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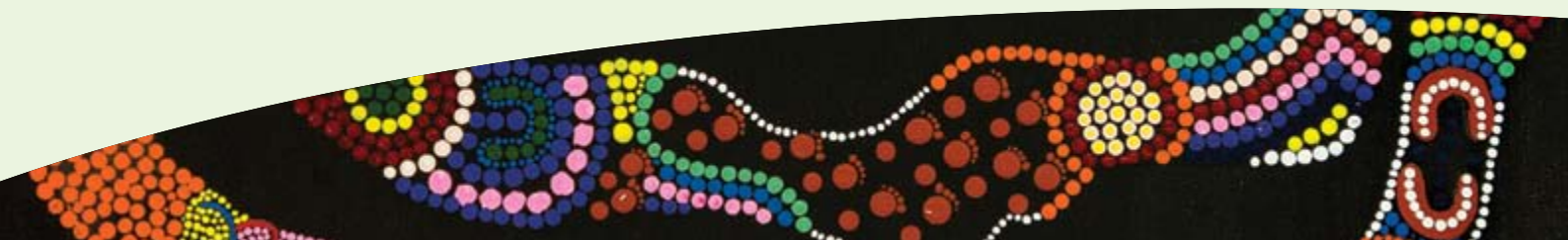
REPORT OF A REVIEW OF A CRITICAL INCIDENT

by the

**ACT INSPECTOR OF
CORRECTIONAL SERVICES**

*Assault of a detainee at
the Alexander Maconochie
Centre on 1 January 2019
(CIR 01/19)*

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

ABOUT THIS REPORT

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ACT Inspector of Correctional Services

We acknowledge the traditional custodians of the ACT, the Ngunnawal people. We acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

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*Assault of a detainee at
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Centre on 1 January 2019
(CIR 01/19)*

Neil McAllister
ACT Inspector of Correctional Services
11 June 2019



ACT INSPECTOR OF CORRECTIONAL SERVICES

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Letter of Transmittal

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Madam Speaker

I am pleased to provide you with a report entitled 'Report of a Review of a Critical Incident by the ACT Inspector of Correctional Services: Assault of a detainee at the Alexander Maconochie Centre on 1 January 2019' for tabling in the Legislative Assembly pursuant to Section 30 of the *Inspector of Correctional Services Act 2017* (ACT) (the Act).

This report was prepared pursuant to Section 17(1)(c) and (d) of the Act.

As required under Section 29 of the Act a draft copy of the review has been provided to The Hon Shane Rattenbury MLA, Minister for Corrections and Ms Alison Playford, Director-General of the Justice and Community Safety Directorate. There were no comments made on the draft report.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'Neil McAllister'.

Neil McAllister
ACT Inspector of Correctional Services
11 June 2019

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1. EXECUTIVE SUMMARY

- 1.1 On 1 January 2019 a male detainee (Detainee V) was assaulted in his cell by his cell-mate (Detainee X) at the Alexander Maconochie Centre (AMC). Detainee V suffered a significant brain injury, which necessitated surgery and from which Detainee V's recovery is ongoing.
- 1.2 At the time the incident occurred (12:20pm) detainees were in their cells for the routine lunchtime lock-in.¹ Staff were notified of the assault when the Master Control Room received a call for help from Detainee V through the cell intercom.
- 1.3 There was no intelligence available to ACT Corrective Services (ACTCS) to suggest that there were "issues" between the victim and the other detainee prior to 1 January 2019.
- 1.4 Detainee V was serving a short sentence of imprisonment at the time of the incident. Detainee X was on remand.
- 1.5 The review found that the "named" detainees were properly classified as Medium Security and that their placement in the same unit was reasonable. However, there was no documentation of a risk assessment taking place when making the decision to place the detainees in a shared cell. A recommendation is made to address this concern.
- 1.6 Overall, the review team finds that the assault was not reasonably foreseeable by ACTCS and the actions of ACTCS following the assault were, with one exception, appropriate in the circumstances. The exception is that the alleged perpetrator of the assault, Detainee X, was held on a segregation order for 27 days post-assault without sufficiently detailed documentation to support the order. Two recommendations are made to address this issue.
- 1.7 As required under s29 of the *Inspector of Correctional Services Act 2017* (ACT) a draft copy of this report was provided to the Hon Shane Rattenbury MLA, Minister for Corrections and Ms Alison Playford, Director-General of the Justice and Community Safety Directorate. Comments received from the Minister and/or the Director-General were considered in the preparation of the final report.

