stakeholders for comment in December 2017. It is anticipated the final report will be made public by the end of February 2018.</li> </ul> |                     |                              |                   |                 |

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### Recommendation 8

|   | Government Position | Lead | Executive Sponsor | Status          |
|---|---------------------|------|-------------------|-----------------|
| That the ACT Ombudsman have the role of reviewing the response to all critical incidents at the AMC, including serious assaults   | AGREED IN PRINCIPLE | LPP  | LPP               | <b>ON-GOING</b> |
| <p><u>Associated Conclusions:</u></p> <p><i>The Inquiry notes the concerns of Narelle King, her family and the broader community about the lack of information about Steven Freeman's assault, and the manner and cause of his death in custody. Two submissions to this Inquiry also raised concerns about the lack of transparency into that matter and other critical incidents at the AMC. The Inquiry concludes that, in order for trust to be restored and maintained in the ACT's corrections system independent reviews are required for all critical incidents at the AMC. In the Inquiry's view, a critical incident would include any serious assault.</i></p> <p><i>The Inquiry concludes that the ACT Ombudsman should be resourced to undertake regular administrative and procedural inspections of the AMC to provide early warning systemic issue and assurance that policies and procedures are in place and implemented effectively.</i></p>   |                     |      |                   |                 |
| <p><u>ACT Government Action</u></p> <ul style="list-style-type: none"> <li>• In response to this recommendation, the Government decided that a new oversight agency was needed to inspect the ACT's correctional centres and services, as well as review critical incidents.</li> <li>• The <i>Inspector of Correctional Services Act 2017</i> was passed in the ACT Legislative Assembly on 30 November 2017. This legislation creates the role of the Inspector of Correctional Services to oversee ACT correctional facilities.</li> <li>• The Inspector will provide a comprehensive agenda for overall improvement of correctional services and lead sustainable change towards best practice in the ACT. This will ensure continuous improvement through the systematic and regular review of correctional centres and services.</li> <li>• The Inspector will work with, but be distinct from, the existing oversight mechanisms undertaken by the Human Rights Commission, ACT Ombudsman, Public Advocate and the Official Visitors program.</li> <li>• The Legislative Assembly will be provided with independent reports from the Inspector, who will be able to conduct unannounced visits to correctional centres, including court cells and transport.</li> <li>• The Inspector will undertake comprehensive and systemic inspections of correctional centres and services every two years, review critical incidents (such as serious assaults), and particular issues referred by the responsible Minister or Director-General.</li> <li>• Once appointed, the Inspector will commence its functions at the Alexander Maconochie Centre immediately, and within two years at the Bimberi Youth Justice Centre.</li> <li>• A nation-wide selection process for the position of Inspector commenced in November 2017.</li> <li>• Interviews with shortlisted candidates were held in the week of 8 January 2018.</li> <li>• An announcements about the appointment to the new Inspector of Custodial Services will be made in the first half of 2018.</li> </ul> |                     |      |                   |                 |

