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ACT Inspector of Correctional Services

# 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 13 January 2020*
*(CIR 01/20)*

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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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# REPORT OF A REVIEW OF A CRITICAL INCIDENT

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*Assault of a detainee at the Alexander Maconochie Centre on 13 January 2020*
*(CIR 01/20)*

Neil McAllister
ACT Inspector of Correctional Services
15 April 2020

**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 13 January 2020' 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 was provided to Shane Rattenbury MLA, Minister for Corrections and Justice Health and Richard Glenn, Director-General of the Justice and Community Safety Directorate, and comments have been considered.

Yours sincerely

Neil McAllister
ACT Inspector of Correctional Services
15 April 2020

# Contents

# 1. EXECUTIVE SUMMARY

1.1 On 13 January 2020 a male detainee (Detainee "V") was assaulted in his cell at the Alexander Maconochie Centre (AMC) by one, and possibly two, other detainees. Detainee V suffered head and other injuries that resulted in his admission to hospital.

1.2 The incident occurred at about 3:30pm while detainees were not confined to cells. It was not observed by staff, who learned of the incident at about 4:15 pm when Detainee V left his cell and entered the unit common area.

1.3 There was no documented intelligence available to ACT Corrective Services (ACTCS) to suggest that there were "issues" between the victim and the other detainees at the AMC prior to 13 January 2020.

1.4 The review found that the "named" detainees were appropriately classified and that their placement in the same high security unit was reasonable.

1.5 Some security practices in the unit in question were less than optimal but it would be speculative to find that these shortcomings contributed to the assault on Detainee V.

1.6 Overall, the review finds that the assault was not reasonably foreseeable by ACTCS and the actions of ACTCS following the assault were appropriate in the circumstances. However, the notification of Detainee V's next of kin occurred after his father had become aware of Detainee V's hospitalisation.

1.7 As required under s29 of the *Inspector of Correctional Services Act 2017* (ACT) a draft copy of this report was provided to Mr Shane Rattenbury MLA, Minister for Corrections and Justice Health and Mr Richard Glenn, 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.

# 2. FINDINGS & RECOMMENDATIONS

| | |
|---|---|
| **Finding 1:** | That the response to the incident by Corrections Officers, AMC medical staff and the ACT Ambulance Service was prompt and efficient. |
| **Finding 2:** | That, contrary to the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019*, ACTCS did not conduct a formal debrief following the incident. |
| **Finding 3:** | That it was not unreasonable to accommodate detainees involved in this incident in the same unit. |
| **Finding 4:** | That there was no intelligence information available to ACTCS to suggest that Detainee V was at particular risk of assault by the alleged perpetrators. |
| **Finding 5:** | That the combination of staff not conducting routine unit patrols, allowing detainees to close cell doors and cover cell door windows during un-lock periods contributed to the delay in discovering Detainee V's injuries. |
| **Finding 6:** | That the record keeping around next of kin notification was inadequate. |
| **Finding 7:** | That the decision to not notify Detainee V's next of kin until the detainee had been admitted to hospital was a technically correct interpretation of s8.1(a) of the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019* (NI2019-266). |
| **Finding 8:** | That a decision could have been made at any time after the assault to contact Detainee V's next of kin, as provided for under s8.1(b) of the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019* (NI2019-266). |
| **Finding 9:** | That the term 'officer-in-charge of a correctional centre' is not defined in the *Corrections Management Act 2007*, and in that regard, its use in ACTCS policies and procedures could be confusing for staff. |
| **Finding 10:** | That it would be prudent for ACTCS to assume that Detainee V is at high risk of further assault whilst he remains in prison in the ACT. |

| | |
|---|---|
| **Recommendation 1:** | That the *Corrections Management Act 2007* be amended to provide a definition for the term 'officer-in-charge of a correctional centre'. |
| **Recommendation 2:** | That s8.1(b) of the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019* (NI2019-266) be revised to read 'where the Officer-in-Charge of a correctional centre considers it prudent to do so, based on their assessment of the severity of the injury/ies or illness'. |

# 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 s17(2)(g) in that it was an assault resulting in the victim being admitted to The Canberra Hospital (TCH).