¹ At the AMC detainees are locked in their cells/cottages for at least an hour each day during the staff lunch break. It was noted in Finding 14 of the ACT Inspector of Correctional Services (2019), *Report of a review of the care and management of remandees at the Alexander Maconochie Centre*, that 'the lunchtime lock-in of detainees is an unnecessary restriction on their time out-of-cells'.

2. FINDINGS & RECOMMENDATIONS

Finding 1:

That AMC staff responded in a timely manner to the incident when it was reported by the victim.

Finding 2:

That the “named” detainees in this report were appropriately classified as Medium security.

Finding 3:

That the decision to place detainees in a shared cell was not properly documented with regard to a considered risk assessment.

Recommendation 1:

That the *Corrections Management (Shared Cell) Policy 2009* be reviewed to require that a risk assessment take place (and be appropriately documented) for every accommodation placement decision.

Finding 4:

That there was no intelligence information available to ACTCS to suggest that Detainee V was at risk of assault.

Finding 5:

There were no failings of security procedures or practices that contributed to the assault on Detainee V.

Finding 6:

That notifications of the incident were made in accordance with relevant policies and procedures but the recording of the notifications was lacking. An incident “checklist” would have assisted staff in recording times of notifications.

Finding 7:

That ACTCS did not record adequate reasons for placing Detainee X on segregation for 27 days.

Recommendation 2:

That segregation orders pinpoint the legal authority for segregation in the Corrections Management Act and where it is for 'security and good order', ACT Corrective Services must provide a rational basis for making or extending the order on those grounds.

Recommendation 3:

That ACT Corrective Services advise ACT Policing that detainees subject to police investigations will not be kept on *investigative segregation* for more than seven days without a formal written request from ACT Policing to extend the order.

3. INTRODUCTION

3.1 Authority to conduct a review of a critical incident

Section 18(1)(c) of the *Inspector of Correctional Services Act 2017* (ACT) (the 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.' This review was conducted at my own initiative.

3.2 What is a 'critical incident'?

Section 17(2) of the Act provides a list of events that are critical incidents, including;

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

This review concerns an event relevant to section 17(2)(g) in that it was an assault resulting in the victim being admitted to The Canberra Hospital.

3.3 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.² This report, like the previous critical incident reports tabled in the Legislative Assembly, has been structured to capture the spirit and intent of section 27 but without specific reference to some of the topics.

3.4 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.

3.5 The Review Team

The review team comprised:

- Rebecca Minty, Deputy Inspector of Correctional Services; and
- Holly Fredericksen, Research and Inspection Officer

² 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, 6.

4. FORM OF THE REVIEW

- 4.1 The Act does not specify what form a review must take. In order to take a consistent approach to the review of critical incidents, the Inspectorate has devised two types of reviews that may be conducted.
- 4.2 The first is a “desk-top” review of documents and reports, including audio/visual records if applicable, provided by ACT Corrective Services and other agencies e.g. ACT Health. A desk-top review does not involve the Inspectorate in direct action such as interviewing staff or detainees and is more likely to be conducted where the circumstances of an incident are reasonably self-evident.
- 4.3 The second form of a review is one carried out by the Inspectorate utilising if necessary, the full powers of the Inspector under the Act. This type of review could be conducted following or instead of a desk-top review and is more likely to be conducted in response to very serious or problematic incidents such as an escape from secure custody.
- 4.4 In the case of the incident that is the subject of this report, I decided to conduct a desk-top review because I was of the opinion that the CCTV recording and officer reports were such that further enquiries were not warranted.