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### Recommendation 9

|  | Government Position  | Lead    | Executive Sponsor | Status          |
|--|--|---------|-------------------|-----------------|
| <b>That the Inquiry's conclusions, which provide detail of various aspects of the treatment in custody of Steven Freeman that were deficient, be addressed with a view to implementing change and bringing about improvement.</b>  | AGREED   | Various | various           | <b>ON-GOING</b> |
| <p>Conclusions that relate directly to, or are covered by other recommendations have been dealt with under those specific recommendations. The remaining conclusions have been dealt with under themes.</p>  |  |         |                   |                 |
| Conclusions  | Action Taken   |         |                   |                 |
| <u>Security</u>  | <u>ACTCS</u>   |         |                   |                 |
| <p><i>RFID Bracelets/anklets - a device able to track a detainee's whereabouts every two seconds. This measure was abandoned in Feb 2011 due to problems with the battery life of RFID bracelets. The Inquiry concludes that the use of RFID bracelets and anklets should be explored again. The use of such bracelets at the time of Steven Freeman's assault would have identified who was in his cell.</i></p>  | <p>ACTCS have investigated reintroducing RFID bracelets into the AMC. Investigations revealed that RFID bracelets are inaccurate and expensive. ACTCS has enhanced the overall security of the AMC including improvements to the CCTV system that better meets the intent of this conclusion.</p>  |         |                   |                 |
| <u>Health Care</u>   | <u>ACT Health</u>  |         |                   |                 |
| <p><i>Intensive care unit - The Inquiry concludes that the next of kin of a detainee at The Canberra Hospital should be provided information about the detainee's condition and prognosis, when the detainee is unconscious and cannot give consent.</i></p>   | <p>It is practice to provide information to all next of kin identified in the clinical record of all clients when they are unconscious. If the clinical records do not identify the next of kin, that information will be sought from alternative sources such as ACT Policing or other medical practitioners such as the person's GP.</p> |         |                   |                 |
| <p><i>The Inquiry was told that Steven Freeman originally appeared in court wearing a hospital gown, but was unable to verify this report. Nevertheless, the Inquiry concludes that ACT Health and ACTCS need to ensure detainees transferred from hospital to the courts are provided with clothes and do not appear only wearing hospital garments. In response, ACT Health told the inquiry it will work with ACTCS to address this issue.</i></p> <p><i>The Inquiry concludes that the standard of Justice Health Service's record keeping and documentation is minimal, if not at times, inadequate.</i></p>              | <p>In July 2017 a joint email from the Acting General Manager of the AMC and Operational Director of Justice Health Service was sent to staff reinforcing the need to ensure that detainees must have appropriate clothing for court. This has resulted in improved arrangements for detainees.</p>  |         |                   |                 |
| <p><i>The Canberra Hospital discharge procedure is for a discussion to be held with the patient's carers. This discussion includes the need for vigilance post-concussive or post-traumatic brain injury syndrome. The symptoms that need to be monitored include any alteration of sleep patterns, increased irritability, impaired concentration, and potential for ongoing headaches which may last for many months after a significant head injury. The Inquiry notes that this discussion is not documented in Steven Freeman's clinical record or discharge summary from TCH. The Inquiry concludes this lack of</i></p> | <p>ACT Health have developed improved notification forms to provide ACTCS that includes information about any observations or symptoms to look for when a detainee returns from hospital. This health form is also used to inform ACTCS of all new inductees onto methadone.</p>   |         |                   |                 |

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| <i>documentation is a deficiency in record keeping.</i>  |  |
| <i>The Inquiry concludes there was no follow-up after 9 September 2015 regarding Steven Freeman's head injury. Justice Health Services did not revisit its 7 May 2015 advice to ACTCS. For its part, AMC staff members did not act upon the Justice Health Services advice of 7 May 2015, for example, assessing whether Steven Freeman had impaired learning or cognitive function.</i>                         | As above.  |
| <i>The AMC relies on information from Justice Health Services to manage detainees both collectively and individually. Accordingly, the Inquiry concludes further that poor clinical record keeping may have an adverse effect on the AMC's ability to make proper provision for any given detainee.</i>  | As above.  |
| <i>The Inquiry concludes that the monitoring of Steven Freeman following his head injury was not adequate. Justice Health Services advised the AMC on 20 May 2015, to cease the observation regime with no information about potential symptoms of concern.</i>  | As above.  |
| <i>The Inquiry concludes also that the AMC was not alerted to the need to monitor Steven Freeman for certain behaviour or issues of concern particularly in relation to his head injury.</i>   | As above.  |
| <i>The Inquiry notes the five month delay in Steven Freeman receiving a dental appointment, and concludes that this delay in obtaining treatment indicates a deficiency in the provision of dental care.</i>   | Over August and September 2017 meetings were held with Dental, MHJADS and ACTCS to develop strategies to improve dental access for detainees. In October 2017, an additional dental day was implemented at the AMC. There are now dental services being provided at the AMC over three days a week, which is an increase from one day a week.  |
| <b>Information Sharing</b>   | <b><u>ACTCS/ACT Health</u></b>   |
| <i>The Inquiry notes that Steven Freeman was likely still withdrawing from his multi-substance use, throughout his time at the Canberra Hospital and on return to the AMC. The Inquiry concludes further that the agencies involved in the care of detainees need to find a way to share relevant detainee-related information, yet take into account all legislative, professional and ethical obligations.</i> | <p>The first schedule of the Arrangement, on 'Information Sharing' ACT Health was signed on 20 November 2017 by Executive Directors of ACT Health and ACTCS, to improve information sharing arrangements between the agencies.</p> <p>The MOU between ACTCS and ACT Policing commits both parties to improved information sharing.</p> <p>An inter-directorate working group with ACTCS, ACT Health, ACT Policing and CSD convened on 5 September 2017 to discuss information sharing arrangements. A representative from the Government Solicitor's Office provided legal advice about information sharing arrangements. This group re-convened on 18 January 2018 to discuss progress on action items.</p> |

