ICS
ACT Inspector of Custodial Services

OICS OPERATING PROCEDURE

Exercising discretion to review a critical incident

Purpose: To provide the decision-making process for the Inspector exercising discretion whether to review a critical incident.

Last Updated: March 2026

Date to be reviewed: March 2029

Context

Critical Incidents are serious incidents that occur in a correctional centre or in the delivery of a correctional service, and at a youth detention centre, as defined in the Dictionary of the *Custodial Inspector Act 2017* (CI Act). The Inspector has discretion whether to review a Critical Incident under section 18(1)(c), CI Act.

The purpose of this document is to set out decision making criteria for exercise of that discretion.

The Inspector will exercise that discretion on the understanding that Corrective Services (ACTCS), the Health and Community Services Directorate (HCSD), Canberra Health Services (and other health service providers) have a duty of care to staff, detained people, and the wider community. The Legislative Assembly intended that the Inspector's Critical Incident review function complement relevant Directorate internal review mechanisms.[1] It is expected that the respective Directorate will also undertake their own evaluation of an incident, including conducting reviews as appropriate.

[1] The Explanatory Statement to the Inspector of Correctional Services Act 2017 notes: 'The definition of a 'critical incident' [for the purposes of the Inspector's review power] establishes a high threshold for incidents that occur in a custodial environment. This definition aims to ensure accountability and public transparency of events that may cause significant impact or harm in a custodial setting. It also reflects that there are appropriate existing internal review mechanisms within correctional centres for the oversight of events or incidents which do not cause significant harm.' (at 14).

Part 1: What is a Critical Incident?

Custodial Inspector Act 2017 **(ACT) – Dictionary**

critical incident means any event in a correctional centre or in the provision of correctional services that involves any of the following:

(a) the death of a person;

(b) a person's life being endangered;

(c) an escape from custody;

(d) a person being taken hostage;

(e) a riot that results in significant disruption to a centre or service;

(f) a fire that results in significant property damage;

(g) an assault or use of force that results in a person being admitted to a hospital;

(h) any other incident identified as a critical incident by a relevant Minister or relevant director-general.

There is no further detail in the CI Act or the CI Act Explanatory Statement. The table below provides further clarity and relevant examples:

Category	Notes
a. The death of a person	[see part 4 below]
b. a person's life being endangered	**A person endangering the life of another** Section 27 of the *Crimes Act 1900* (ACT) concerns 'Acts endangering life etc', and relates to actions of one person endangering the life of another person. Examples of 'a persons life being endangered' included in the Crimes Act that may be relevant to the Inspector's discretion are: (a) chokes, suffocates or strangles another person so as to render that person insensible or unconscious or, by any other means, renders another person insensible or unconscious; or

	(b) administers to, or causes to be taken by, another person any stupefying or overpowering drug or poison or any other injurious substance likely to endanger human life or cause a person grievous bodily harm; or (c) discharges any loaded arms at another person or so as to cause another person reasonable apprehension for his or her safety; or (d) causes an explosion or throws, places, sends or otherwise uses any explosive device or any explosive, corrosive or inflammable substance in circumstances likely to endanger human life or cause a person grievous bodily harm; or (e) sets a trap or device for the purpose of creating circumstances likely to endanger human life or cause a person (including a trespasser) grievous bodily harm; or (f) interferes with any conveyance or transport facility or any public utility service in circumstances likely to endanger human life or cause a person grievous bodily harm. **A person's actions endangering their own life** Serious self-harm/attempted suicide and serious drug overdoses are examples of circumstances where a person's life may be endangered due to a person's own actions. Elsewhere in the statutory definition of critical incidents, 'admission to hospital' is a key indicator used to establish that an assault or use of force meets the threshold. On that basis, the Inspector will generally consider that an act of self-harm has reached the level of seriousness of a critical incident if it results in an admission to a hospital inpatient unit or ward.
c. an escape from custody	Note that 'custody' is defined broadly to include, for example, escape from a secure part of a facility, from the custody of a corrections officer or youth detention officer during escort, from an escort vehicle, or from a health facility whilst under escort.

