ICS
ACT Inspector of Correctional Services

REPORT OF A REVIEW OF A CRITICAL INCIDENT

by the

ACT INSPECTOR OF CORRECTIONAL SERVICES

Death in custody at the Alexander Maconochie Centre on 1 February 2022
(CIR 03/22)

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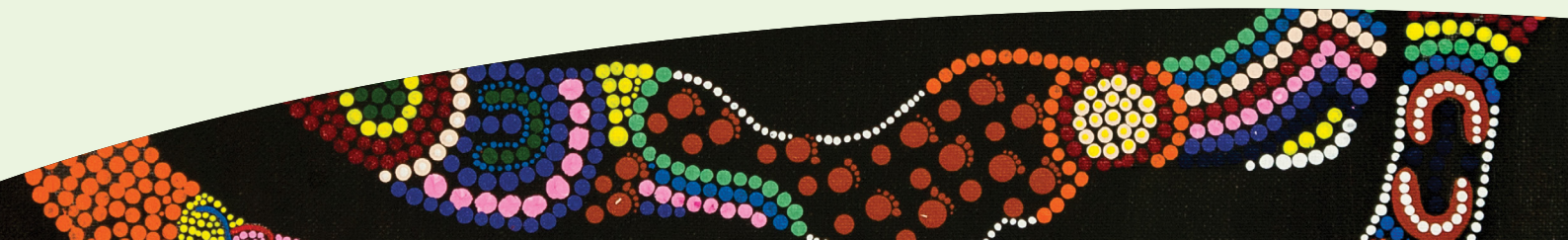

Rainbow Serpent (above and cover detail)
Marrilyn Kelly-Parkinson of the Yuin Tribe (2018)

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

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

About this report

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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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Death in custody at the Alexander Maconochie Centre on 1 February 2022
(CIR 03/22)

Neil McAllister
ACT Inspector of Correctional Services
August 2022

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GLOSSARY

Term	Meaning
ACTAS	ACT Ambulance Service
ACTCS	ACT Corrective Services
ACTP	ACT Policing (AFP)
AMC	Alexander Maconochie Centre (ACT adult prison)
CM Act	*Corrections Management Act 2007* (ACT)
CMH	Custodial Mental Health (mental health services at AMC operated by Canberra Health Services)
CO	Corrections Officer (prison officer)
CPR	Cardiopulmonary Resuscitation
CTU	ACTCS Court Transport Unit
Hoffman	Hoffman knife – a tool used to safely remove ligatures (ropes etc) from persons attempting to self-harm or suicide.
ICS Act	*Inspector of Correctional Services Act 2017* (ACT)
Inspector	ACT Inspector of Correctional Services
JACS	Justice and Community Safety Directorate (responsible for ACTCS)
Mandela Rules	United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)
MCR	Master Control Room (at AMC)
MU	Management Unit (used as a COVID-19 isolation unit at the time of this incident)
OICS	Office of the Inspector of Correctional Services
PCR	Polymerase Chain Reaction (type of test for COVID-19)
PH	Primary Health (primary health services at AMC operated by Canberra Health Services)
SCIT	Specialist Communities and Interventions Team (ACTCS team based at AMC providing specialist support to detainees)

1. EXECUTIVE SUMMARY

A death in custody is a deeply tragic occurrence. OICS acknowledges the trauma caused by this incident to the deceased's parents and family, friends and loved ones, and extends our sincere condolences to them.

OICS also acknowledges the impact of this incident on first responders, detainees and staff.

In tragic circumstances, a male detainee aged in his 20s (Detainee A) was found deceased in a cell in the Alexander Maconochie Centre (AMC) Management Unit (MU) at about 7pm on 1 February 2022[1].

The MU at the time was being utilized as a COVID-19 isolation unit for all new receptions to the AMC. Subject to any findings of the ACT Coroner, it appears that the detainee used a bed sheet to hang himself from a horizontal bar on the rear door of the cell which provides access to a small outdoor bricked courtyard. The detainee had been admitted into custody at the AMC at about 3:30pm on 31 January 2022, approximately 27 hours before his death. There is evidence that Detainee A was thoroughly assessed by mental health professionals on his admission to AMC who did not identify any indicators that Detainee A was at risk of self-harm or experiencing suicidal ideations.

Detainee A identified a design flaw in the construction of the rear cell door which allowed him to slide a sheet under a horizontal rail and create a hanging point. Most regrettably, this risk had been identified and reported by AMC Facilities Management staff in 2015 but had not been addressed by the then AMC General Manager. There was also another unaddressed design fault with the rear cell doors that had been identified in 2020 which although not related to the death of Detainee A, raised serious concerns about the safety of the doors and ligature points.

Recommendation 2:

That *immediate* action be taken to ensure the rear cell doors in the Alexander Maconochie Centre Management Unit do not present any foreseeable risks of ligature points and are in accordance with relevant cell safety standards consistent with the use of the unit.

The review identified concerns around detainee observations conducted by Corrections Officers (COs). Detainee A was risk-assessed by Justice Health as not requiring any special observations for his physical or mental health beyond the standard in-person observations for all detainees in the MU which were hourly observations. The 5pm observations were not carried out (despite being signed off later in the evening). The 6pm observations were carried out at 6:03pm. Detainee A took steps to hang himself between 6:03pm and approximately 7pm when his body was discovered. Detainee A also obscured both CCTV cameras in his cell around 5:20pm. It appears this was not apparent to COs at the time, but even if it had been, it was not common practice in the unit to require the cameras to be uncovered.

On finding Detainee A during a routine medication and COVID-19 observation round, custodial and nursing staff took action to untie the ligature and commence Cardiopulmonary Resuscitation (CPR) pending the arrival of paramedics. Unfortunately, it was discovered he was unconscious, had an absent pulse, was not breathing or responding, his lips and extremities were cyanotic and his pupils were fixed and dilated.

1 The deceased's family requested that he not be referred to by his name in this report.

When the ambulance was called by the Master Control Room (MCR), the urgency of the incident (suspected hanging) was not conveyed clearly, although ACT Ambulance Service (ACTAS) advised that this did not delay the despatch of an ambulance.

Recommendation 1:

That written guidance is developed jointly by ACT Ambulance Service, Justice Health and ACT Corrective Services for use when an ambulance is called to AMC.

There was an issue concerning staff access to a Hoffman knife (Hoffman)[2]. Staff could not find a Hoffman in the MU and had to remove the noose by hand. While it would appear that using a Hoffman to cut Detainee A's noose was unlikely to have made a life-saving time difference in the commencement of CPR, it is deeply concerning that a decision was made in 2012 by the then head (Executive Director) of ACT Corrective Services (ACTCS) to remove the Hoffmans from various location around AMC without ensuring alternative means for staff to access them were already in place, potentially putting the lives of detainees at risk.

Recommendation 5:

That ACT Corrective Services ensure that a Hoffman knife is issued to each (custodial) Corrections Officer at the start of their shift.

The review finds that the attempted resuscitation of Detainee A was undertaken in a highly skilled and professional manner by custodial and nursing staff, and they worked well together as a team.

The review notes that although there are a range of operational documents relating to management of at-risk detainees, and suicide prevention training is conducted, there is no overarching suicide prevention framework.

Recommendation 3:

ACT Corrective Services, Canberra Health Services and Winnunga consider whether an overarching suicide prevention framework or strategy along the lines of the Victorian Corrections Suicide Prevention Framework is necessary, and if so, jointly develop one within a year.

The physical environment and regime in the COVID-19 unit at the time was relevant to the review because Detainee A was subject to it. We examine and comment on the MU and COVID-19 isolation in part 7 of this report.

2 A Hoffman knife is a tool used in prisons and other places of detention in Australia and many other countries to safely remove ligatures (ropes, etc) from persons attempting to self-harm or suicide. Its design does not allow it to be used as a stabbing implement.

Recommendation 4:

That ACT Corrective Services develop guidance for operations of the COVID-19 unit to ensure it is the least restrictive environment possible in the circumstances. This guidance must consider protective factors and supports such prioritising detainee's contact with the outside world and have key performance indicators around timeframes for setting up detainee phone lists. All COs working on the COVID-19 unit must have specific training on operationalising this guidance.

OICS concludes that while the apparent suicide of Detainee A as an individual was not reasonably foreseeable by ACTCS, the potential for actual or attempted suicide in the manner in which this apparent suicide occurred (the cell door hanging risk) had been known by ACTCS since 2015.

2. CONTEXT, SCOPE AND METHODOLOGY

2.1 Authority to conduct a review of a critical incident

Section 18(1)(c) of the *Inspector of Correctional Services Act 2017* (ACT) (ICS Act) provides that the Inspector '**may** review a critical incident on the inspector's own initiative or as requested by a relevant Minister or relevant director-general'. [emphasis added] However, the ICS Act does not provide guidance as what the Inspector should consider when deciding whether to review a critical incident, noting that we have elected not to review some relatively low-level ACT Corrective Services (ACTCS) incidents in the past (detailed in our annual reports). In order to provide some clarity around this decision making process, we have developed and published an **operating procedure** on our website which sets out criteria for conducting a review.

We determined that this incident met the following criteria:

- Seriousness. A death in custody is at the most serious end of the scale and therefore a Critical Incident review is essential.
- Public reporting. Whilst a death in custody in the ACT involves a review by the ACT Coroner which is a public process, this can take some time. The OICS report will be available to provide the family and friends of the deceased information about their loved one's death in a shorter period, and the report will be available to assist the Coroner. Furthermore, given OICS specific experience in corrections oversight an OICS Critical Incident review will be particularly corrections-focused.
- Prevention. This is the first death in the Alexander Maconochie Centre since the Office of the Inspector of Correctional Services was established. A Critical Incident review provides an opportunity for identifying lessons learned to prevent reoccurrence of death or serious harm in custody. Given the importance of what is at stake (the life, health and safety of detainees), any opportunities for prevention in this case are extremely important.