## 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.[1] This report, like the previous critical incident reports tabled in the Legislative Assembly, has been structured to capture the spirit and intent of s27 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 s28(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:

- Neil McAllister, Inspector of Correctional Services;
- Jessica Horua, A/g Deputy Inspector of Correctional Services; and
- Holly Fredericksen, Assistant Inspector of Correctional Services.

1 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, p.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 Office of the Inspector of Correctional Services (OICS) 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 ACTCS and other agencies e.g. ACT Health. A desk-top review does not involve OICS 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 OICS 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 reports were such that further inquiries were not warranted.

# 5. THE REVIEW

## 5.1 How, when and where the incident occurred

5.1.1 At the time of the incident Detainee V was alone in his cell with the door closed but unlocked. He had last been formally seen by staff at lunchtime and was uninjured at that time. At approximately 3:30pm three detainees (W, X and Y) enter the cell and close the door behind them. Detainee X is the cell-mate of Detainee V. A fourth detainee (Z) takes up a position outside where he appears to be tidying up a refrigerator but constantly glances towards the officers' station and Detainee V's cell – he is on lookout duty. At one point, Detainee Z opens the door of the cell next to Detainee V's cell and leaves the door right-angle to the wall, further impeding any view from the officer's station. A number of other detainees also begin pacing up and down in the floor space between Detainee V's cell and the officers' station.

5.1.2 Detainees X and W leave the cell at about 3:40pm followed by Detainee Y a minute or so later. The door is closed behind them. In the next 10 or 15 minutes a few other detainees look in Detainee V's cell, close the door and walk away. None raise the alarm with staff.

5.1.3 At 4:02pm, Detainee V drags himself partially out the cell door in a sitting position and appears to be trying to attend to a bleeding wound(s) with toilet paper. He would not have been visible to staff in the officers' station at this time because he was behind the open cell door. He then retreated back into the cell, still in a sitting position, when two other detainees enter the cell then leave.

5.1.4 Oddly, Detainee Z also enters the cell with a towel and seems to attempt to clean up blood off the floor and then seems to render first aid the Detainee V. At 4:12pm, Detainee Z can be seen trying to walk

Detainee V out of the cell but Detainee V initially appears reluctant and tries to pull back into the cell. He then complies and is walked to a bench seat in the common room where he sits while Detainee Z offers him a towel and water. At this point Detainee V has a lot of blood around his head and is clearly in a very groggy state. Staff are somehow alerted to the situation and reach Detainee V at 4:13pm, some 45 minutes after the assault occurred.

5.1.5 ACT Health advised that Detainee V suffered 'multiple lacerations (scalp, ankle), bruising and fractures (nasal bone, hyoid and cricoid cartilage)'.[22] The injury to Detainee V's throat resulted in him being placed in an induced coma at TCH.

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

5.2.1 The response by Corrections Officers to the incident, when it became known to them, was rapid and efficient. Similarly, AMC medical staff and a visiting doctor began treatment of Detainee V within minutes of being alerted. At one point Detainee V was being treated by the doctor, four nurses and four ambulance officers. ACT Ambulance Service did not report any difficulties in accessing the patient. The total incident response time (16:13–17:06) was 53 minutes.

**Table 1: Chronology of response to the assault on Detainee V**

| Time | Event |
|---|---|
| **16:13** | Staff become aware of V's situation and go to his assistance – move him back into the cell |
| **16:15** | A number of staff attend the unit and lock in other detainees |
| **16:16** | First nurse arrives on scene |
| **16:18** | Second nurse arrives with medical cart |
| **16:19** | Third nurse arrives with wheelchair |
| **16:20** | Call logged by ACT Ambulance Service as a 'priority 2 urgent case' – normal road speed |
| **16:30** | V now receiving treatment by a doctor and four nurses |
| **16:31** | Ambulance call upgraded to 'priority 1' – lights and sirens (patient unconscious) |
| **16:32** | Second ambulance assigned |
| **16:37** | First ambulance arrives at AMC |
| **16:40** | Second ambulance arrives at AMC |
| **16:44** | First ambulance officers arrive in unit (as shown on CCTV) |
| **17:06** | Ambulance with Detainee V departs AMC, arriving at TCH at 17:18 |

NB: Information concerning ambulance response was provided by the Chief Officer, ACT Ambulance Service by email on 20/01/20.

