ICS
ACT Inspector of Correctional Services

REPORT OF A REVIEW OF A CRITICAL INCIDENT

by the

ACT INSPECTOR OF CORRECTIONAL SERVICES

Serious fire at the Alexander Maconochie Centre on 14 November 2020

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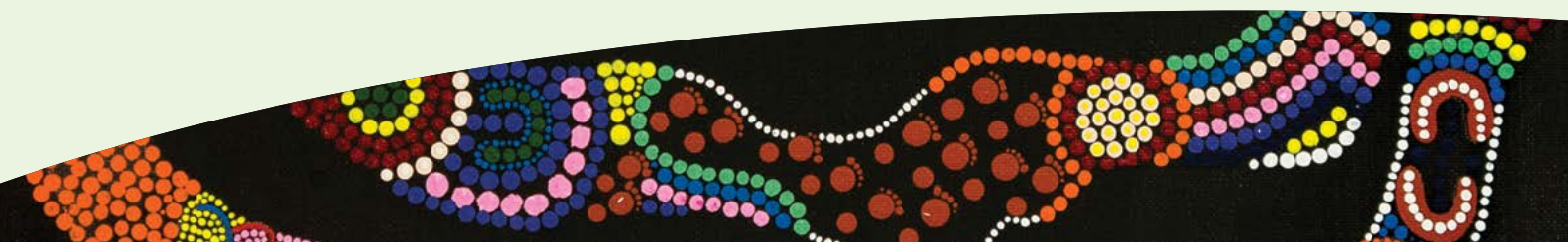

Rainbow Serpent (above and cover detail)
Marrilyn Kelly-Parkinson of the Yuin Tribe (2018)

'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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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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Serious fire at the Alexander Maconochie Centre on 14 November 2020

Neil McAllister
ACT Inspector of Correctional Services
20 April 2021

ICS

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GLOSSARY

Term	Meaning
ACTCS	ACT Corrective Services
ACTFR	ACT Fire & Rescue
ACTP	ACT Policing (AFP)
AMC	Alexander Maconochie Centre (ACT adult prison)
BA	Breathing Apparatus
CO	Corrections Officer ("prison officer")
ICS Act	*Inspector of Correctional Services Act 2017* (ACT)
Inspector	ACT Inspector of Correctional Services
MCR	Master Control Room, AMC (central location for CCTV monitoring and gate control)
OICS	Office of the Inspector of Correctional Services
Sally port	Secure vehicle access entry to AMC
SC2	Sentenced Cottage 2

1. EXECUTIVE SUMMARY

On 14 November 2020, during the night shift (at 11:07pm), a fire was lit most likely near the skylight of a stairwell foyer of Sentence Cottage 2 (SC2) at the Alexander Maconochie Centre (AMC). The fire was allegedly started by one or more detainees, who had breached their locked Pod door by means which are unclear. Intelligence information subsequently identified three potential suspects. However, there is no CCTV coverage of the relevant area which could assist in confirming the identity of the perpetrator(s). The damage from the fire was extensive and SC2 was deemed to be uninhabitable, resulting in the loss of 28 beds for several weeks.

The fire was extinguished by AMC staff before the arrival of ACT Fire and Rescue, with no reported injuries to either staff or detainees.

The review concluded that the fire was dealt with professionally by the night shift staff, but training of staff was found to be lacking and there was a significant ACTFR access problem on the night.

The review also made a number of observations and recommendations relating to security, which are contained in a confidential annex. However, we note that ACTCS took prompt action to address the security of the Pod doors in SC2.

The methodology adopted for the review is set out in **Appendix 1** to this report.