2.2 What is a 'critical incident'?

Section 17(2) of the Act provides a list of events that are critical incidents. This review concerns an event relevant to section 17(2)(a) ('the death of a person') in that a detainee died in the AMC, in the custody of ACTCS.

2.3 What must the Inspector report on?

Section 27 of the Act requires that the Inspector include certain things in a report of a review. In a previous report the Inspector noted that this section was directed towards the content of 'examinations and reviews' of correctional centres and correctional services but was ambiguous in relation to the content of reviews of critical incidents.[3] This report, like the previous critical incident reports tabled in the ACT Legislative Assembly, has been structured to capture the spirit and intent of section 27 but without specific reference to some of the topics.

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

2.4 Public interest considerations relating to this report

Section 28(1) of the Act provides that 'the Inspector must consider whether any part of the report must be kept confidential because—

(a) there are public interest considerations against disclosure; and

(b) those considerations outweigh the public interest in favour of disclosure.'

Section 28(2) details grounds of public interest against disclosure. In accordance with section 28(2)(d), certain information that might reveal the identities of detainees and staff involved in the incident has been withheld in this report.

2.5 The review team

The review team comprised:

- Rebecca Minty, Deputy Inspector of Correctional Services (Lead Reviewer)
- Neil McAllister, Inspector of Correctional Services
- Pip Courtney-Bailey, Assistant Inspector of Correctional Services (Review Coordination)
- Maureen Hanley, Clinical Health Reviewer (contracted expert)

2.6 Methodology

This Critical Incident review involved gathering and reviewing relevant documents and files from ACTCS, Justice Health, and ACT Police; inspecting AMC registers; viewing CCTV footage; interviews with ACTCS and Justice Health staff, and a site visit to the AMC. We also talked informally with Detainee A's immediate family.

3. HOW, WHEN AND WHERE THE INCIDENT OCCURRED

3.1 Detainee A's background

Detainee A was born in NSW and was in his late 20s at the time of his death on 1 February 2022. He did not identify as Aboriginal or Torres Strait Islander. He had no history of mental health conditions, serious injury or illness that was known to ACT Corrective Services (ACTCS), Justice Health or ACT Policing (ACTP). Over recent years his work took him to various places in New South Wales, and most recently to Canberra.

Over the three years preceding his death, he had been in a relationship with a de facto partner, and they had resided together in in Canberra. In November 2020 the partner had called the police after an altercation. As a result, Detainee A was arrested and charged with family violence offences and remanded in the AMC, his first time in custody.

3.1.1 Previous episode in AMC

Detainee A was detained at the AMC for a period of 33 days in 2020, before being granted bail. All detainees undergo a Primary Health (PH) screening by Justice Health, and a mental health screening by Custodial Mental Health (CMH) on admission. CMH did not identify any significant mental health concerns during the mental health screening. However, they gave him a 'S3' risk rating[4] with hourly observations as a precaution 'due to denial of overdose and inconsistencies'[5]. It appears Detainee A was reviewed in person by CMH clinicians three times during this incarceration episode before his case was considered at a multidisciplinary review meeting and closed to CMH. This was 13 days after his admission.

During this first incarceration there were no intelligence holdings[6] or disciplines recorded in relation to Detainee A. He was classified as Minimum (closed) security classification.

Detainee A was bailed 33 days after entering custody and was ultimately sentenced to a 12 month Good Behaviour Order.

3.2 Arrest and detention on 31 January 2022

In the early hours of the morning of 31 January 2022 Detainee A was involved in an altercation with his partner/former partner[7] at their shared rental property. Detainee A was taken by police to the Watch House at around 6am. ACT Policing (ACTP) paperwork indicated (based on 'visual assessment'), no risk factors for suicide, self-harm or drug withdrawal, although the form did note 'yes' to the question 'appears to be under the influence of alcohol or drugs', with annotation 'CO2 cannisters'[8].

4 A 'S' is given as a risk alert for suicide or self-harm. There are four levels with S1 being an 'immediate risk', S2 a 'significant risk', S3 a 'potential risk' and S4 a 'history of risk'. See *Corrections Management (Risk Alerts) Policy 2019.*

5 This assessment by CMH appears reasonable given there was a clinical record (viewed by OICS) concerning a previous incident where ACT Ambulance Service had been called out to a potential deliberate overdose, something that Detainee A had denied at the time.

6 Intelligence holdings may include, for example, information about suspected involvement in introduction of contraband such as drugs or phones into the AMC, or known associations with gangs or violent groups etc. Intelligence holdings are gathered from a range of sources (human sources, phone intercepts etc) and managed by the ACTCS Intelligence Unit.

7 It is not clear to OICS whether the relationship was ongoing at the time of Detainee A's arrest on 31 January 2022.

8 Reference to 'CO2 cannisters' is not understood by OICS.

Around mid-morning, Detainee A was transferred to the custody of ACTCS at the ACTCS Court Transport Unit (CTU) which is in the ACT Courts precinct. He appeared in the ACT Magistrates Court by Audio-Visual Link. The result of this appearance was that he was remanded in custody, due to reappear in court on 22 February 2022.

3.3 Assessment at the Court Transport Unit

Detainee A was held at the CTU until early afternoon. During his time in the court cells, CTU staff completed an 'Initial Assessment' form. Not all fields on this form were completed, but the sections relating to mental health risks were completed and did not identify any immediate risks. This form lists 'nil' next of kin, 'nil' medical conditions, 'nil' mental health conditions', 'nil' current medications and 'nil' drug use. Uncompleted sections include whether the detainee had any identifying features ('tattoos', 'eye colour' 'hair colour'), and the diagram for noting where on the body identifiable markings are, was not completed. This is despite Detainee A having extensive tattoos on his upper torso, left side of his torso and right leg. This form also does not provide a space for the name of the CO who completed it, or the time/date it was completed. This absence of important details on the form is unacceptable.

In the CTU, a Return and Transport Risk Assessment form was also completed. The purpose of this form is to enable the CTU staff to identify any relevant risks relating to a detainee's physical or mental wellbeing relevant to CTU accommodation or transport to the AMC. The form asks questions relating to risk of suicide or self-harm (including, 'Is the detainee expressing thoughts of suicide or self-harm in the previous 48 hours?', does the detainee 'have a history of suicide attempt/s within the past 12 months?') as well as whether the 'detainee appears to be under the influence of drugs or alcohol?'. The form notes that if certain risks are identified, further processes must be adhered to (for example, 15 minute observations, informing the CTU Manager, contacting Forensic Mental Health etc). No risks were identified on the Return and Transport Risk Assessment form. It is noted that page two of the form erroneously has the detainee listed as first time in custody, whereas the following page correctly identifies that it was not his first time.

At around 3pm, Detainee A was transferred from the CTU to the AMC.

3.4 Arrival and induction at the AMC

On arrival at AMC's admissions unit at around 3:20pm, Detainee A was taken through the initial induction and assessment processes. He was placed in a holding cell (a basic cell with a toilet, bench, and access to an external courtyard). He stayed here for the next two hours while initial assessments were carried out. In CCTV footage from this time he does not appear outwardly agitated or distressed.

3.4.1 Admissions phone call

At around 3:45pm Detainee A made an admissions call to his partner/former partner. In the call Detainee A did not identify any intent to self-harm. There is discussion around the circumstances of him entering custody; and some discussion around getting assistance with things he needed due to being in custody – returning a hire car, collecting his car, receiving money in custody etc. The partner/former partner finishes the call by telling Detainee A that she loves him, will answer his calls and that she is not going anywhere. Detainee A finishes the call saying he loves her too.

3.4.2 *Initial health screenings at the AMC*

Primary Health Assessment

At around 5:00pm Detainee A has a health admission assessment. This was done by a PH Nurse and CMH Nurse jointly, with each completing their respective forms.

The Primary Health Admission Assessment records, that Detainee A:

- did not report any acute or chronic health issues but did advise that he was prescribed medication at night for insomnia, which he had been receiving for the last six months but had not taken it for the last five days;
- disclosed recent cocaine use (see *Cocaine risks* section below)l; and
- was pleasant and cooperative during the interview.

Clinical observations were taken which were within acceptable clinical limits.

The PH nurse contacted the on-call medical officer and advised them of the detainee's admission, who recommended no specific ongoing treatment.

Detainee A was given a COVID-19 PCR test on admission to AMC and placed on COVID-19 Daily – 5 day Surveillance Quarantine Review.

The Consent to Release and/or Share Personal Information Form was signed by Detainee A on admission and used to obtain collateral information from community health providers to ascertain if Detainee A had been prescribed the medication that he had stated he had been taking. Health staff called the community GP nominated by Detainee A on 1 February 2022 where it was advised that Detainee A had not been prescribed the medication in the community. OICS cannot explain this discrepancy.

Custodial Mental Health Assessment

A Custodial Mental Health Induction Screening Form was completed by a CMH nurse. The completed form noted, amongst other things:[9]

- that the nurse had reviewed 'MHAGIC', which is the electronic health record used in community mental health in the ACT. The nurse noted there was a reference to an overdose in 2020 (the incident referred to in footnote 5 above), the same drug and alcohol history as the PH nurse and noted there were no signs of current withdrawal;
- that Detainee A denied any psychiatric history, described his mood over the past two weeks as being 'depressed' and stated he was sleeping approximately two hours per night for the last six weeks;
- that Detainee A did not report a history of self-harm or suicide attempts and did not report currently having any thoughts of self-harm or suicide. Detainee A also reported there was no family history or self-harm or suicide; and
- Detainee A's mental state was unremarkable, except for possible depression and some issues with a willingness to cooperate with the assessment.