**Finding 1:**

That the response to the incident by Corrections Officers, AMC medical staff and the ACT Ambulance Service was prompt and efficient.

2 Email to the Inspector dated 04/02/20.

## Staff debrief

5.2.2 This assault constituted an 'incident' under the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019*. Under this policy a 'hot debrief' should occur immediately after every incident followed by a 'formal debrief' within 14 days of the incident. A hot debrief was conducted, however it was not followed-up by a formal debrief. This omission was unfortunate given that the purpose of a formal debrief (s15.2 of the Policy) is to:

(a) examine an incident in its entirety;

(b) work through the incident as it occurred;

(c) consider how the incident was managed;

(d) identify and address any concerns; and

(e) identify opportunities for continuous improvement, including changes to policy and in particular the ACTCS Emergency Management Framework.

**Finding 2:**

That, contrary to the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019,* ACTCS did not conduct a formal debrief following the incident.

### 5.3 Assessment, classification and accommodation of the detainees

5.3.1 The unit where the incident occurred is designated as High security. The review team inspected the security classification documents for each detainee involved in the incident. Detainee V and three of the alleged perpetrators were appropriately classified as Medium security. The fourth alleged perpetrator was classified as Minimum security but had been moved from Minimum security accommodation due to his behaviour.

5.3.2 All the detainees involved in the incident, including the victim, had extensive and similar criminal histories. It was not unreasonable to accommodate them together given that there was no intelligence information to suggest that they posed a clear risk to each other e.g. previous assaults, threats, etc. However, in the closed environment of prisons, associations and friendships between prisoners can change very quickly for no obvious reason, and in that regard, there is always a risk that any prisoner might be assaulted by a one-time friend or criminal associate.

5.3.3 We note that Detainee V was seriously assaulted at the AMC in 2017, however there is no information to suggest that the 2017 and 2020 incidents are related. Further, the convicted perpetrator of the 2017 assault, whilst still held at the AMC, was accommodated in a different unit on 13 January 2020.

**Finding 3:**

That it was not unreasonable to accommodate detainees involved in this incident in the same unit.

### 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 There was considerable intelligence interest in all the detainees suspected of being involved in this incident. It is not appropriate to reveal the nature of the intelligence in this report other than to say that it related to concerns about their involvement in illegal activities within the AMC. Having reviewed the intelligence profiles of the detainees there was nothing to indicate that Detainee V was *particularly* at risk of assault by the four alleged perpetrators.

5.4.2 In the course of reviewing this and previous critical incidents at the AMC, OICS has been extremely impressed by the thoroughness and quality of the work of the ACTCS intelligence team. Their detainee intelligence profiles and incident summaries would stand-up well against similar product in other jurisdictions.

**Finding 4:**

That there was no intelligence information available to ACTCS to suggest that Detainee V was at particular risk of assault by the alleged perpetrators.

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

5.5.1 Detainees are free to move around the unit during periods when cells are unlocked, including visiting other detainees in their cells. The CCTV vision of the unit on 13 January 2020 shows frequent comings and goings of detainees, sometimes groups of two or three, in and out of cells on both the lower and upper landings. The location and design of the officers' station is such that staff do not have a good view of the cells, and particularly of the cells on the upper landing.

5.5.2 Given these line-of-sight impediments, OICS was concerned to see that, on viewing several hours of CCTV vision captured on 13 January 2020, hardly a staff member was to be seen in the area of the unit where the assault took place. There was no evidence of routine unit patrols i.e. "dynamic security". This is an issue that OICS noted during the Healthy Prison Review of the AMC in 2019.

5.5.3 In other prisons in Australia it is not unusual for prisoners to be locked out of their cells during normal "business hours". In these centres, prisoners may elect to be locked-in their cells for reasons such as study, rest and so on, but are not free to come and go as they please – they are either in or out. However, this is not an option at the AMC because units do not have toilets in the communal areas.