d. a person being taken hostage	The *Crimes (Hostages) Act 1989* (Cth), section 7, defines hostage-taking as where a person: (a) seizes or detains another person (in this section called the hostage); and (b) threatens to kill, to injure, or to continue to detain, the hostage; with the intention of compelling: (c) a legislative, executive or judicial institution in Australia or in a foreign country; (d) an international intergovernmental organisation; or (e) any other person (whether an individual or a body corporate) or group of persons; to do, or abstain from doing, any act as an explicit or implicit condition for the release of the hostage. This is adopted from the International Convention Against the Taking of Hostages and may be relevant to determine if the situation was a hostage-taking one.
e. a riot that results in significant disruption to a centre or service	Riot: 'a violent disturbance of the peace by a crowd; an outbreak of violent civil disorder or lawlessness' (*Oxford English Dictionary)*. Significant: 'sufficiently great or important to be worthy of attention' *(Oxford English Dictionary)*.
f. a fire that results in significant property damage	Significant: 'sufficiently great or important to be worthy of attention' (*Oxford English Dictionary*).
g. an assault or use of force that results in a person being admitted to a hospital	As outlined in respective Memorandum of Understanding with ACTCS and HCSD, 'admitted to hospital' is defined as 'a patient who undergoes a hospital's admission process to receive treatment and/or care, as per the ACT Health *Canberra Health Services Operational Procedure: Admission to Discharge*, as amended or replaced from time to time.'

h. any other incident identified as a critical incident by a relevant minister or relevant director-general.	Only the Ministers and Directors-General responsible for the *Corrections Management Act 2007* and the *Children and Young People Act 2008* can identify an incident as a critical incident. If they have done this, no evidence is required of whether it fits another category of critical incident.

To determine whether an incident may be considered a Critical Incident, it may be necessary to make further inquiries such as site visits, information requests etc.

Part 2: Notification of critical incidents

Detaining authorities must notify OICS of any incident that may be considered a Critical Incident in accordance with agreed protocols between entities. This is generally within 4 hours of becoming aware of the incident. An Initial Agency Report must generally be provided within 24 hours of the initial notification.

Should OICS become aware of potential critical incidents from sources other than Directorates (for example, from other oversight agencies, detained people, staff, or media), OICS will contact relevant senior management to clarify details of the incident in a timely way.

Part 3: Should OICS review a Critical Incident? (other than a death in custody)

For matters that are Critical Incidents under the CI Act, a review should be conducted if it is in the public interest to do so. This involves considering the following factors.

i. Seriousness of the incident including impact on affected persons

Critical Incidents are ones that are sufficiently serious, in that they may cause significant impact or harm in a custodial setting.[2] The more serious the incident, the more likely the Inspector will exercise the discretion to review. Seriousness will depend on the type of incident and the circumstances, but the degree of harm and impact on an affected person's human rights will be relevant. Objectively judging the degree and severity of harm to a person arising from an incident will be difficult, particularly based on the materials initially provided to OICS. Nonetheless, the following incidents are likely to be at the more serious end of a spectrum of potential harm:

- incidents causing severe physical or mental pain or suffering

[2] Explanatory Statement to the Inspector of Correctional Services Bill 2017, 14.

- Incidents involving humiliating, inhuman or degrading conduct or practices that that are discriminatory
- Admission to hospital may be relevant, as might a staff member's capacity to return to work.

Any additional attributes of the people involved (e.g. a person's status as an Aboriginal or Torres Strait Islander person, or other attributes protected under the *Discrimination Act 1991*) will be considered. There may be intersectional or compounding issues which together raise significant rights issues for a person involved.

ii. The role of detaining authorities (or entities acting on their behalf).

When assessing a critical incident, the Inspector should consider the extent to which the detaining authority's actions or inactions contributed to the harm. This includes assessing whether those actions were intentional, negligent, or reckless.