5. THE REVIEW

5.1 How, when and where the incident occurred

- 5.1.1 The incident occurred during a lunchtime lock-in, at approximately 12:20pm in a two-story male unit at the Alexander Maconochie Centre (AMC). Staff became aware of the incident when Detainee V used his cell intercom to call for help. The Master Control Room (MCR) received this call and made a radio call requesting staff assistance.
- 5.1.2 When Corrections Officers (COs) attended the cell at approximately 12:23pm, they witnessed, through the cell door window, Detainee X physically assaulting Detainee V and they observed that Detainee V had a bloodied face and head. COs entered the cell, handcuffed and removed Detainee X from the cell and held him on the landing. A CO called a Code Pink (Medical Emergency). Nursing staff arrived approximately 5 minutes later.
- 5.1.3 At approximately 12:40pm, Detainee V was escorted from the cell in a wheel chair. Detainee V was assessed by medical staff at the Hume Health Centre at the AMC before being taken to The Canberra Hospital (TCH) where he was admitted that evening with a suspected subdural hemorrhage. His injuries were listed as moderate on the AMC Detainee Injury Form (on a scale of fatal/critical/moderate/minor), however his condition deteriorated. On 3 January Detainee V underwent brain surgery. He remained at TCH until at least 23 January 2019 when he was granted bail.
- 5.1.4 Immediately following the incident, Detainees V and X separately made remarks to staff about the assault. Detainee X stated that he was provoked and both detainees indicated that the incident was regarding a dispute over “smokes”. Detainee X has been charged by the police with *Assault occasioning grievous bodily harm*.

5.2 The timeliness and effectiveness of ACTCS' response to the incident

- 5.2.1 Staff became aware of the incident when contacted by Detainee V at 12:20pm, during lunchtime lock-in, through the cell intercom. Five COs responded to a radio call from the MCR and attended the cell. Staff promptly entered the cell, immediately separated the detainees and attended to Detainee V's injuries until nursing staff arrived.
- 5.2.2 Detainee X was escorted to an interview room nearby where his injuries were photographed. He was then escorted to the Management Unit where his shoes and socks were sealed in an evidence bag.
- 5.2.3 COs photographed and filmed the cell before it was secured. The quality of the filming was less than ideal, as the footage is somewhat jumpy and sporadic in the scan of the cell. The evidence of a seemingly violent assault occurring (bloodstains, clumps of hair etc.) is nevertheless clearly visible.
- 5.2.4 An informal debrief was conducted after the incident in accordance with the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2018 (No. 2)*. The informal debrief did not identify any areas requiring follow up.

Finding 1:

That AMC staff responded in a timely manner to the incident when it was reported by the victim.

5.3 Assessment, classification and accommodation of the detainees

- 5.3.1 Detainee V (victim) was a medium security detainee serving a short sentence for a violent offence.³ This was Detainee V's first time in custody and he had been in the AMC since late 2018. His criminal history consists of minor historical matters. He is about 40 years old and is of a culturally and linguistically diverse background. It was recorded on his admission form that, at admission, he had expressed anxiety to AMC staff about this being his first time in custody.
- 5.3.2 Detainee X is a medium security detainee on remand, charged with violent offences. Detainee X is about 20 years old and has a criminal history as a young person involving numerous serious offences for which he served a period in youth detention. Detainee X has known mental health concerns for which he was prescribed medication by AMC health staff after admission.
- 5.3.3 Neither detainee identifies as Aboriginal or Torres Strait Islander.

³ Detainee V has lodged an appeal of his conviction subsequent to the assault, and has been granted bail.

Security Classification

- 5.3.4 The AMC detainee classification policy sets out the factors that must be considered in determining a detainee's security classification and the effects of security classification on accommodation placements.⁴ Medium security is the default classification for new receptions to custody where high levels of risk are not identified.⁵
- 5.3.5 Having reviewed the criminal histories and related materials the review team is satisfied that the "named" detainees were appropriately classified as Medium security.

Finding 2:

That the "named" detainees in this report were appropriately classified as Medium security.

Accommodation in a shared cell

- 5.3.6 Detainees V and X were sharing a cell at the time of the incident. The *Corrections Management (Shared Cell) Policy 2009* states that 'consideration must be given to who shares a shared cell and whether this is in the best interests of both prisoners [sic]'.⁶
- 5.3.7 When allocating detainees to a shared cell, the policy states that both detainees should be asked about their preference. Other factors that must be considered include 'the vulnerability of one prisoner [sic] to abuse by the other' and the availability of accommodation types. Case notes detailing information used in making the decision must be made. However, the exception to this is where the decision on placement is made on the basis of 'available bed space'.⁷
- 5.3.8 The issue this raises is that there is no transparency around decisions to place detainees in a shared cell when the decision is made because of space restrictions. The rise in the population of detainees in the AMC means many more detainees are having to share cells. If COs are not required to write a case note, there is no evidence of them considering detainee vulnerabilities and risks, as set out in the Shared Cell Policy, when deciding which detainees are placed in a shared cell together.
- 5.3.9 Case notes are a risk mitigation measure for ACTCS as they demonstrate that COs turned their mind to factors outlined in the Shared Cell Policy. It is important that risk assessments are done even when crowding limits the AMC's placement options, or necessitates more complicated options (for example, relocating a number of detainees within a unit in order to achieve the lowest risk). It would be counterintuitive to have a considered risk reduction process for detainee placement to the point that there is only one bed left and then put the next detainee to arrive in that one bed without considering risk.
- 5.3.10 Regarding the detainees in this incident, there is no record of the reasons why they were placed in a shared cell or that appropriate factors were considered. For example, the CALD background of Detainee V and his anxiety about this being his first time in custody, and Detainee X's history of mental health issues. There was also a considerable age difference (some 20 years) between the two detainees. It is unknown whether the detainees were asked about their preference. It is unclear in this case if the decision to place the detainees together in a shared cell was made on