5.5.4 We also noted that every cell visible (10) on the primary camera had its observation window covered by a towel, usually with the door closed. Put simply, staff would have no idea what is going on in those cells unless they opened every door.

**Finding 5:**

That the combination of staff not conducting routine unit patrols, allowing detainees to close cell doors and cover cell door windows during un-lock periods contributed to the delay in discovering Detainee V's injuries.

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

5.6.1 The ACTCS policies and procedures relevant to incident notification are the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019* and the *Corrections Management (Incident Reporting) Operating Procedure 2019* (No 2).

5.6.2 Both the policy and the operating procedure require 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 shortly after staff were aware that it had occurred and attended AMC and TCH that evening.

5.6.5 The *Incident Reporting, Notifications and Debriefs Policy* also deals with notification of critical incidents to the Inspector of Correctional Services.[3] More detailed arrangements concerning critical incidents are set out in a Memorandum of Understanding (MOU) between the Inspector and ACTCS (dated August 2018).[4] With regard to this incident, oral and written notifications were provided to the Inspector in accordance with the MOU.

3 As defined in s17(2), *Inspector of Correctional Services Act 2017.*

4 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.

## 5.7 Notification of next of kin

5.7.1 The *Incident Reporting, Notifications and Debriefs Policy* provides that:

> 8.1 The Officer-in-Charge of a correctional centre is responsible for notifying a detainee's next of kin, as soon as practicable:
>
> (a) where the detainee has experienced a serious injury or illness and been admitted to a health facility; or
>
> (b) according to a direction of the Deputy General Manager or above.

5.7.2 In the case of Detainee V, he arrived by ambulance at TCH at about 5:20pm on 1 January 2020. Although he received care and treatment on arrival, he was not formally admitted to TCH until 8:22pm[5] when was taken to the Intensive Care Unit.

5.7.3 At the AMC there was a discussion amongst senior managers[6] at around 7:00pm–7:30pm about whether Detainee V's nominated next of kin (his father, "Mr V") should be notified of the incident.[7] The managers decided/agreed that they should follow the letter of s8.1(a) of the policy and await notification of Detainee V's admission to TCH before contacting Mr V.

5.7.4 Following advice from ACTCS officers at TCH that they thought it likely that Detainee V would be admitted, the AMC Operations Manager telephoned the AMC Deputy General Manager (DGM) at about 8:20pm to seek approval to notify Mr V of his son's hospitalisation. The DGM told the Operations Manager to call the General Manager Custodial Operations (GMCO) for approval to notify Mr V.

5.7.5 In our opinion this referral to the GMCO was unnecessary given that the policy clearly states that the DGM had authority to approve the request – s8.1(b) of the policy refers.

5.7.6 At about 8:25pm the Operations Manager called the GMCO and, it appears, was given approval to call Mr V after they (staff) had found out which ward and bed number Detainee V was to be placed in and the visiting times for that ward 'in order to provide informed information to detainee [V's] next of kin.'[8] Given that the ACTCS staff at the hospital were not in a position to provide such information at that time, it further delayed notification of Mr V. In our opinion, it was unnecessary to wait until ACTCS had this information because Mr V could have easily located his son by asking at TCH reception, as do many visitors to hospitals.

5.7.7 In a bizarre and unfortunate turn of events, Mr V was visiting his wife at TCH on the evening of 13 January and happened across his son being taken to the ICU at about 8:45pm. At this time Mr V was unaware that his son had been taken to hospital. On hearing of this encounter, the Operations Manager called Mr V at 8:56pm but it appears the call was not answered (7 seconds duration). A second call was made at 8:58pm, which appears to have been answered (4 minutes, 10 seconds duration), followed by a third call at 9:05pm (1 minute, 34 seconds duration).[9]

5.7.8 The Operations Manager reported that he had a conversation with Mr V and Mrs V (second call) and explained, in general terms, that Detainee V had been assaulted in his unit at the AMC and that police were investigating the incident.[10] According

5 Email from ACT Health to the Inspector dated 04/02/20.
6 This did not involve the General Manager Custodial Operations or Deputy General Manager.
7 Report of the AMC Operations Manager, 8:20pm, 13/01/20.
8 Ibid.
9 Telephone log provided by ACTCS.
10 Mr V confirmed this contact – meeting with OICS on 12/02/20.

to the Operations Manager, Mrs V said words to the effect 'What is going on at the AMC, as this is the second time [V] has been seriously assaulted in the AMC' (presumably referring to the 2017 incident). The Operations Manager did not case note the notification to Detainee V's next of kin as required in s8.4 of the *Incident Reporting, Notifications and Debriefs Policy* until 25 February, over 6 weeks after the incident. In addition, the Operations Manager did not complete an Incident Report Form detailing the notification until 19 January.