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|   | <p>CSD agreed to provide information on youth justice histories when requested by ACTCS. Ongoing discussions regarding the most effective and efficient manner of sharing this information continue.</p> <p>ACT Policing and ACT Health are progressing work on developing supporting schedules to support the Arrangement and existing MOUs. A new Information Sharing schedule will support improved information sharing to assist in the care, treatment and support of health consumers. This work is ongoing.</p>   |
| <p><i>The AFP/ACTCS MOU covers transfer of custody and other topics including intelligence exchange, investigations, police responses to incidents at the AMC and DNA back-capture. The Inquiry notes that ACT Health is not a party to the MOU, but concludes it would also benefit from a transfer from ACT Policing of health, wellbeing and other relevant information.</i></p>   | <p>ACT Policing and ACT Health are exploring adding schedules to an existing MOU to meet the expectations of this conclusion, as noted above.</p>  |
| <p><i>The Inquiry notes that ACT Policing's record of interview of 27 April 2015, made reference to Steven Freeman's recent illicit drug and alcohol use. The Inquiry notes also that ACT Policing did not provide this information to ACTCS until 15 March 2016, almost a year after Steven Freeman's admission to the AMC. The situation may explain why the ACTCS CTU Risk Assessment Form records that Steven Freeman showed no signs of being under the influence of substances. The Inquiry concludes that there was a deficiency in procedure, in that ACT Policing did not provide this information to ACTCS or ACT Health.</i></p> | <p>ACTCS and ACT Policing are exploring adding schedules to the MOU to meet the expectations of this conclusion, as noted above.</p>   |
| <p><i>The Inquiry concludes that the lack of comprehensive approach to information sharing between ACT Policing and ACTCS was a factor in Steven Freeman's assault in April 2015.</i></p>   | <p>The Inquiry noted that since August 2015, ACT Policing now provides the following information to ACTCS in relation to each detainee:</p> <ul style="list-style-type: none"> <li>• the statement of facts for the current charges</li> <li>• a list of all victims</li> <li>• a list of known associates; and</li> <li>• a list of ACT Policing alerts which record those who are relevant to the safety of the detainee and other detainees at the AMC, any victims, the AMC or the Community.</li> </ul> <p>The Inquiry also concluded that ACTCS and ACT Policing update their MOU to reflect changes made in August 2015. This MOU was updated and signed on 28 April 2017 (see recommendation 2).</p> |