9 It is important to note that this self-reported information may not correspond with histories known to family members or close friends.

The CMH nurse determined Detainee A was a nil 'S' rating for suicide or self-harm risk and nil 'P' rating for psychiatric conditions[10].

The CMH nurse also completed an ACT Health Suicide Vulnerability Assessment Tool with Detainee A. On this form, the CMH nurse noted that, amongst other things:

- Detainee A was in custody for charges related to assault and displayed an underlying irritability towards the assessment;
- Detainee A's 2020 overdose was discussed and the CMH nurse noted there were situation stressors which precipitated the incident (OICS notes that the overdose was not described as "self-harm");
- Detainee A displayed no evidence of major mental illness or mood disorder and denied any thoughts of self-harm or suicide;
- no follow up with CMH was recommended. The CMH nurse also noted that the detainee had been advised on how to self-refer to CMH; and
- Detainee A had been discussed with the on call medical officer and the handover/notification form had been provided to ACTCS.

The CMH nurse noted in electronic progress notes that no observations were indicated but COs would do 60-minute observations anyway.

OICS notes the discrepancy between clinicians subjective assessment of Detainee A's willingness to undertake assessments, but makes no further comment on this matter.

Cocaine risks

The ACTP Report indicated that Detainee A 'had a history of substance abuse including alcohol, cocaine and steroids'. On 31 January 2022 Detainee A reported to Justice Health during intake health screening that he had used alcohol and other drugs in the last four weeks but denied injecting any drugs/substances in the last three months. He also stated he used[11] cocaine daily, clinical notes indicate he said 7gm a day initially, but he later said 7gm over the last 6-7 days prior to his incarceration, and he last used the substance 30 January 2022. The CMH intake form notes no signs of current withdrawal. Further, the clinical notes state in relation to induction that he 'denies having any withdrawal symptoms right now. Notified client that nurses will be doing med rounds twice daily and advised to inform nurses if need arise.'

It is reasonably clear that Detainee A disclosed taking cocaine on 30 January 2022 but is unclear how much (grams) he ingested at that time.

OICS notes that Detainee A apparently died by suicide between 6:30pm and 7:00pm on 1 February 2022. If he last ingested cocaine on 30 January as he disclosed, he *may* have been experiencing cocaine withdrawal whilst in the MU (see extracts from the Australian Government Department of Health fact sheet '**Cocaine: What you need to know**' at Appendix 1 to this report).

OICS notes that at the time of Detainee A's death, JH did not have any guidelines in relation to management of detainee withdrawal from cocaine (or other stimulants).

10 See footnote 4 above in relation to S risk ratings. P risk ratings relate to 'psychiatric condition that requires immediate treatment or diagnosis, including known or suspected conditions that have not been confirmed' and range from P1 (a serious condition requiring immediate or intensive care) to P3 (a stable psychiatric treatment requiring appointment or continuing treatment) and PA (suspected psychiatric treatment requiring assessment). See *Corrections Management (Risk Alerts) Policy 2019.*

11 The CMH screening form states the route was 'INH' (inhalation) whereas the CMH screening form states the route of ingestion was 'smoke'.

3.4.3 Initial Corrections assessments

An ACTCS Induction Form was completed. This form indicated that Detainee A was 'not a known drug user' (note that the information Detainee A provided to Justice Health during the initial health assessment about his recent drug use was not shared with ACTCS). The 'Admissions Supervisor Recommendation' was for Detainee A to be given a security classification of 'medium' (which is the default for new admissions), to be placed in 'mainstream' (i.e., not in protection), and to be accommodated in the 'new reception area (male)'.

Attached to the induction form were the three Justice Health notification forms (Primary Health, COVID-19 Primary Health, and Custodial Mental Health). These forms are used by Justice Health to share relevant detainee health information with ACTCS that may assist ACTCS to manage the health and wellbeing of a detainee. These forms do not go into specifics such as clinical history, diagnosis or medication. The Primary Health form indicated no medical observations were required, and there were no signs or symptoms to look for.

Just after 5:00pm, Detainee A was moved from the Admissions Unit to cell 3 of the MU for COVID-19 isolation.

3.5 Placement in the COVID-19/Management Unit

Since the start of the COVID-19 pandemic but prior to the outbreak of COVID-19 Delta variant in Canberra, there was no specific unit at the AMC for new admissions to be separated from the wider detainee population. In September 2021 a decision was taken, for reasons discussed at section 7.2 of this report, to use the MU as a COVID-19 quarantine/isolation unit.

The MU is a freestanding single storey unit at the AMC with 14 cells designed to accommodate one detainee each (i.e., the design capacity of the unit is 14). The unit is rectangular in shape with seven cells on each side of a 'dayroom' and a fully enclosed officer station with windows on three sides looking out into the 'dayroom'. Each cell has a door to a small outdoor yard (about 2.5m wide x 3.5m long), fully bricked with a mesh roof. There is no exercise equipment in the yards and no rain protection from the mesh metal roof. Each cell is fitted with a CCTV camera in the corner of the cell and in the outdoor space that can be viewed on a screen in the unit's officer station (the COs on duty can 'bring up' cameras on a TV monitor in the officers station).

As noted, Detainee A was placed in cell 3 in the MU. This cell is on the 'hard side' of the unit, generally used for separate confinement prior to the unit being converted to a COVID-19 unit.

Source: ACTP, 2022

This cell has a basic fit out: a shower and toilet are in a corner closest to the door. A bench with a basic mattress is along one side of the wall and a TV behind a polycarbonate case fixed to the top wall. There is no desk or chair or place to store belongings or other items. Induction packs with information are in the cells for new arrivals containing information about the AMC.

Upon arrival in cell 3, Detainee A was provided with a hot meal in a disposable meal package by a CO and they exchanged some words before the cell door was closed. There was no further engagement between Detainee A and COs that evening, either in person or through the cell intercom[12].

The next day (February 1st), the nurses arrived for their routine health checks of the COVID-19 unit and morning medication round at around 11:00am. Detainee A buzzed the intercom mid-morning to ask if he could give the COs his list of phone numbers to be put on his phone account. New detainees complete a form to identify up to five personal contact telephone numbers they would like to be able to dial (at their own cost) on AMC detainee telephones (although in the MU, cordless phones are utilised as detainees are not permitted to exit the cells to access the unit phone in the MU dayroom because of COVID-19 transmission risk). ACTCS then must validate these numbers (ensuring the potential recipients do want to be contacted by the detainee and they are legally permitted to be contacted i.e., not subject to court orders precluding contact, etc).

The CO responded, 'yeah I'll come and get it off you in a minute'. It appears that this did not occur, as at about 1:30pm Detainee A buzzed again to ask COs to pick the form up. He is told by the CO 'we are going to do it this afternoon mate, I'll come and collect them next time I'm out, just stick it under your door mate, and I'll pick it up'. It is not clear if this occurred. OICS was not able to locate a completed phone request form. At around 4:15pm a CO delivered what appears to be a meal package to cells in the unit, including passing one to Detainee A through the cell hatch.

Although ACTCS records have an observation on Detainee A signed off as completed at 5:00pm, it appears that this was not in fact done. The dayroom CCTV camera shows that no one approached the door to Detainee A's cell between 4:15pm and 6:03pm. Interviews with COs suggest observations of cell 3 were not done by CCTV either[13]. The 6:00pm observations were completed at 6:03pm with a CO appearing to have a brief exchange with Detainee A through the cell door. Refer to section 6.2.1 of this report for further comment on this matter.

12 Detainees can buzz their cell intercom at any time to speak with staff if they wish to do so.

13 CCTV observations are not good practice in any case compared to in-person observations e.g. a detainee could appear to be sleeping on CCTV but they may not be breathing. However, the use of CCTV may be useful for monitoring the behaviour / actions of detainees in certain circumstances.

3.6 The incident

3.6.1 Staff immediate response

Two Justice Health staff attended the MU at around 6:30pm for evening COVID-19 health checks and medication rounds. At around 7:00pm they approached Detainee A's cell for a COVID-19 health check (as he was not on any medication), accompanied by a CO who was conducting observations and assisting with the medication rounds. As the CO approached Detainee A's cell, he noticed the observation window in the cell door was obscured and lent forward to open the cell door 'hatch'. In doing so, he observed Detainee A in a sitting position at the back of the cell with both legs extended forward and his buttocks/hips off the ground, with a sheet around his neck and attached to the external yard door.

The CO immediately called a 'Code Pink' (medical emergency) on his radio and motioned towards a CO who was in the officer station to electronically unlock the cell door. The CO who had just discovered Detainee A entered the cell followed closely by both Justice Health nurses. That CO checked for breathing and a pulse. The CO then exited the cell and went into the officer station looking for a Hoffman Knife (Hoffman) to cut the sheet. He was unable to locate a Hoffman and about 30 seconds later he exited the officer station, accompanied by the CO that had been in the officer station and both entered Detainee A's cell (this whole process taking approximately one minute). One CO took the weight of Detainee A while the CO that had discovered Detainee A untied the sheet from around Detainee A's neck.

Nursing staff undertook an initial clinical assessment and found Detainee A to be unconscious, had an absent pulse, was not breathing or responding, his lips and extremities were cyanotic and his pupils were fixed and dilated.