4 *Corrections Management (AMC Detainee Classification) Policy 2012*, Notifiable Instrument NI2012-299.

5 Ibid.

6 NI2009-162.

7 *Corrections Management (Shared Cell) Policy 2009*, Notifiable Instrument NI2009-162.

the basis of 'available bed space' (which would obviate the need for considering and documenting factors under the current policy). Even if it was, a case note to that effect should have occurred.

Finding 3:

That the decision to place detainees in a shared cell was not properly documented with regard to a considered risk assessment.

Recommendation 1:

That the *Corrections Management (Shared Cell) Policy 2009* be reviewed to require that a risk assessment take place (and be appropriately documented) for every accommodation placement decision.

5.4 Whether there was any intelligence or other information in existence prior to the incident which might have indicated that the incident was reasonably foreseeable

- 5.4.1 The review team examined ACTCS intelligence notes made on the "named" detainees prior to the incident:

Detainee V (victim)
No relevant notes/flags⁸

Detainee X
No relevant notes/flags

- 5.4.2 There were no notes that "linked" the detainees directly or indirectly through others. There were also no reports of Detainee X having any "issues" with Detainee V prior to the incident on 1 January 2019.

- 5.4.3 Neither Detainee V or X had any in-custody incidents relating to this period of detention.

Finding 4:

That there was no intelligence information available to ACTCS to suggest that Detainee V was at risk of assault.

5.5 Whether agency and centre procedures and practices relating to security and detainee supervision were complied with

- 5.5.1 The unit is subject to constant staff presence except during lunch lock-in. At the time of the incident, all detainees were locked in their cells. The correct procedure was followed when Detainee V called for help using his cell intercom. MCR made a radio call for staff assistance as soon as they received communication from Detainee V.

Finding 5:

There were no failings of security procedures or practices that contributed to the assault on Detainee V.

5.6 Whether agency and centre procedures and practices relating to notifications of serious incidents were complied with

- 5.6.1 The ACT Corrective Services policies and procedures relevant to incident notification are the Incident Reporting, Notifications and Debriefs Policy⁹ and the Incident Reporting Operating Procedure.¹⁰

⁸ An intelligence flag is an alert indicating that a person *may* be involved in some illegal activity.

⁹ *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2018* (No 2), NI 2018-458.

¹⁰ *Corrections Management (Incident Reporting) Operating Procedure 2018* (No 2), NI2018-457.

5.6.2 Section 4.1 of the Incident Reporting Operating Procedure requires that ACT Policing be notified of incidents that may require their attendance (e.g. alleged assault). ACT Policing was advised of the assault on Detainee V, although the time at which this occurred is not recorded. Police attended the AMC at approximately 2pm on the afternoon of the incident.

5.6.3 Section 5.1 of the Incident Reporting Operating Procedure requires that ACTCS is to notify the next-of-kin in the event that a detainee is 'seriously injured'. Staff attempted to contact Detainee V's wife numerous times with no success initially. Detainee V advised that he did not want anyone else contacted. It is the Inspectorate's understanding that Detainee V's wife was eventually contacted but there is no notation on ACTCS' electronic system or paper file as such, contrary to the requirement under Section 5.4 of the Incident Reporting Operating Procedure.

5.6.4 Section 9 of the Incident Reporting, Notifications and Debriefs Policy deals with notification of critical incidents to the Inspector of Correctional Services.¹¹ More detailed arrangements concerning critical incidents are set out in a Memorandum of Understanding (MOU) between the Inspector and ACTCS (dated August 2018).¹² With regard to this incident, written notifications were provided to the Inspector in accordance with the MOU.