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|   | This conclusion is also addressed through the new admissions process mentioned above.  |
| <i>The Inquiry concludes youth justice information should be available to the AMC when it is assessing the accommodation placement options for new detainees.</i>   | ACTCS and CSD are developing a process to support improved information sharing under s136 of the <i>Crimes (Sentencing) Act 2005</i> between ACTCS and CSD around youth justice histories. This is an administrative process that will allow CSD to provide information about a detainee's Youth Justice histories during the induction process.   |
| <i>The Inquiry concludes that Justice Health Service's failure to inform both the AMC and TCH about Steven Freeman's "significant daily ice habit" was a deficiency.</i>  | ACTCS and ACT Health have developed the over-arching Arrangement and Supporting Information Sharing Schedule to improve detainee health care and safety arrangements at the AMC (Also refer to Recommendation 4)   |
| <i>The Inquiry concludes that this situation (above) reveals an instance of inadequate information sharing in relation to Steven Freeman.</i>   | As above.  |
| <i>The Inquiry concludes that in future, Justice Health Services should ensure that it shares all relevant health information about a detainee who is transferred to hospital.</i>  | As above.  |
| <i>Steven Freeman's experience at the AMC indicates that inadequate information sharing was a factor in the deficiencies evident in his treatment. Accordingly, the Inquiry concludes that, if AMC management is to have overall responsibility for outcomes and incidents relating to detainees, it must have access, to the extent possible, to all relevant information.</i>   | As above.  |
| <i>The Inquiry notes that ACT Human Rights Commission initiative to convene regular meetings of oversight agencies. This forum enables otherwise disparate efforts to be coordinated. The Inquiry notes also that Prisoners Aid has recently joined this group. The Inquiry concludes that for each member agency to respond more effectively to detainee issues, there is a need for them to be as informed as possible about the AMC. Oversight can only be effective if information from detainees is available.</i> | The ACT Human Rights Commission convenes a monthly AMC oversight meeting with relevant stakeholders including ACT Ombudsman, AMC Official Visitors, Winnunga Nimmityjah Aboriginal Health and Community Services to consider issues that have been brought to the attention of the agencies regarding the AMC. The purpose of the meeting is to ensure a rigorous and collaborative approach to issues brought to the agencies through complaint mechanisms, OV's visits, direct contact with detainees and other sources of information. This informs the work of the oversight agencies and enables us to take a strategic approach in responding to those issues through our regulatory |

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|  | and oversight functions as well as draw them to the attention of relevant ACTCS and ACT Health staff in regular oversight meetings convened by ACTCS.  |
| <b>Detainee Management</b>   | <b>ACTCS</b>   |
| <i>When Steven Freeman arrived at the AMC he would have been unwell and vulnerable after a prolonged period of drug and alcohol use. The Inquiry concludes that a number of factors combined to place Steven Freeman unknowingly in harm's way at the AMC.</i>   | Policies and Procedures about the induction and assessment process are currently being developed and will be completed by the end of April 2018.   |
| <i>The Inquiry concludes also that had measures and processes adopted since Steven Freeman's assault been in place when he was admitted, including the assessment of new receptions in a separate unit generally for five days, the likelihood of his being assaulted would have been significantly reduced.</i>   | A new induction process has since been implemented by ACTCS for all new admissions to the AMC. This process is vital to ensuring the appropriate placement of detainees (Also refer to Recommendation 6)   |
| <i>Information which ACT Policing knew regarding Steven Freeman's illicit drug and alcohol use and difficulty in answering questions was not available to ACTCS and Justice Health Services. It meant that the opportunity for appropriate assessment and treatment for Steven Freeman on his arrival at the AMC was lost. The Inquiry concludes also that a placement at AMC based on detoxification and rehabilitation would have been more appropriate.</i> | As part of the new induction process, and in addition to the other assessments completed by ACTCS, all detainees also receive a joint assessment by the Primary Health Team and Forensic Mental Health Service within Justice Health Services. This assessment process screens for mental and physical health concerns and referral for treatment and care as issues are being identified. This process is inclusive of direct questioning around Aboriginal and Torres Strait Islander status. Under this process identified persons can also be referred to the Aboriginal Liaison Officer. (Also refer to Recommendation 6) |
| <i>The Inquiry notes the AMC's induction process required Steven Freeman himself to identify detainees of concern. The assessment took place when, unknown to the ACTCS, Steven Freeman had been using illicit drugs and alcohol for a prolonged period. The Inquiry concludes this approach placed too great an onus on Steven Freeman to identify the risk in the accommodation options.</i>   | Intelligence checks occur with all new detainees at the AMC with ACT Policing. These checks help identify further information about the detainee's history and any potential association risks. Another assessment is completed when the ACT Policing checks are returned. This includes a declaration by the detainee with the sentenced supervisor discussing any safety and security risks. This process is subsequently reviewed by an Area Manager prior to any relocation. A detainee will not be moved out of new admission placement until all intelligence checks are completed. (Also refer to Recommendation 6)     |
| <i>The Inquiry concludes that, at the time, the AMC admission process was deficient in that it relied on Steven Freeman to provide</i>   | This conclusion continues to be addressed through an Information   |