Nursing staff instructed COs to place Detainee A on the ground and opened Detainee A's airway. Nursing and custodial staff commenced resuscitation, with the nursing and custodial staff rotating through cardiac compressions and nursing staff managing the airway.

The nurse in charge of the incident requested an ambulance be called, requested that the Automatic Electronic Defibrillator (AED) located in the MU be brought to the scene, and radioed another nurse to bring the emergency bag for the COVID-19 unit from the Hume Health Centre.

At 7:03 pm the AED pads were placed on the detainee and the AED recorded that there was "no shockable rhythm".

The ACT Ambulance Service (ACTAS) arrived and at 7:19pm two ACTAS paramedics entered the cell and took over coordinating the management of the incident. Nursing staff provided a clinical handover to the paramedics while COs continued cardiac compressions. At 7:20pm the paramedics requested that Detainee A be moved from cell 3 to the open area on the 'soft side' of the COVID-19 Unit to allow more space.

The paramedics changed the AMC AED to an ACTAS AED which also recorded ECG tracings. The ACTAS AED also recorded "no shockable rhythm" for the detainee. At 7:25pm three additional Careflight staff attended AMC to assist the paramedics with the management of the detainee as they were near the AMC at the time and were aware of the emergency via radio communication. The paramedics continued advanced life saving techniques until 7:43pm when they pronounced life extinct.

ACTP attended at 8:40pm. The ACTP Forensic Officers arrived on site just after 9:00pm and continued to interview staff until 11:00pm.

3.6.2 Debriefs and follow up

Initial debriefs

An informal debrief was held on the night.

A hot debrief was held the next morning, chaired by the AMC General Manager, and attended by AMC senior operational staff, COs involved in the incident, AMC programs staff, representatives from the Chaplaincy, the Intelligence Unit, and the Assistant Director of Nursing from Primary Health. The hot debrief included a staff welfare check. The written report of the hot debrief notes staff perception that they had worked well as a team in responding to the incident. Feedback included that the collaboration between ACTCS and PH nurses was good. Two issues were noted. First, the access to Hoffmans and that 'staff couldn't find one in the MU on the night'. Second, staff noted that they were unsure of the details they should provide as scribe for an incident of this type and requested investigation of possible training.

Formal debrief

The formal debrief was held on 15 February 2022 and chaired by the Acting Assistant Commissioner, Community Corrections. This was attended by relevant COs, AMC senior managers, responding PH nurses, the Assistant Director of Nursing and a responding doctor from Southcare. Apologies from ACTP were noted. There is no mention of an invitation or apologies from ACTAS.

The formal debrief notes that 'there was agreement that the teamwork and decision making was of the highest level through the incident', and that staff worked as a team to provide effective CPR. There was discussion regarding the initial call to ACTAS, and whether the information provided conveyed the serious nature of the incident. It was noted that a second call to ACTAS was made to convey the urgency.

A key area for improvement noted was the fact that there was no Hoffman within the unit. The formal debrief report states immediate action has been implemented so all areas at AMC have a Hoffman, with managers responsible for accountability. A longer-term improvement suggested by staff was for all COs to be issued a Hoffman daily as part of their uniform kit.

Other issues discussed include scribes feeling under prepared for the task, the lack of food post incident (some staff being held back for five hours after the completion of a 12 hour shift), the impact of this death on other detainees, and concern about lack of detail in the relevant policies around processes post death being pronounced.

Support for staff

On the night of the incident and following, ACTCS Peer Support Officers were available to provide peer support onsite and to check in with staff. On 3 February 2022, a Commissioner's message was issued to all ACTCS staff outlining professional assistance available to staff impacted by the incident.

Specialist support from an interstate expert in occupational trauma for first responders was provided onsite for several days, including individual and group sessions, as well as a session for peer support staff. Staff were reminded about access to the Employee Assistance Program, and a psychologist from an EAP provider was onsite for 1:1 or group session, and staff peer support was available. The ACTCS Specialist Communities and Interventions Team (SCIT) also provided 1:1 assistance to staff as required.

The staff OICS spoke to felt that the level of staff support generally met their needs.

Support for detainees

Detainees were advised of the death via email from the General Manager the following afternoon. In this email, detainees were encouraged to seek support through Chaplaincy, custodial staff, CMH or PH staff, or Lifeline (available as a free call number from unit telephones – accessible for timed 10 minute calls when detainees are not locked in although the phones have limited privacy from detainees who may walk past).

In the days following the death, members of the SCIT checked in with a number of detainees who were accommodated in the MU on the night of the death, and also other detainees with known vulnerabilities. SCIT also emailed all detainees offering support and providing a variety of means to get in touch with the team. OICS understands that very few detainees sought out support in response to this email. It is noted that Detainee A was a new arrival, had not been housed in an accommodation unit, had only had a brief previous period of incarceration and therefore may not have been known to many other detainees.

OICS notes that efforts were made by ACTCS, particularly the SCIT to offer support to detainees in the wake of the death in custody. Notwithstanding this, when OICS was onsite at AMC for reasons not related to this review, a number of detainees unprompted raised concerns that the death in custody left them and other detainees feeling unnerved and they felt they had no easily accessible mental health / counselling support. In these discussions detainees often also referred to their more general concerns about the lack of sub-acute mental health support and counselling at AMC including for depression and anxiety, as well as their concerns about the austere environment of the MU as a COVID-19 isolation unit on induction (discussed further in section 7.2 of this report).

4. APPROPRIATENESS OF ADMISSION SCREENING

4.1 ACTCS initial screening and risk assessment

As noted in Part 3 of this report, overall the ACTCS initial paperwork was poorly completed. Records are, at various points incorrect or incomplete. This includes, for example, ACTCS' electronic system recording that Detainee A did not make a phone call on admission, whereas he did in fact make one. Page 2 of the CTU 'Return and Transport Risk Assessment Form' incorrectly indicated it was Detainee A's first time in custody, but page 3 of the same form indicated it was not his first time. Key fields on the CTU 'Initial Assessment' form were incomplete including Detainee A's height, eye colour, hair colour, tattoos/scars/markings, and clothing.

This inadequate induction and assessment record keeping by ACTCS is a matter of concern generally.

Finding 1:

That the induction assessment of Detainee A conducted by ACT Corrective Services at the Court Transport Unit contained factual errors about his history in custody and his physical appearance.

4.2 Justice Health initial screening and risk assessment

As described in Part 3 of this Report the PH and CMH assessments conducted on new admissions to AMC are comprehensive and cover a broad range of health issues to be screened by the nurses.

Both nurses who undertook the admission assessments were experienced clinicians who had received training in the admission assessment process and were assessed as being competent prior to being permitted to undertake the assessments unsupervised. The screening forms were fully completed without obvious inconsistencies.

Finding 2:

That the mental health assessments, including in relation to self-harm risks, appeared thorough and did not raise any concerns for the mental health practitioners.

5. APPROPRIATENESS OF INCIDENT RESPONSE

The attempted resuscitation of Detainee A was undertaken very well by custodial staff and PH nurses. It appeared coordinated and all the staff appeared confident in the management of the resuscitation requirements. The PH nurses documented their management of the incident thoroughly in the detainee's health record.

Finding 3:

That the attempted resuscitation of Detainee A was undertaken in a highly skilled and professional manner by custodial and nursing staff, and they worked well together as a team.

OICS was advised that on the evening of the incident there were three nursing staff on duty instead of the five initially rostered. The vacancies were due to staff being furloughed due to being COVID-19 positive or a close contact. We do not believe the lack of a full complement of nursing staff impacted on the management of the incident.

When an ambulance was called by the Master Control Room (MCR), the urgency of the incident (suspected hanging) was not conveyed in full. OICS put the following questions to ACTAS in relation to the ambulance call out:

ACTAS response to OICS questions[14]

OICS: If further details of the incident (in particular, that the detainee was unresponsive and it was a suspected hanging) were provided in the call at 19:00 would this have triggered a more rapid response from ACTAS compared to the response that occurred at that time?

- From the initial call, the closest ambulance was dispatched [sic] as a priority 1 (lights and sirens) to the AMC at 19:01
- At this time the provision of extra information would not have provided a faster initial response
- If ACTAS were aware in the initial call the patient was unresponsive this may have resulted in a second ambulance to be dispatched [sic] to the AMC more rapidly
- Following the second call and the nature of the updated information, a second ambulance was dispatched [sic] at 19:12

OICS: Would it be of assistance for future callouts for ACTCS and ACTAS to jointly develop a 'script' for MCR operators to use when calling an ambulance so that ACTAS has the information it needs to provide the most appropriate response depending on the circumstances?

- It would be beneficial for a script to be developed and ACTAS are willing to work with ACTCS to develop one
- As a starting point, the priority information the call takers require to ascertain the most suitable ambulance response is:
  - Is the patient awake and talking?
  - Is the patient breathing normally?
  - Exact location of the patient

14 ACTAS email to OICS dated 21 April 2022.

Recommendation 1:

That written guidance is developed jointly by ACT Ambulance Service, Justice Health and ACT Corrective Services for use when an ambulance is called to AMC.

6. ISSUES ARISING

6.1 Known physical risk of hanging point from rear cell doors

The MU rear cell doors have horizontal metal bars, with Lexan (polycarbonate) fixed behind the bars.

It appears that Detainee A had managed to thread a sheet through a small gap between the metal bars and the Lexan on the rear cell door and suspend himself from the sheet. While some people may find it distressing, we felt it necessary to include this photo in the report to clearly show the door design fault.