Finding 6:

That notifications of the incident were made in accordance with relevant policies and procedures but the recording of the notifications was lacking. An incident "checklist" would have assisted staff in recording times of notifications.

5.7 Whether the incident revealed any issues pertinent to the *Human Rights Act 2004 (ACT)*

5.7.1 The review team notes that this incident involving detainee on detainee violence potentially engages a number of rights in the *Human Rights Act 2004 (ACT)* (HR Act). Of most relevance to Detainee V as the victim of the assault is the right to protection from cruel, inhuman or degrading treatment in s10(1)(b), and the right to humane treatment when deprived of liberty in s19 of the HR Act.

5.7.2 These human rights provisions require ACTCS to take positive steps to protect detainees from violence and ill-treatment by other detainees, including by implementing measures such as security screening and risk assessment in accommodation placement, searching and confiscation of weapons. In this case, the review team's view is that appropriate positive steps were taken by ACTCS and that the assault was not reasonably foreseeable.

5.7.3 However, the treatment of the alleged perpetrator (Detainee X) after the incident, by way of placing him in prolonged segregation also engages human rights under the HR Act. In particular, the right not to be tried or punished more than once for the same offence (s24 HR Act) and the right to humane treatment when deprived of liberty (s19 HR Act).

¹¹ As defined in section 17(2), *Inspector of Correctional Services Act 2017*.

¹² The MOU is appended to an earlier report, 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*, Canberra.

Post incident segregation

- 5.7.4 The response to an incident such as this (a detainee on detainee assault in the AMC) can be a criminal investigation or an ACTCS disciplinary investigation, but not both concurrently.¹³ The reason for this is the rule against double jeopardy: it may be a breach of someone's human rights to punish them twice for the same offence.¹⁴ Being subject to both a criminal conviction and (serious) disciplinary sanctions over the same incident would amount to double punishment.
- 5.7.5 Criminal investigations take priority, but if the police decide there is not enough evidence to continue the investigation, charges are dropped, or charges are heard in court but not proven to the criminal standard of beyond reasonable doubt, it is open for ACTCS to commence a disciplinary investigation. If a breach is proved, ACTCS may apply a disciplinary sanction (for example, a financial penalty, withdrawal of privileges, or segregation – which is called separate confinement when it is imposed for a disciplinary breach).
- 5.7.6 In this case, ACT Policing opened a 'job' shortly after the incident on 1 January 2019. ACTCS placed Detainee X in segregation in the Management Unit immediately after the incident. It is entirely appropriate for ACTCS to separate an alleged perpetrator immediately after the incident. The grounds for segregation were cited on the *Detainee Notification of Segregation* form as 'to protect the security or good order at the correctional centre'. There is no reference to the specific provision of the CM Act authorising this segregation decision.¹⁵

- 5.7.7 There are a number of sections of the CM Act that allow ACTCS to separate a detainee from the general population for different purposes. Most relevantly, a detainee can be segregated for the safety and security of the centre, or for investigative segregation. Investigative segregation under s161(3) of the CM Act may be used where:

'the opportunity for the detainee to associate with anyone else creates, or is likely to create, a risk of:

- (a) harm, or threatened harm, to the detainee or anyone else; or
- (b) the perverting, or attempted perverting, of an investigation, under this part; or
- (c) undermining security or good order at a correctional centre.'¹⁶

It is not stated on any electronic or paper file the review team viewed that Detainee X was subjected to investigative segregation at this time or subsequently.

- 5.7.8 On 8 January 2019 Detainee X's segregation was reviewed and extended with the reason noted as: pending action from ACT Policing. This was recorded in a case note but there is no evidence of a *Segregation Review Form* being completed.
- 5.7.9 On 16 January 2019 Detainee X's segregation was again reviewed and continued with the reason cited as: pending ACT Policing action.¹⁷

13 Section 155(3), *Corrections Management Act 2007* (ACT) states '[a] disciplinary charge for the disciplinary breach must not be started, or further dealt with, under this chapter if a prosecution for the criminal offence has been started in a court'.

14 Section 24 *Human Rights Act 2005* (ACT).

15 Based on the wording on the form, it could be a reference to one or two different segregation provisions: either s90(1)(b) of the CM Act ('segregation – safety and security') **and/or** to s161(3)(c) of the CM Act ('investigative segregation').