2. RECOMMENDATIONS

Recommendation 1:	That ACT Corrective Services explore options for providing staff with appropriate "heavy-duty" clothing that they can access quickly and change into, or put over their normal uniform, to provide better protection against heat, fire and chemicals.
Recommendation 2:	That ACT Corrective Services ensure that Fire Refresher Training (including Breathing Apparatus) for all relevant staff is brought up to date as a matter of urgency and review processes are implemented to ensure that mandatory training is provided when it is required to maintain currency.
Recommendation 3:	That ACT Corrective Services take urgent action to ensure that the Alexander Maconochie Centre ring road gates are keyed alike.
Recommendation 4:	That ACT Corrective Services investigate engineering options for the safe evacuation of detainees from upper level Pods in all Cottages in the Alexander Maconochie Centre.
Recommendation C1:	(redacted)
Recommendation C2:	(redacted)
Recommendation C3:	(redacted)
Recommendation C4:	(redacted)

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) (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.'* This review was conducted at the initiative of the Inspector.

3.2 What is a 'critical incident'?

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

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

This review concerns an event relevant to section 17(2)(f) in that a fire occurred at the Alexander Maconochie Centre on 14 November 2020 that caused significant damage to the Sentenced Cottage 2. The ICS Act does not define the term 'significant' but a revised MoU between ACT Corrective Services and OICS (currently in draft) refers to the Oxford English Dictionary: *Significant may mean sufficiently great or important to be worthy of attention.* The Inspector formed the view that this incident was significant for a number of reasons:

- the extent of the damage and the estimated repair cost of approximately $40,000[1];
- the number of beds that were 'offline' for a period because of the damage; and
- security issues raised by the fact that this incident occurred after night lock in, and that detainees allegedly let themselves out of their Pod and started the fire.

3.3 What must the Inspector report on?

Section 27 of the ICS 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 ICS 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. Further, and relating to section 28(2)(a) the Inspector decided that for security reasons this report does not describe the means by which detainees may have breached various security measures in SC2.

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1 Email from ACTCS dated 05/02/21.

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.

A "security issues" appendix (**Appendix 2**) has been fully redacted in the tabled version of this report. However, it has been provided to the ACT Minister for Corrections and the Director-General, ACT Justice and Community Safety Directorate. The Inspector wishes to make clear that "security redactions" to this and other OICS reports are only made to provide for the safety of staff, detainees and visitors at ACT correctional centres by withholding information that (some) detainees and their associates in the community could exploit for illegal purposes.

4. FORM OF THE REVIEW

The ICS 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.

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.

The second form of a review is one carried out by the Inspectorate utilising if necessary, the full powers of the Inspector under the ICS 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.

In the case of the incident that is the subject of this report, the Inspector decided to conduct a full review because of the serious nature of the incident.

5. THE REVIEW

5.1 The incident

5.1.1 Background

Sentenced Cottage 2 (SC2) is a two-storey low security unit, accommodating both sentenced and remand detainees. The unit can house 28 detainees in four 'Pods' (A, B, C and D), with each Pod housing seven detainees. Pods A and B are at ground floor level and Pods C and D are on the first floor.

Each Pod is self-contained, comprising a common living area, individual bedrooms, laundry/ablutions and shower, kitchen and a secure open veranda area for access to fresh air. The unit has a central foyer and stairwell.

The Pods remain open and unsecured throughout the day but the four Pod entry doors in the central foyer, and the single unit entrance, are secured at night.

5.1.2 Cause of the fire

Electronic records indicate that one of the Pod doors had been breached ten minutes prior to the fire being detected. Based on the scene of the fire, it appeared that the fire started near the skylight, and spread down to the stairwell from there. Whilst the review team were presented with a number of theories as to the chain of events, there is no CCTV coverage of the cottages and the precise circumstances cannot be determined. Further, the motive for lighting the fire is unclear.

Initial intelligence information gathered after the event identified a number of suspects that may have been involved. However, due to a lack of further evidence, no discipline charges were laid against detainees for lighting the fire.