Source: ACTP, 2022

The risk that if the Lexan came loose from the bars, a ligature could be threaded through and used as a suspension point had been identified by AMC Facilities Management in 2015. An email was sent from the Director, Facilities Management to the then General Manager of AMC on 5 June 2015:

> Hi [Name withheld],
>
> [Name withheld] and [Name withheld] have completed the upgrade work to the Management door panels. There was a small issue that was identified yesterday with the [deleted] supplied however maintenance will replace them and send them back under warranty.
>
> **I'd suggest that we review the doors and consider adding intermediate fixing to the horizontal bars to prevent the lexan bowing out (which could allow a ligature to be tied around a horizontal bar)**. [emphasis added]
>
> Kind regards,
> [Name withheld]

On the same day, the following response was received from the then General Manager of AMC:

> Thanks [Name withheld]
>
> I will need to have a look before any decision is made.
>
> Thanks
> [Name withheld]

The Director, Facilities Management advised OICS that 'The GM at the time didn't support making any modifications to the door'. ACTCS provided the following comments on the draft of this report:

> ACTCS understands that the then GM viewed the door in person. It is understood that the GM did not want to make additional modifications to the door which would depart from the original door design. This was because there was no obvious ligature point (significant force or tools would be required to create a gap). It was also noted that it is extremely difficult to eliminate all ligature points. Also … the GM was of the view that the MU wasn't for at-risk detainees, and he would prefer to eliminate the risk by using CSU for at-risk detainees than an engineering solution.

OICS notes that the original design of the doors had already been modified by ACTCS in May/June 2015 by replacing Perspex with Lexan i.e. the Lexan was a retrofit which may have been in response to an incident in February 2013 where a detainee broke a piece of "perspex" off the rear door in his MU cell.[15]

In the course of conducting this review, OICS became aware of another design fault with the rear doors which although not related to the death of Detainee A, raises serious concerns about the safety of the design of the doors and suicide prevention at AMC.

On 13 May 2020 an Indigenous detainee self-harmed in the MU (prior to it being converted to the COVID-19 unit) by attaching a ligature (an item of clothing) to the cell external door. He placed the ligature in the door frame and slammed the door, then placed the end around his neck, spinning and dropping in an attempt to hang himself. The detainee was in the exercise yard rather than the cell side of the door. A report on the incident noted:

> It appears that the act of slamming the door has caused damage to the locking mechanism and when the door shut the handle has disconnected meaning that despite every effort the handle continued spinning but would not allow access into the yard [from inside the cell] to get to the detainee.[16]

The detainee was able to slam the door because there was no mechanism to lock the cell door in an ajar position[17].

Source: Pedavoli Architects 'Management Unit Review' draft report. Door in ajar position but not locked to the wall.

15 Peer Review of Preliminary Findings of the Inquiry by the Health Services Commissioner, ACT Human Rights Commission, in the Matter of [detainee name], Knowledge Consulting Pty Ltd, October 2014 (unpublished).

16 AMC Hot Debrief Report dated 13 May 2020. Access to the detainee was made by opening the external gate into the outside yard with some significant delay over access to the correct keys.

17 In 2021 Pedavoli Architects conducted a 'Management Unit Review'. In their draft report dated 13 April 2021 comments were made about the rear cell doors that access the exercise yard in each cell where it was noted (p.9) that 'There is no mechanism to secure the door in the open position. AMC advised that this is an operational issue.'

The detainee fortunately was revived but had to be intubated by ACTAS in the ambulance before being transported to hospital. This incident is discussed further in part 7 of this report.

The 13 May 2020 incident prompted a 'Procurement Threshold Exemption Brief' from the then Commissioner, ACTCS to the Director-General of the Justice and Community Safety Directorate (JACS). That Brief sought an exemption from ACT Government Procurement rules that require a public tender process for the procurement of goods, services or works to the value of $200,000. Paragraph 6 of that brief stated:

> Due to an **incident that occurred in the AMC on 13/5/20**, it has been identified that all of the high security doors in the AMC's Management and Crisis Support Units are **no longer fit for purpose** and present a safety risk to detainees and custodial officers. As a result, up to 42 doors require urgent replacement. [emphasis added]

The estimated value for the work was $610,000. A reason for the exemption being sought was that:

> Due to the inherent safety risk identified with the current doors, the replacement of these doors has been deemed as urgent and needed within a timeframe that would not allow for a standard open market tender process.

This brief was approved by the Director-General on 2 June 2020, with an annotation 'as per brief'.

OICS notes that the brief did not explain why the doors were 'no longer fit for purpose' or how this assessment was related to the 13 May 2020 incident as cited in the brief i.e. what was the problem(s) the new doors were going to fix? We also note that the brief did not mention the 2015 warning about the Lexan panels in the rear MU cell doors.

In crude terms, the $610,000 equated to about $14,500 for each of the 42 doors. The estimate was explained in a JACS' brief dated 28 May 2020[18]:

> (Name) advised this value is based on previous quotes, as attached. For example, 1 door replacement at $16,721, and or 5 doors for $51,151 which is $10,230 a door, all GST incl.
>
> On further queries about the price breakdown (name) advised the $610,000 was based on a few discussions he had with the AMC facilities manager, who advised that ACTCS received doors between $10–15,000 per door (GST ex.). The estimate cost used was $13k GST ex or ($14,300 GST inc). This costing based on the different configurations and modifications between the outer, inner, and CSU doors (they all have slightly different requirements).
>
> That resulted in a figure of $600,600 GST incl ($14,300*42), for 42 doors. So ACTCS rounded the estimates up to $610,000 to give a little contingency and allow for any modifications that might be needed after manufacture if things don't fit.
>
> The figure used is an estimate, noting that the final price could come back either slightly higher or lower depending on the supplier's bid. ACTCS advised they will then be in a position to negotiate value for money options due to the large number of doors required.

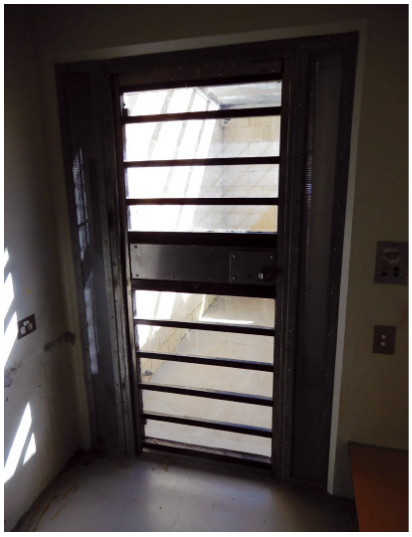
OICS understands that due to budget constraints the MU scope of work was subsequently reduced to replacement of the MU front cell doors only. However, one might have expected that replacing the rear MU cell doors would have been the priority.

18 Review of Select Brief, Exc: 2020/00233.

On 8 June 2022, ACTCS offered to provide OICS with a detailed statement on the cell doors project but this had not been provided by the time the report was finalised for tabling in the Legislative Assembly.

Following the project approval (2 June 2020), Pedavoli Architects conducted a 'Management Unit Review' in 2021. In their draft report dated 13 April 2021 comments were made about the rear cell doors that access the external yard in each cell:

Cell door (cell to yard)



Door to yard, inside view and external view

The door to the Cell Exercise Yard is steel ladder frame with glazed infill.
The glazing enables daylight to the cell. The ladder frame can be used as a climbing aid.

Contemporary management cell design includes a solid door leaf and a fixed window adjacent to provide daylight. As general principle, glazing is not provided at low level in cells in order to mitigate against impact damage.

Source: Pedavoli report, 2021

The Pedavoli report notes that 'contemporary' design doors should have been a 'solid (steel) door leaf' with lighting provided via a window in the rear wall. For example:

Source: Pedavoli Architects, 2022

In comments provided to OICS on a draft of this report, ACTCS disputes the Pedavoli Architects opinion that the rear cell doors do not meet 'contemporary cell design':

> ACTCS notes that the MU doors are consistent with relevant cell standards, as such we would contend that there are no design fault issues with the rear cell doors

OICS does not agree with the ACTCS view 'that there are no design fault issues with the rear cell doors'.

Finding 4:

That at the time of Detainee A's death in 2022, ACTCS was aware of a serious design fault in the rear cell doors which had been known since 2015.

Finding 5:

That in 2020 the Director-General of the Justice and Community Safety Directorate approved an urgent purchase of replacement doors for the AMC Management/COVID-19 unit due to 'inherent safety risk identified with the current doors'. For reasons unclear to OICS, the rear MU doors had not been replaced at the time Detainee A utilised the rear door as a ligature point.

Since the death of Detainee A, ACTCS advised OICS that it had undertaken modification work on all the MU rear doors with intention of removing possible hanging points[19]. While OICS welcomes this initiative, we do not have the technical expertise to agree or disagree with the efficacy of the modifications and must make clear that the **risks associated with the design and construction of these doors into the future rests entirely with ACTCS**.

Recommendation 2:

That *immediate* action be taken to ensure the rear cell doors in the Alexander Maconochie Centre Management Unit do not present any foreseeable risks of ligature points and are in accordance with relevant cell safety standards consistent with the use of the unit.

6.2 Observations of Detainee A in the Management Unit

This review finds that on the day of his death, CO observations on Detainee A were deficient.

Detainee A had been assessed by Justice Health as not requiring additional observations based on his mental health (assessed as S-nil, P-nil by CMH) or physical health (assessed as M-nil by PH). However, all detainees placed on COVID-19 segregation are subject to hourly observations.

19 An OICS inspection of the cell 3 door on 28 April 2022 noted that some type of rubberised hard filler had been injected between the bars and the Lexan panel to seal the gap.