Detaining authorities have a duty to take reasonable steps to prevent, minimise, or manage the risk of ill-treatment, including violence between detained people. Therefore, when an incident involves:

- Violence between detained people, or
- Self-harm

it is relevant to consider whether the harm could reasonably have been prevented by the detaining authorities, based on the information available at the time.

iii. Public reporting

The role of the Inspector is to make prison and youth detention more transparent through public reporting, as all examinations and reviews must be tabled publicly in the ACT Legislative Assembly. Certain material may be excluded from a report on public interest grounds. In relation to public reporting, the Inspector can consider:

- **If public reporting would add value?**
  If the incident is already widely known (for example, through media coverage or court proceedings), the Inspector will consider if important facts are not yet on the public record, but are of public interest.

- **Privacy concerns:**
  Public reporting can affect the privacy of people involved, including detained people and staff. This is especially important for youth detention because:

  - There are only a small number of young people in custody in the ACT.
  - It is an offence to disclose the identity of a young person on remand or serving a sentence.

  The Inspector must consider if the ability to not identify any people directly, and to redact parts of the report will appropriately protect privacy and meet natural justice requirements (giving anyone who might be negatively affected a chance to respond).

- **Impact on legal processes:**

  Consideration must be made to ensure that if a review is conducted, publication of that review does not impact or interfere with criminal proceedings. This includes avoiding commentary that could be seen as "sub judice," meaning comments that might influence or appear to influence a matter currently before the courts.

iv. *Prevention*

It is also important to consider whether reviewing the incident will help prevent similar incidents in the future or lead to broader improvements in how such incidents are managed. Critical incident reviews can support prevention in several ways—for example, by making recommendations that government then acts on, by highlighting issues the detaining authority may not have been aware of, or by prompting greater public attention to a matter.

v. *Resources*

The resources necessary to undertake the review must be considered. This includes staff time, engaging expert contractors, and any other expenses eg publication related costs. This must be all considered in light of OICS workloads and priorities.

vi. *Litigation*

It is relevant to consider if there is, or likely to be, litigation on foot in parallel to the potential review and if so, how an OICS review will interact with that litigation. In particular, if there is or likely to be criminal charges arising from the incident, OICS would need to ensure its investigation complements, rather than complicates such a process. If a review were to occur in such circumstances, generally OICS should not compel information under s 22 of the CI Act (as the limitations on the use of that information set out in s 25 will apply).

vii. *Whether other entities are considering the matter*

Under s 31 of the CI Act, the Inspector must not delay or unnecessarily duplicate the exercise of functions by the:

- Auditor-General
- ACT Human Rights Commission (including, for example, the Discrimination Commissioner, Health Services Commissioner)
- Integrity Commission
- Ombudsman
- Official Visitors
- Adjudicator conducting a review of a segregation or disciplinary decision under the *Corrections Management Act 2007*
- A person conducting a review of a segregation or disciplinary decision under the *Children and Young People Act 2008*

- A police officer investigating a fraud or other criminal matter
- Worksafe ACT

OICS will consider whether these entities are already involved in the matter. The entities can disclose relevant information to OICS to the extent that it is reasonably necessary to determine if there is duplication of functions (s 35 CI Act).

If another investigative entity is considering a matter, consideration should be given to the scope of that review and possible output and/or outcome from that process (for example, will there be a public report, will the review consider systemic issues?). If a critical incident review by OICS would unnecessarily duplicate functions, then OICS must not review the incident. If a review by OICS would not wholly duplicate what another entity is doing, OICS will consider the following options:

- Refer all or part of the matter to another entity that is already dealing with the matter;
- Consider conducting a joint review with that entity;
- Plan an OICS review so that it does not overlap with the work of the other entity.

viii. Is the matter better dealt with by another entity?

Under section 32 of the CI Act, the Inspector can choose not to review the matter and instead refer it to an investigative entity, if they reasonably believe that the other body is better suited to handle it.