5.1.3 Staff response

At 11:07pm on the 14 November 2020, a Corrections Officer (CO) on duty in the Master Control Room (MCR) noticed the 'Fire' strobe light in the MCR activate. MCR focussed the external cameras in the vicinity of SC2 onto the cottage and could see smoke coming from the building.

At 11:09pm MCR responded to an intercom call from SC2 where a detainee stated, 'Hey miss, there's a fire in the staircase cottage 2'. MCR questioned the detainee 'There's a fire?' and the detainee responded 'Yeah, a fire cottage 2'. MCR then called, via the radio, a Code Red (fire) in SC2.

Two COs responded from a nearby unit to investigate the call and contacted the CO2 in charge of the night shift requesting his attendance at the scene. As both officers proceeded outside, they reported seeing a large amount of smoke, as well as a visible glow of orange coming from the roof of SC2, and signs of fire emanating from the open vents located on the roof of SC2, directly above the stairwell.

MCR was advised that there was an actual fire and requested ACT Fire & Rescue (ACTFR) be contacted to attend and for any available staff to proceed to SC2 with Breathing Apparatus (BA) on. MCR then contacted the ACTFR via a direct phone line and the CO2 radioed all available staff to attend SC2 with BA.

At 11:12pm the CO2 contacted the (off-site) Duty Manager (Senior Director Accommodation), to advise of a fire in SC2 and discuss un-securing the cottage front door to the foyer, which was agreed.

There was a large amount of black smoke spilling out of the foyer, forcing three responding COs to retreat for their safety. The CO2 completed a circuit of the cottage to check the security of the cottage and confirm there were no more fires. He was able to speak to some detainees through the cottage windows, who stated that there were no fires in the Pods.

A CO reported that the stairwell was full of smoke and he could only partially see with the use of his BA flashlight. As he got to the stairs, he could see that the lower four steps were aflame, which he extinguished, and noticed that there was a container of some sort of liquid on the bottom step.[3]

Photo 1: Plastic container on stairwell

Source: ACTCS 2020

Shortly after, two COs entered the foyer, and a CO used his extinguisher to put out the remnants of the fire. A CO then climbed to the top of the stairs looking into Pods C and D to check there was no smoke, or flames, in either Pod. However, he was only able to check Pod C, as Pod D had a curtain across the inside of the entrance door window. While this practice is not permitted, it is a common occurrence at the AMC and is difficult to police.

Three COs then used up their extinguishers, dousing the whole stairway before exiting, noting at this time that the "plastic" skylight above the staircase was completely burnt out (see Photo 2). The intensity of the fire is best described by a CO who reported, 'this fire was so hot that our boots were melting to the tiles and the steel handrails radiated a frightening amount of heat along their full length.'

3 Believed to be water (ACTCS email dated 02/02/21).

Photo 2: Ceiling and melted skylight in the foyer

Source: ACTCS 2020

At 11:15pm the ACTFR arrived at the AMC and were escorted through the ring road gates to SC2, arriving at the cottage at about 11:50pm.[4] ACTFR inspected the fire scene and confirmed the fire was out. ACTFR was briefed on the incident by the CO2, including advice of the discovery of a container of liquid on the bottom step in the foyer. On receipt of this advice, ACTFR required Hazardous Material (HazMat) personnel to attend the Centre due to uncertainty about the container and other material in the foyer. ACTFR did not consider it necessary to enter any of the Pods for inspection.

The CO2 directed an officer to retrieve batons in case officers were required to enter the SC2 Pods. The batons were subsequently distributed, and the CO2 also instructed COs to do an external patrol of the other cottages. Nothing of concern was noticed.

By this time a number of detainees from each Pod were located in their Pod's open veranda area, communicating with officers. An officer reported that 'detainees in C Pod of Sentenced Cottage 2 were making fun of the situation and thought it was a big joke, presenting as elevated and excited'.[5] Another officer reported that detainees 'from Delta Pod had been sitting or standing in the exercise area the whole time and were asking CO1 (name) for her phone number and laughing at everything done by us or the firemen.'[6]

A CO went to the Sentenced Cottage officers' station and made an announcement over the loudspeaker to all SC2 detainees, asking anyone affected by the fire to tell the officers at the front of the cottage. He then repeated this message. No detainee reported any harm or injuries.