6.2.1 *In-person observations*

COs are required to complete a Detainee Observation Form, recording the time of observation, the occurrence (for example, what they were doing at the time e.g. sitting on bed in cell), and recording their signature. The reverse of these forms provide instructions for use (relevantly):

- observations must be conducted in person, not by camera;
- the recording of observations must be made contemporaneously – at the time of observation; and
- observations must describe the detainee's behaviour as observed by the corrections officer (including any dialogue, requests and concerns such as refusal to eat and the appearance of the detainee).

On 1 February 2022, the 4:00pm observations of Detainee A were conducted by a CO at around 4:15pm (though signed off as occurring at 4:00pm). The 5:00pm observations were signed off as occurring at 5:00pm, however, based on the relevant CCTV camera of the dayroom, OICS concludes that no in-person observations of Detainee A occurred at this time. CCTV footage indicates there were no in-person observations on Detainee A between 4:15pm and 6:03pm.

Just before 5:20pm, Detainee A obscured the CCTV camera in his cell with a label taken from the small bottle of milk provided as part of a meal. He also obscured the external yard camera around this time. The issue of covering the CCTV cameras is discussed below.

At 6:03pm, a CO conducted in-person observations on Detainee A.

The 6:03pm observations were not recorded contemporaneously. It appears that the CO was advised later that evening by an ACTCS staff member who had reviewed the CCTV footage that these observations occurred at 6:03pm. This appears to explain why these observations were not signed off as occurring precisely on the hour like every other earlier observations that day.

The CO in question notes in his incident report 'due to the need to attend to other detainees needs within the unit, the hourly observations were carried out on time at 1800hrs, however the detainee observations sheet was not filled out at that time. At 1900hrs the incident occurred and I again was unable complete the observation sheet.'

Although it is clear that Detainee A was alive at 5:00pm, the omission by the CO of conducting in-person observations at 5:00pm, and the retrospective rather than the required contemporaneous completion of the observation log, is concerning.

Observations of detainees are a key safeguard to protect detainee life, safety and wellbeing. The ACTCS detainee observation sheet clearly sets out acceptable standards for how it should be completed and has a straightforward table for recording observations. It is unacceptable for COs to be signing off on observations that did not occur or did not occur in the manner required. Furthermore, the descriptions accompanying the observations of Detainee A on 1 February represent extremely poor practice as the description 'in cell' is used for every observation prior to 6:00pm. This does not describe what was occurring. The CTU observations of Detainee A included appropriate descriptions such as 'laying on bench in cell', 'standing at door' etc.

OICS has not made a recommendation to ACTCS in relation to accuracy of CO observations as it was not within scope of this review to explore the standard of observation taking across all posts and the practice of staff generally. However, accuracy of observations is a matter of vital importance which should be emphasised in recruit training and part of performance oversight by senior COs of more junior COs.

Finding 6:

No in-person observations of Detainee A occurred at 5:00pm on 1 February 2022 despite being signed off as occurring, contrary to operational guidelines.

OICS notes that the MU was staffed as a two CO post at the time of the incident. On 1 February 2022 there were 15 detainees in the unit (meaning some cells had two detainees accommodated in them which is a terrible situation for a unit where cells are only designed to accommodate one person, and there is no time out of cell provided). The COs rostered on this unit on this day noted it was busy: a detainee in the unit was heightened in the afternoon and it took some time for a CO to talk to him and assist with deescalation. All new AMC receptions in this unit need to get phone accounts set up and may have a range of other needs such as access to lawyers and court (usually done via the unit cordless phone passed into the cell), contact with Welfare Officers or Sentence Management Officers (usually done through the intercom in the officer's station). A CO advised OICS that he had to chase up paperwork outside the unit for a period during the afternoon of 1 February leaving only one CO on the post during that time.

The MU operating as a COVID-19 isolation unit is a high turnover, high risk environment and a particularly demanding post. OICS is of the view that it should be staffed by more than two COs.

Finding 7:

That the COVID-19 unit is a demanding post and it would appear that two COs are at times insufficient to effectively carry out crucially important administrative tasks such as setting up phone lists as well as spending time to meaningfully engage with detainees.

6.2.2 Observations via CCTV camera

Cell 3 of the MU unit has two CCTV cameras. One is located in the right-hand corner on entering, above the bed. The other is located in external yard accessed by the cell's rear door. Detainee A obscured both cameras just before 5:20pm. He did this by affixing to the camera the label taken from a milk container provided in an AMC meal pack. The COs on duty indicated that they were unaware that the camera had been obscured prior to discovering Detainee A.

However, even if COs were aware of the camera being covered up it would seem there is no clear and consistent requirement by operational management to require detainees to uncover cameras. A senior manager noted to OICS that 'COVID-19 detainees' in the MU were not on the usual separate confinement (s 184, CM Act disciplinary) regime that they would be if the unit was being used for its intended purpose as a management unit, and noted detainees sought privacy. Furthermore, it was put to OICS by this senior manager that if the cameras are uncovered, detainees often simply cover them again (e.g., using wet toilet paper) as soon as the CO leaves the cell. It was noted by the senior manager that if detainees did not willingly uncover their camera it was more complex given the COVID-19 environment as it would require the security team with everyone in full PPE to enter the cell to uncover the camera, which may be soon re-covered.

OICS notes that detainees covering up their cameras may often be an expression of a desire for privacy, but it can also be an indication that a detainee is contemplating some action that they wish to not be observed by staff.

Each cell in the MU did have CCTV installed. Given the challenges COVID-19 isolation pose for mental and physical health making it a higher risk setting than a usual jail induction unit, OICS is of the opinion that ACTCS should have made a deliberate decision (articulated in a policy, procedure, or written direction) about whether CCTV in the MU should have been used as an additional monitoring tool to safeguard detainee health and wellbeing. This is not a straightforward decision, as the potential benefit in upholding the right to life for detainees wishing to self-harm or attempt suicide undetected must be considered in light of the impact CCTV cameras have on limiting a detainee's right to privacy, and the risks associated with possible uses of force to uncover cameras if required, as discussed above.

If ACTCS had produced a policy/procedure/post instruction for the MU operating as a COVID-19 unit, operations and management may (should) have considered potential risks to physical and mental health posed by the unique environment of COVID-19 isolation, and mitigation strategies could be identified and integrated into unit procedures and regime. This is discussed further in Section 7.2.

6.3 Suicide prevention framework

There are a range of policies, procedures, guidelines etc issued by ACTCS and Justice Health that are relevant to suicide and self-harm. The most 'specific' ACTCS policy relating to suicide and self-harm is the *Corrections Management (Court Transport Unit Person at Risk Management) Operating Procedure 2021* and the *Corrections Management (Management of At-Risk Detainees) Policy 2019*. These only relate to detainees that may be eligible for or already identified as 'at-risk' by CMH (refer to footnotes 4 and 9 in relation to suicide risk and psychiatric condition risk ratings). These documents focus mostly on procedural requirements.

There is suicide prevention training carried out for COs, including training delivered by CMH and this collaboration is positive to see.

However, there is no overarching suicide prevention framework. In 2015 Victoria developed a Correctional Suicide Prevention Framework that seeks to 'provides a single overarching whole-of-system prevention framework to complement existing standards and procedures'. It outlines the interplay between environment, procedures, training and culture. OICS sees merit in an overarching guiding framework for key stakeholders (including ACTCS and Justice Health and Winnunga).

Finding 8:

ACTCS does not have any overarching suicide prevention framework or strategy.

Recommendation 3:

ACT Corrective Services, Canberra Health Services and Winnunga consider whether an overarching suicide prevention framework or strategy along the lines of the Victorian Corrections Suicide Prevention Framework is necessary, and if so, jointly develop one within a year.

7. OTHER MATTERS ARISING FROM THIS REVIEW: PREVENTIVE MEASURES

7.1 Preface

The Explanatory Statement for the *Inspector of Correctional Services Bill 2017 states that:*

> As an additional level of oversight, the establishment of the Inspector supports a comprehensive agenda for the **continuous improvement of corrections in the ACT**, to increase transparency and deter mismanagement, unfairness and corruption. [emphasis added]
>
> The establishment of **the Inspector is an opportunity to take a collaborative approach to identify strengths and areas for improvement**. It will also be an opportunity to identify achievements, increase staff engagement and lead sustainable change towards best practice. [emphasis added]

Section 6 of the ICS Act states:

> Object of Act
>
> (1) The main object of this Act is to promote the continuous improvement of correctional centres and correctional services.
>
> (2) This is to be achieved particularly by providing a framework for—
>
> (a) the systematic review and scrutiny of the correctional centres and services; and
>
> (b) independent and transparent reporting.

The Explanatory Statement describes the purpose of Clause 6 (s 6 of the ICS Act):

> The purpose also reflects the requirements and expectations around the establishment of a national preventive mechanism [NPM] under OPCAT, and other international documents created to ensure the humane treatment of people deprived of liberty, including the *United Nations Standard Minimum Rules for the Treatment of Prisoners* and the *United Nations Principles for the Protection of All Persons under Any Form of Detention*.[20]

This part of the report deals with matters of a preventive nature with the intention of identifying 'areas for improvement' in the delivery of correctional services at the AMC.

20 OICS notes that the ACT Government designated OICS to be an NPM on 12 January 2022. OICS has primary responsibility for inspection and reporting in relation to the AMC, ACTCS Court Transport Unit and Bimberi Youth Justice Centre.

7.2 COVID-19 management at the AMC

During the course of the review, OICS was mindful that Detainee A died in a cell in the MU which at that time was being used to isolate new admissions who were subject to COVID-19 (PCR) testing.