Statement of reasons for the decision

A decision should be made as soon as practicable and communicated to the relevant agency. This will typically be within 30 days, but may be longer (for example, due to delays in information relevant to an assessment being provided).

Reasons for a decision whether to conduct a critical incident review should be recorded. If a review is conducted, these reasons should be outlined in the introductory section of the public report. If a decision is made not to review a critical incident, the Inspector will consider summarizing the reasons in a letter to the relevant agency or referring entity.

Part 4: Process for exercising discretion for a death in custody

Coroner has not yet made findings

A Critical Incident under the CI Act includes 'the death of a person' in custody. This power overlaps with the power of a coroner who must hold an inquest into the manner and cause of death of a person who dies in custody, including holding a public hearing.[3]

The Inspector must ensure the exercise of their functions does not delay or unnecessarily duplicate the exercise of functions by a coroner.[4]

The Coroner's office should always be consulted prior to OICS undertaking any formal information gathering activities such as speaking to witnesses or seeking documents.

The Inspector may disclose to the Coroner information relevant to a death in custody. However, the Coroner may not be able to accept material from OICS that is or may be privileged, such as:

- Completed reports tabled in the Legislative Assembly (s 27 of the CI Act), which may attract parliamentary privilege.[5]
- Material compelled by the Inspector. A person who has provided information to the Inspector under s 22 of the CI Act is entitled to an immunity which prevents any information obtained from them that may incriminate them being used against them in civil or criminal proceedings (s 25, CI Act).

Therefore, a decision about commencing a critical incident review should generally be deferred until a Coroner has made findings and concluded an inquest into a death in custody.

Alternatives to critical incident reviews of deaths in custody

Nonetheless, OICS may assist ACTCS and the Coroner in several ways without engaging in a formal critical incident review under the CI Act.

Firstly, the Inspector may undertake a 'Preliminary Assessment' involving a desktop review of relevant material voluntarily provided by ACTCS with a focus to identify any immediate risks or concerns for the attention of detaining authorities (or entities acting on their behalf), and where relevant make suggestions to prevent or reduce risk of recurrence.

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[3] See ss 3C, 13(1)(i) and 34A(2) of the *Coroners Act 1997* ("the Coroners Act").

[4] Section 31(1)(f) of the CI Act.

[5] *Williams v Director-General of the Justice and Community Safety Directorate* [2025] ACTSC 396, 357-420.

The purpose of a Preliminary Assessment is to provide an independent and timely initial assessment after a death in custody to identify any readily apparent concerns that may have contributed to a death or pose risks for potential recurrence.

In some circumstances, as an alternative or in addition to undertaking a Preliminary Assessment, the Inspector may seek leave before the Coroner to become an interested party to the coronial inquest (as provided under Div 5.3 of the Coroners Act). However, consideration must be given to the resources implications for OICS participating in a hearing.

Exceptional circumstances justifying a review during an inquest

Exceptional circumstances that may justify a critical incident review prior to coronial findings being made could include:

- There are relevant issues that the Coroner has indicated they will not consider.
- Clear and compelling reasons for why the review cannot commence after the Coroner has made findings? For example, issues that should be addressed urgently and may be better suited to a public Critical Incident review as opposed to a Preliminary Assessment.

Only if exceptional circumstances arise, should the criteria in Part 3 then be applied to consider a critical incident review into a death in custody prior to coronial findings be made.

If a review is started, a person should not be required to provide information or produce a document or other thing to the Inspector under s 22 of the CI Act while an inquest is ongoing.

After the Coroner has made findings

Once the Coroner has made findings concerning a death in custody, the usual assessment of whether the Inspector should undertake a critical incident review set out in Part 3 of this operating procedure should be applied. This will usually be to assess if there are residual matters not considered as part of the Coronial inquest, or if the Coroner has referred any matters to the Inspector.

Part 5: Annual reporting

The OICS will publish information in its annual reports about the number of critical incidents referred to it during a reporting period, and the number of reviews conducted.