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| <i>information about his own risk factors rather than AMC-collected information from a wider range of sources (such as ACT Policing, Just Health Services and Youth Justice)</i>  | Sharing Working Group.   |
| <i>The Inquiry concludes that there was a deficiency in Steven Freeman's treatment at the AMC, in that the period of induction and admission was insufficient.</i>  | As above.  |
| <i>The Inquiry notes the inconsistency in the legislation on the question of whether remanded detainees should have individual case plans. Given the long periods of time a detainee sometimes spends on remand at the AMC, the Inquiry concludes that individual case management plans should be in place for remanded detainees.</i>  | This conclusion is being addressed through the development of a Rehabilitation Framework, which is scheduled to be completed by early 2018.  |
| <i>The Inquiry concludes that the lack of a structured day at the AMC inevitably leads to boredom, which invites the possibility and added risk of detainees using illicit drugs.</i>   | A structured day has been implemented in the new female accommodation unit. It is intended that this will be refined and rolled out across the AMC over time.  |
| <i>The Inquiry notes that Steven Freeman was not drug tested on admission because he was assaulted within hours of induction and taken to TCH. The Inquiry notes also that on his return to the AMC from TCH, Steven Freeman was not drug tested either. The Inquiry concludes it was a breach of the ACTCS Drug Testing Policy that Steven Freeman was not drug tested at admission.</i>   | The Drug Testing and Admission policy and operating procedure is currently under review and will be complete by the end of April 2018.   |
| <i>The Inquiry concludes also it was a deficiency in Steven Freeman's treatment in custody that he was not referred to a therapeutic program, such as the Solaris Therapeutic Community.</i>  | This is currently being considered as part of the Rehabilitation Framework that is scheduled to be complete by early 2018.   |
| <i>The Inquiry concludes that the solely punitive response to Steven Freeman under the 2015 ACT Drug Testing Policy was inappropriate.</i>  | ACTCS is currently reviewing The Drug Testing policy and will include referrals to drug and alcohol support services or counselling for detainees that provide positive urinalysis results. This will be completed by the end of April 2018.   |
| <i>The Inquiry concludes also that a more appropriate response would have included therapeutic treatment, which would have assessed Steven Freeman, in order to understand the reason(s) for the renewed drug use, including a consideration of whether that drug use was a form of "self-medication" for one reason or another.</i>  | As above.  |
| <i>The Inquiry notes that, while both Official Visitors are female, until very recently, all Aboriginal case managers and Indigenous Liaison Officer at the AMC were male. Accordingly, female Aboriginal and Torres Strait Islander detainees could not be supported by equivalent Indigenous female staff. The Inquiry concludes further that this situation was inappropriate. Moreover, an Indigenous leadership forum told the Inquiry that this situation may also have been culturally inappropriate. Having passed on these observations to ACTCS, the Inquiry notes that, with effect from 2 November 2016, the AMC has seconded a female Aboriginal case manager.</i> | <p>ACTCS has since appointed an extra Official Visitor under the <i>Official Visitor Act 2012</i>. Currently there is one male Official Visitor and two female Official Visitors, one of whom is the Aboriginal and Torres Strait Islander Official Visitor.</p> <p>There are currently two Aboriginal Case Managers. There is also an Aboriginal Liaison Officer at the AMC.</p> <p>Winnunga now attend the AMC on a weekly basis to provide support services to women detainees.</p> |