The practicalities that were in place at the time of the Critical Incident were based on advice from Justice Health that detainees would be PCR tested on day 0 (arrival at AMC), placed in a single cell in the MU, and then PCR tested on day 5. If the day 5 PCR came back negative the detainee was moved to another unit in AMC. If COVID-19 was detected on day 0 or day 5, the detainee would spend 14 days in the MU cell in isolation. This isolation period could be extended if a detainee returned a positive PCR test on day 14.

Noting that Detainee A spent only about a day in COVID-19 isolation, OICS accepts that there is no evidence that the COVID-19 unit operational practices at AMC were a causal factor in his apparent suicide[21]. However, some of those AMC practices raised serious concerns for us regarding the minimization of harm for detainees undergoing COVID-19 isolation.

7.2.1 Utilisation of the Management Unit for COVID-19 isolation

In mid-August 2021 the ACT went into lockdown due to the transmission of the Delta variant of COVID-19 in the community. In mid-September, although no COVID-19 cases had yet been detected in the detainee population, ACTCS decided to utilise the MU as a COVID-19 isolation unit. The MU was the preferred approach because it had single cells with a small external bricked courtyard for access to fresh air. The airflow in this unit was assessed as not shared, limiting the potential from transmission between cells. It was also close to Admissions and the Hume Health Centre. There is no doubt that establishing a COVID-19 Unit limited transmission of COVID-19 into the general detainee population for a significant period of time. ACTCS further noted in response to a draft of this report that 'the introduction of the COVID-19 Unit allowed for the easing of other restrictions within the AMC. It allowed, in part, for the re-commencement of visits which would not have been possible without the isolation unit.' OICS is not critical of the decision per-se to establish an isolation unit.[22]

7.2.2 Legal and operational framework for isolation unit

There is a legal basis under s 92 of the CM Act for detainees to be segregated on health grounds if it is necessary to prevent the spread of disease.

Running the MU as a segregation facility to prevent the spread of disease was a novel situation for AMC management, with different risks and constraints as compared to running MU for its design purposes. It is understandable that there may not have been a policy, procedure, Commissioner's Instruction or post instruction formulated from day one of the new health segregation arrangements given the rapidly evolving situation with the ACT's COVID-19 outbreak, including staff absent due to COVID-19 infection or close contact risks. However, there should have been some clear directions developed in as timely a way as was possible in the circumstances

21 Noting that the Coroner may form a different conclusion.

22 Jails are a high risk setting for transmission of COVID-19 given the number of people living in close proximity and sharing facilities. Jails also have a higher proportion of people with disability and chronic health conditions that may make them vulnerable to more severe disease. The high 'churn' of people going into custody (particularly on remand) and released into the community (particularly on bail or parole), significant number of staff on rotating shifts as well as high number of professional and personal visitors to the jail also poses a risk to jail population where COVID-19 is circulating in the community.

about how the MU was to run. ACTCS provided a comment on the draft of this report '[t]he way COVID-19 is managed at the AMC is always done in consultation with Justice Health and Canberra Health Services and therefore is subject to change, and always in accordance with health advice'. The fluid nature of the pandemic should not, however, preclude guidance and directions from being issued and then updated as required.

OICS heard inconsistent messages from ACTCS staff on whether the *Corrections Management (Management of Segregation and Separate Confinement) Policy 2020* applied. It appears to OICS that detainees were isolated on health grounds under s 92 of the CM Act (necessary to 'prevent the spread of disease'). Yet, the *Management of Segregation and Separate Confinement Policy*, that should have been applied was not being followed. For example, detainees on health segregation under that policy must be considered at a multi-disciplinary meeting each week 'to consider the detainee's health condition, mental and physical health and the effect of segregation on the detainee'. This was not occurring, and in reality, it may not have been practicable or appropriate given the high volume of detainees on health segregation and the pandemic situation, but surely this is indicative of a need for a revised approach, that could be articulated for example, through a Commissioner's Instruction initially. A formal governance structure would also be a means to prompt identification of potential human rights issues and how to ensure limitations on rights are the least restrictive as possible whilst still meeting the health imperative of limiting the spread of COVID-19.

7.2.3 Daily living conditions in the COVID-19 unit

From reviewing this Critical Incident, OICS developed a picture of the environment in the MU in the period January-March 2022 in particular. It was an extremely austere environment with fairly limited opportunity for human engagement and support. Detainees remained in their cells for the duration of their isolation period except in exceptional circumstances. The MU only had 14 cells and so at times, two detainees shared a cell, which provided no social distancing nor privacy given the cells were designed as management cells for one person. If they tested positive on day 0 or day 5 this could be a period of 14 days or more.

Detainees were not allowed many items in their cell – for example, no kettles or personal effects. There was no access to exercise equipment. OICS heard from detainees and staff that there was almost no written material such as books and magazines to occupy time (one reason for this according to multiple staff was that any written material would have to be destroyed after use), although ACTCS contends that 'magazines, colouring books and pencils and reading books and playing cards were provided to COVID cells'. Most staff interactions with detainees were via cell door hatches or cell intercoms and OICS observed CCTV footage of health observations taking place through the cell hatch rather than with the door open. Both ACTCS and JH have stated that the door should be open unless reasons otherwise, and action has been taken to ensure this practice occurs. We heard from detainees that there were significant delays in setting up phone lists in order that they could contact the outside world. We also heard about delays or challenges in accessing lawyers, and noted case notes of this occurring.

7.2.4 *Human rights, isolation, and initial hours in custody*

Initial hours in custody are a period of higher risk of self-harm and suicide.[23] It is important that newly arrived detainees have access to protective factors, such as an admission phone call (and timely establishment of phone/email list to set up a means for detainees to contact family and loved ones), access to their lawyer, access to medical care, and access to other supports within the jail such as peer support, the Chaplain, or Aboriginal and Torres Strait Islander Liaison Officers where relevant.

The COVID-19 pandemic required modification to admission and induction processes in AMC to reduce the risk of transmission of disease. COVID-19 isolation in a single cell with very limited in person contact, and limited access to fresh air and sunlight creates a further mental stress on a newly arrived detainee. These detainees may be stressed about many factors such as the charges they are facing, their family situation, and they may be withdrawing from alcohol or drugs. This combination of factors heightens the importance of ensuring detainees in COVID-19 isolation have access to protective factors, and mental stimulation for their mental health and wellbeing. OICS holds significant concerns that detainees were not able to, or had limited access to, protective factors, and had very little to keep them mentally occupied whilst undergoing a significant period of isolation.

The CM Act sets out minimum living conditions. It includes an obligation on the Director-General of JACS to ensure, as far as practicable, that detainees have:

- access to one hour of fresh air and exercise per day;
- adequate opportunities to remain in contact with family members, friends, associates and others;
- reasonable access to news and educational services (including library); and
- reasonable access to religious, spiritual and cultural needs.

Notwithstanding that there is a clear legal basis for isolating detainees on health grounds, detainee entitlements under the CM Act continue to apply as far as practicable, and the *Human Rights Act 2004* (ACT) requires that limitation on rights be reasonable in the circumstances. OICS saw no evidence of detainee's rights being considered in a systematic way at an operational management level when establishing the MU as a COVID-19 isolation unit. If this had been done, there should have been more measures put in place to ensure that COVID-19 isolation was done in the least restrictive way possible, whilst still meeting the pressing need to avoid transmission of COVID-19 in the AMC (discussed below).

In relation to access to fresh air and exercise, the ACT Supreme Court had only months prior to the September 2021 decision to use the MU for quarantine declared that affording 'access to the rear courtyard of the MU at the AMC did not comply with section 45 of the *Corrections Management Act 2007*' (the *Davidson* decision). A June 2019 operating procedure relating to separate confinement was declared invalid to the extent that it deemed opening the rear cell door to count as a detainee's minimum one hour of fresh air and exercise.[24] OICS was informed that 'COVID-19 detainees' in the MU were not able to access the caged external MU exercise yard because it would have, according to ACTCS, necessitated COVID-19 cleaning after each use.

23 Willis M et al. (2016) 'Self-inflicted deaths in Australian prisons'. *Australian Institute of Criminology – Trends & Issues in Crime and Criminal Justice no. 513, Canberra.*

24 *Davidson v Director-General of Davidson v Director-General of the Justice and Community Safety Directorate* (SC328/2020), per orders of Loukas-Karlsson J.

At the time of the death in custody incident in February 2022, 4.5 months after the COVID-19 quarantine unit was established, there was still no policy, procedure, guidance, or post instructions on how it should operate. Most crucially, as the COVID-19 unit was essentially running a de facto *solitary confinement* regime justified on health grounds, it should have been clearly apparent to ACTCS (particularly considering the *Davidson* decision months earlier) that some thought be given to ensuring that isolation for the detainees is the least restrictive possible in the circumstances. Two important measures to reduce the impact of isolation would include access to exercise and fresh air outside the bricked external yard and access to the outside word e.g., utilising tablets for video calls and prioritising access to phone calls (e.g., timely set ups of accounts and free or subsidised calls).

"SOLITARY CONFINEMENT"

Nelson Mandela Rules[25]

44. For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days.

45.1 Solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority.

Guiding Principles for Corrections in Australia[26]

3.3.7 Prisoners placed in segregation/separation and/ or placed in a management or high security unit are managed under the least restrictive conditions consistent with the reason for their separation and to the extent necessary to minimise the associated risk…

Finding 9:

ACTCS did not give sufficient consideration to measures to mitigate the impact of the inhospitable environment of the COVID-19 isolation unit on physical or mental health, and ensuring restrictions were the least restrictive possible in the circumstances.