16 *Corrections Management Act 2007* (ACT), s161(3).

17 This was recorded on a Segregation Review form, with two grounds being selected: 'to protect the security or good order at the correctional centre' and 'to protect the safety of someone (other than the detainee) at the correctional centre' again without reference to the CM Act, with the next review stated as being required in 21 days (6 February) or before 'depending on outcome from ACT Policing'.

5.7.10 Detainee X's segregation was revoked after 27 days, on 27 January 2019 with the reason recorded as the 'victim of this assault was bailed and is not at any risk from detainee [X]'. While AMC staff had undertaken the good practice of regularly reviewing Detainee X's segregation, the lengthy segregation Detainee X was subjected to raises a number of concerns.

Pinpointing lawful authority for segregation

5.7.11 The first issue is that the forms used by ACTCS when directing and reviewing segregation do not state which section of the CM Act the detainee is being segregated under. This has important implications because investigative segregation must be reviewed every 7 days¹⁸ whereas segregation for safety and security must be reviewed every 21 days.¹⁹

Rational basis for segregation

5.7.12 Another inconsistency is that Detainee V remained at TCH for the duration of Detainee X's segregation, so was not at risk of harm from Detainee X. It is puzzling that the reason Detainee X's segregation was ultimately revoked was because Detainee V had been bailed, noting that Detainee V had not been at the AMC since the assault.

5.7.13 Furthermore, it is not clear why 'awaiting ACT Policing action' justifies continuing segregation. The police had already attended the AMC on 1 January 2019 and subsequently. The MoU between ACT Policing and ACTCS, revised after the Moss Review into the death in custody of Steven Freeman notes:

'2.15 ACT Policing will liaise with the Deputy General Manager or General Manager, ACTCS about any potential risk factors to the detainee or other detainee/s as they progress with any investigation or charges.'

The review team saw no evidence or documentation on electronic or paper files that the police needed Detainee X to be segregated for the purposes of their investigation.

5.7.14 Before segregation directions are extended, ACTCS should consult with the police on the status of the investigation and appropriately document this on relevant forms / case notes to justify extending segregation on the grounds that ACTCS are 'awaiting ACT Policing action'. For example, whether police still have aspects of their on-site investigation pending (e.g. interviews with witnesses, release of the crime scene etc). It is not acceptable to keep a detainee on segregation on the basis that police *may* want to talk to her/him at some time in the future.

5.7.15 Without detailed reasons recorded for the segregation (beyond simply stating it was for security or good order) it could amount to de facto punishment, which would be contrary to the purposes of the relevant segregation orders under the CM Act.

5.7.16 It need not be discussed at length that segregation in the Management Unit, whatever its legal basis, may not be a pleasant experience. Whilst detainees on segregation still receive entitlements under the CM Act such as an hour out of their cell, the opportunity for meaningful contact with others and participation in programs and activities

¹⁸ Corrections Management Act 2007 (ACT), s163(2)(c).

¹⁹ Corrections Management Act 2007 (ACT), s90(5)(c).

is significantly limited. The physical and mental impact of prolonged solitary confinement has been well-documented. The former Special Rapporteur on Torture, Juan Mendez, in his report to the UN General Assembly noted that solitary confinement can amount to cruel, inhuman or degrading treatment or punishment when used for a prolonged period, which is defined as in excess of 15 days.²⁰ This is not to comment specifically on Detainee X's experience of segregation in this case but simply to note that segregation orders must have a rational basis and be the least restrictive in the circumstances to comply with the HR Act.

Finding 7:

That ACTCS did not record adequate reasons for placing Detainee X on segregation for 27 days.

Recommendation 2:

That segregation orders pinpoint the legal authority for segregation in the Corrections Management Act and where it is for 'security and good order', ACT Corrective Services must provide a rational basis for making or extending the order on those grounds.

Recommendation 3:

That ACT Corrective Services advise ACT Policing that detainees subject to police investigations will not be kept on *investigative segregation* for more than seven days without a formal written request from ACT Policing to extend the order.

6. OTHER MATTERS ARISING FROM THE REVIEW

- 6.1 There were no other matters arising from the review.

²⁰ United Nations (2011) 'Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment' (5 August, United Nations General Assembly A/66/268).