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| <u>Culturally Safe Practice</u>  | <u>ACT Health</u>  |
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| <p><i>The Inquiry notes that in relation to Justice Health Service’s staff members, 7 had completed cultural awareness training, 4 through an e-learning package, and 3 attended face to face. The Inquiry understands that a new e-learning package, which is expected to be ready the end of 2016, is being developed. A face-to-face training package was sought without success. The Inquiry concludes that this level of training (above) is inadequate, both in terms of the proportion of staff members who have undertaken the program and the method of training.</i></p> | <p>A female Aboriginal Liaison Officer (ALO) attends the AMC to support female detainees. As at September 2017, the ALO has attended six times resulting in 90 occasions of service with detainees.</p> <p>To date, 86% of Justice Health Service staff have completed the e-learning Working with Aboriginal and Torres Strait Islander People.</p> <p>Further cultural awareness face to face training will be completed by the end of 2018. Two training sessions in AMC and Bimberi, for the Forensic Mental Health Team occurred in late November 2017 and one training session has occurred at Dhulwa with two more sessions booked. This will also incorporate a refresher training component for staff who have been previously trained.</p>   |
| <p><i>The Inquiry concludes that all Justice Health Services staff should undertake cultural awareness training, on commencement at the AMC, and on a refresher basis thereafter. This training is particularly important while the ACT continues to have a significant number and proportion of Aboriginal and Torres Strait Islander persons in custody.</i></p>   | <p>ALOs provided cultural awareness training in September and November 2017 to Mental Health, Justice Health and Alcohol and Drug Services (MHJHADS) orientation program for all new staff. This training will continue to be included as a standard item on the orientation program.</p> <p>As part of its commitment to providing culturally appropriate and responsive services, MHJHADS have also developed Practice Standards for its Aboriginal and Torres Strait Islander Liaison Officers and included consultation with other internal and external stakeholders. These Practice Standards are not only aimed to help define the roles of Liaison Officers and establish and articulate guidelines around their practice, but are also designed to embed a culturally responsive framework for MHJHADS more broadly.</p> <p>As part of the planned ACT Health re-alignment of Canberra Hospital and Health Services, a Centre for Excellence for Aboriginal and Torres Strait Health Services has also been</p> |

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|   | proposed. Linked to this proposal, there is also a current recruitment process underway within ACT Health to employ a Clinical Director for Aboriginal Health Services.   |
| <b>Bail/Sentencing</b>  | <b>LPP</b>  |
| <i>Aboriginal and Torres Strait Islander considerations in bail and sentencing - The Inquiry concludes the options available to Magistrate Dingwall in considering Steven Freeman's bail application were lacking in that the Aboriginal community was not able to participate and there were limited supported accommodation options available for the magistrate to consider outside the AMC.</i> | <p>The Aboriginal Legal Service and LPP have developed a Bail Support trial. It aims to reduce the number of Aboriginal and Torres Strait Islander people on remand and reduce the amount of time spent on remand.</p> <p>Permission was sought and granted from the United Ngunnawal Elders council to name the trial 'Ngurrumbai' (Nuh-ram-buy), a Ngunnawal word meaning 'Perceive'.</p> <p>The Ngurrumbai Bail Support trial was launched on 7 December 2017.</p> |
| <b>Others</b>   |   |
| <i>The Inquiry concludes further that a number of factors, (i.e. His likely being unwell and vulnerable, placement in a cell furthest away from the officers' station, and that other detainees may have known about his arrival at AMC) combined with the result that Steven Freeman was placed unknowingly in harm's way.</i>   | These conclusions are mainly observations that are further explored in other recommendations. They have been noted.   |
| <i>The Inquiry concludes the ACTCS response following Steven Freeman's assault was appropriate.</i>   | As above  |
| <i>The Inquiry concludes the Justice Health Services immediate response to Steven Freeman's assault was appropriate.</i>  | As above  |
| <i>The Inquiry notes that these conclusions are not a reflection on the provision of service provided by Justice Health Services. The Inquiry concludes that it is wholly professional.</i>   | As above  |
| <i>The Inquiry concludes that any detainee concerns about the arrangements for visits at AMC is a matter for the ACT Ombudsman, ACT Human Rights Commission and Official Visitors.</i>  | As above  |