Recommendation 4:

That ACT Corrective Services develop guidance for operations of the COVID-19 unit to ensure it is the least restrictive environment possible in the circumstances. This guidance must consider protective factors and supports such prioritising detainee's contact with the outside world and have key performance indicators around timeframes for setting up detainee phone lists. All Custodial Officers working on the COVID-19 unit must have specific training on operationalising this guidance.

25 UN General Assembly, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*, 29 September 2015, UN Doc A/C.3/70/L.3.

26 Government of Australia, *Guiding Principles for Corrections in Australia*, 2018.

7.3 Hoffman knives

This report notes that COs in the MU were unable to cut the ligature around Detainee A's neck because they could not locate a Hoffman in the unit (section 3.6.1 of this report).

A Hoffman is a tool used in prisons to safely remove ligatures (ropes etc) from persons attempting to self-harm or suicide. Its design does not allow it to be used as a stabbing implement by prisoners:

Photo: a Hoffman Knife, the blade part is the internal curve.

While the lack of access to a Hoffman does not appear to OICS to have been a contributing factor in the death of Detainee A (see below), OICS has serious concerns about how the distribution of these Hoffmans was being managed at AMC before and at the time of the incident and the potential impact this could have had on the safety of the detainee population as a whole.

The *Corrections Management Intervention (Hoffman) Knife Procedure* ***2013*** *(RESTRICTED)* [emphasis added] provides that (at AMC):

> Intervention (Hoffman) knives are issued to all Supervisors on duty by Area Managers. This will occur at the beginning of each shift when handcuffs are issued. The identification number of the knife being issued is to be recorded against the name of the Supervisor receiving it in the Issues Register and signed for by the Supervisor.

The procedure also contemplates that Hoffmans will be available in 'break the glass' boxes in officer stations:

> If a Supervisor is present, he/she is to use the Intervention (Hoffman) knife which has been issued to him/her to cut the ligature. Otherwise, the Corrections Officer is to urgently locate the closest break glass box with an intervention (Hoffman) knife (e.g. located in the officer station), proceeding there with haste. If working with other Officers, the Corrections Officer can ask a colleague to collect the knife whilst they support the body weight of the detainee to ameliorate the effect of gravity before the knife can be used.

This procedure also highlights the importance of retaining the knot intact, noting 'the knot must be retained as evidence (i.e. not cut the knot if possible)'. This is for the purposes of incident investigation and coronial matters.

The OICS notes that AMC and the CTU have significantly different procedures about the issue of Hoffmans. Noting the AMC procedure cited above, the *Corrections Management (Court Transport Unit – Intervention (Hoffman) Knife) Operating Procedure* ***2021*** [emphasis added] requires that: at the start of a shift, Intervention (Hoffman) knives will be removed from the handcuff cabinet along with officers' handcuffs.

- Officers must secure the Intervention (Hoffman) knives in their personal issue Hoffman knife pouch attached to their duty belt;
- At the end of a shift, officers must return the Intervention (Hoffman) knives to the handcuff cabinet along with their handcuffs; and
- At the completion of each shift, Supervisors must ensure that all Intervention (Hoffman) knives have been returned to the handcuff TRAKA cabinet, and sign the *Supervisor Compliance Logbook* to acknowledge this.

In essence, the AMC procedure stipulates that Hoffmans will only be issued to supervisors and placed in break glass boxes in officer stations while the CTU procedure requires that they be issued to all (custodial) Corrections Officers[27] and carried on their duty belt.

Finding 10:

That the Hoffman knife issue procedure at the Court Transport Unit is/was a far more sensible approach to detainee safety than the procedure that applied at AMC, notwithstanding that the deficient AMC procedure was not even being followed at the time of Detainee A's death.

In responding to this incident, no Hoffman could be located in the MU at the time of the incident which meant the noose could not be cut from Detainee A's neck. Instead, a CO supported the weight of Detainee A's body whilst another CO untied the sheet. The lack of a Hoffman resulted in a delay of up to a minute in commencing resuscitation on the detainee as a CO went into the officer station to attempt to locate a Hoffman and returned and undid the noose by hand. This undoing of the noose is not considered best practice and does not comply with ACTCS policy[28].

It attempting to understand why Hoffmans were not available in the MU, OICS became aware of an operational decision to withdraw Hoffmans from being issued at AMC. Commencing around mid-October 2011, a "discussion" about Hoffmans involved a number of senior officers from AMC and ACTCS head office, including the ACTCS Executive Director (now titled "Commissioner")[29]. The partial email trail obtained by OICS was somewhat difficult to follow but it seems that concerns were raised about COs being allowed to take Hoffmans home with them:

> 18 October 2011
>
> *(to single addressee)*
>
> …
>
> Custodial staff are issued with Hoffman knives and these are a part of uniform issue. Officers take these home when they complete duty and bring them in before.
>
> Notwithstanding the official purpose, I understand that carrying knives is prohibited in the ACT as a general legislative prohibition…

27 'Custodial' refers to COs who are involved in the direct control and management of detainees as opposed to COs who might be rostered in roles such as the Master Control Room.

28 Not intended as criticism of the CO who untied the noose.

29 Given the passage of time, all but one of many staff mentioned in these emails have left ACTCS and all the various position titles have changed, which makes it difficult to determine who (functional positions) were involved in the conversation.

After quite a bit of internal debate the Executive Director wrote:

> 29 November 2011
>
> *[10 ACTCS addressees]*
>
> Dear All
>
> I believe we should review. We should not be issuing to every officer. Apart from the expense – it is not operationally necessary.
>
> They can be issued each day on parade – with a system for handover in arvo or indeed, be allocated to certain posts…

On 21 May 2012 the Superintendent AMC (now titled General Manger AMC) sent a submission about Hoffmans to the Executive Director, noting among other things:

> Currently ACTCS individually issue Hoffman knives to all staff…There are over 150 Hoffman knives currently issued to correctional officers. The change in process is to have all these Hoffman knives returned to the Deputy Superintendents of the respective areas and be issued on a daily basis to all Supervisors.
>
> In addition, specified buildings within the AMC, CTU and PDC[30] will have a break glass box installed in the control room or officers station [for storage of a Hoffman]…

The ED agreed to the recommendations made in the submission:

- That you approve 25 break glass boxes be purchased and installed within the AMC, CTU and PDC .
- That you approve the return of all Hoffman knives issued to all Corrections Officers.
- That you approve a new procedure of Hoffman knives being issued to Supervisors on a daily basis.

In OICS' opinion, this was an ill-considered decision in that even if it had been properly implemented, COs would not have immediate access to a Hoffman on their person in the event of an emergency requiring them to cut a ligature.

In the case of Detainee A, the inability of COs to access a Hoffman may not have made a difference given that the initial clinical assessment by the nurses indicate Detainee A was unconscious, had an absent pulse, was not breathing or responding, his lips and extremities were cyanotic and his pupils were fixed and dilated.

Recommendation 5:

That ACT Corrective Services ensure that a Hoffman knife is issued to each (custodial) Corrections Officer at the start of their shift.

30 PDC – Periodic Detention Centre at Symonston (now closed).

7.4 Failure to properly document a serious self-harm incident

The attempted hanging incident that occurred in the MU on 13 May 2020 (refer to part 6.1 of this report) has no direct connection to the death of Detainee A.

However, a matter of major concern is that there is no case note of this incident in the Custodial Information System, ACTCS' electronic record. Case notes are an important mechanism for COs and non-custodial ACTCS staff to share information about detainee treatment and care. That something as important as a serious attempted suicide by an Indigenous detainee with an extensive history of self-harm incidents was not recorded is inexcusable.

Finding 11:

That there was no case note recorded on the ACTCS electronic system of an incident in the Management Unit in 2020 involving an Indigenous detainee attempting to hang himself on the back door of the cell.

Appendix 1: Extracts from Australian Government fact sheet on cocaine

The Australian Government Department of Health fact sheet '**Cocaine: What you need to know**'[31] notes:

Risks from using heavier doses [cocaine] on a long term basis include:

- Anxiety, irritability, aggression, paranoia
- Low mood, lethargy and irritability during the 'comedown' phase

Cocaine psychosis symptoms include:

- Unusual thoughts (the person may believe that other people or forces are reading his/her mind or putting thoughts into his/her head that are not his/her own)
- The person may feel that he/she has special powers
- Paranoia (feeling extremely suspicious and frightened)
- Hallucinations (the person may see or hear things that aren't there, or feeling as though someone is touching him/her when there's nobody there)

For some people, the symptoms can be more serious and can last for more than a few days – these people are more likely to need treatment in a hospital. If the symptoms last more than a few days, this could also indicate that the person has a long-term psychotic illness such as schizophrenia.

Users often experience a 'comedown' phase, or 'crash', when the drug starts to wear off. This can last a few days and symptoms can include:

- Feeling uncomfortable
- Lethargy (having little or no energy or motivation)
- Irritability
- Paranoia

People who are dependent on (addicted to) cocaine may experience unpleasant symptoms for longer. These are called withdrawals.

Withdrawals from cocaine usually start around 6–12 hours after last use. There are three phases:

1. Crash: feelings of fatigue, flat or low mood, increased sleep and reduced cravings.
2. Withdrawal: energy levels and mood are extremely changeable, cravings, disturbed sleep, bad dreams, trouble concentrating, agitation, trouble moving and loss of appetite. Anxiety is common. These symptoms can last several weeks.
3. Extinction: persistence of withdrawal features, gradually subsiding. This can take several months.

31 National Drug and Alcohol Research Centre (2014) *Cocaine: What you need to know.*

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