**Finding 6:**

That the record keeping around next of kin notification was inadequate.

5.7.10 In summary, this incident has highlighted the rigidity of the *Incident Reporting, Notifications and Debriefs Policy* with regard to notifying next of kin 'where the detainee has experienced a serious injury or illness'.

5.7.11 Even a lay observer could see that Detainee V was quite seriously injured[11] and it would have done no *harm* for Mr V to have been contacted as soon as his son had been transported from the AMC at about 5pm, and s8.1(b) of the policy makes provision for such an action.

5.7.12 However, in our opinion, there is a flaw in s8.1(b) in that it provides for the GMCO or DGM to make the decision to notify next of kin. We believe it should be a decision of the 'Officer-in-Charge of a correctional centre' because he/she has immediate operational responsibility. However, the term 'Officer-in-Charge of a correctional centre' is not defined in the *Corrections Management Act 2007*, which could be confusing to staff. We take it mean a Corrections Officer who is the most senior officer at the AMC at that time.

**Finding 7:**

That the decision to not notify Detainee V's next of kin until the detainee had been admitted to hospital was a technically correct interpretation of s8.1(a) of the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019* (NI2019-266).

**Finding 8:**

That a decision could have been made at any time after the assault to contact Detainee V's next of kin, as provided for under s8.1(b) of the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019* (NI2019-266).

**Finding 9:**

That the term 'officer-in-charge of a correctional centre' is not defined in the *Corrections Management Act 2007*, and in that regard, its use in ACTCS policies and procedures could be confusing for staff.

**Recommendation 1:**

That the *Corrections Management Act 2007* be amended to provide a definition for the term 'officer-in-charge of a correctional centre'.

**Recommendation 2:**

That s8.1(b) of the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019* (NI2019-266) be revised to read 'where the Officer-in-Charge of a correctional centre considers it prudent to do so, based on their assessment of the severity of the injury/ies or illness'.

11 Observed on CCTV footage.

5.7.9 The family expressed concerns to the review team[12] about their difficulties in obtaining medical information about Detainee V after he was admitted to hospital and subsequently on his return to AMC. While AMC management was sympathetic to the requests, privacy laws required that Detainee V give written consent to the sharing of his medical records, including with family members. This issue was eventually resolved when the required authorisation was obtained from Detainee V.

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

5.9.1 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.

5.9.2 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 opinion is that appropriate steps were taken by ACTCS and that the assault was not reasonably foreseeable.

## 5.10 The future placement and management of Detainee V

5.10.1 The 13 January 2020 assault on Detainee V is the second serious assault he has experienced since 2017. The first assault also resulted in significant injuries and hospitalisation. While the two incidents do not appear to be related, this cannot be taken as certain given that there are complex relationships between individual prisoners and groups of prisoners (e.g. rival bikie gangs) that play-out within prison walls and often spill out into the community and vice versa. This "community" factor is particularly relevant in the ACT given the small population and the concentration of most of the population in Canberra. The 2020 assault may not be the end of the threat to Detainee V, particularly if his friends or associates retaliate against the perpetrators either within the AMC or in the community.

5.10.2 Detainee V has some time to serve on his sentence. This creates problems for ACTCS for his placement and management given that the ACT has only one adult prison (the AMC), and due to the relatively small size of the AMC and over-crowding issues, there are limited accommodation options for a Medium security high-risk detainee.

**Finding 10:**

That it would be prudent for ACTCS to assume that Detainee V is at high risk of further assault whilst he remains in prison in the ACT.

12 Meeting with OICS on 12/02/20.

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