The CO2 consulted the Duty Manager about evacuating the detainees from SC2 or for staff to enter each Pod to check on the welfare of detainees. It was agreed that either course of action was potentially unsafe for staff given the number of detainees in each Pod and the unit as a whole compared to how many COs were available. The Duty Manager instructed the CO2 to leave SC2 secure for the day shift to manage.

The CO2 then asked all officers who had been involved in the incident whether there were any injuries, with none reported. He then instructed each officer to return to their normal duties. He again contacted

4 According to one Officer Report it could have been 11:40pm.

5 Officer report dated 14/11/20.

6 Officer report dated 15/11/20.

the Duty Manager with an update, advising that ACTFR did not consider it necessary to enter any of the Pods and SC2 had been resecured.

Once ACTFR had completed their tasks they left the AMC at 00:35am, 15 November. The Fire Board in the sally port (which duplicates the Fire Board in the MCR) was re-set by ACTFR on the way out.

The Duty Manager did not attend the AMC, as she considered that the CO2 had properly managed the incident and the incident was under control.

Following the incident, COs conducted periodic patrols of the area for the remainder of the shift. At 01:47am on 15 November, the Officer in Charge sent an email to all AMC staff advising of an actual fire in SC2, during night shift of 14 November 2020. He provided a brief overview of the circumstances and ACTFR attendance times. He concluded by stating that staff responded to the incident professionally and in time.

Finding 1:

That the Alexander Maconochie Centre staff response to the fire in Sentenced Cottage 2 was prompt and effective in minimising damage and protecting the lives of detainees.

5.1.4 Post incident response – 15 November 2020

Peer Support

At the conclusion of the night shift, each CO was approached and asked if they required Peer Support. None was required.

Hot Debrief

At 07:15am a Hot Debrief was conducted at the AMC gatehouse. The debrief was attended by all COs involved in the response.

Staff expressed concern regarding the different keys required to open various gates during the incident, to allow for ACTFR access and the extra time spent identifying the correct key/s. The debrief minutes record that all gate padlocks should be keyed the same, that this was the responsibility of Maintenance and this was to be actioned as soon as possible. No further issues/concerns were raised. The debrief concluded at 07:30am.

Formal Debrief

A Formal Debrief, according to the Corrections Management (Incident Reporting, Notifications and Debrief) Policy 2020 policy, is a 'structured process following an incident that is intended to offer staff the opportunity to work through the incident chronologically, identify key issues for learning's to mitigate recurrence and to assist in addressing operational or staff wellbeing concerns'.

Part 16.2 of the policy states: *A formal debrief will occur when there has been a … act of concerted ill-discipline.* The AMC did not conduct a Formal Debrief of the incident.

OICS considers the incident was an act of concerted ill-discipline in accordance with Part 16.2 (e) of the Formal Debrief policy, resulting in extensive damage to the cottage and long term loss of detainee accommodation. Failing to conduct a Formal Debrief misses the opportunity for staff to work through the incident chronologically, identify lessons learned and actions to mitigate recurrence; and to assist in addressing operational, or staff wellbeing concerns.

Finding 2:

That contrary to requirements in the *Corrections Management (Incident Reporting, Notifications and Debrief) Policy 2020*, there was no formal debrief held.

Notification to Police

The Hot Debrief minutes record that ACTP were contacted at 08:08am on 15 November 2020. The police were provided with an overview of the incident. ACTP did not attend the centre to the best of our knowledge.

Assessment of SC2 damage and movement of detainees

The AMC Fire Protection Manager and AMC Director of Facilities conducted an initial damage assessment of SC2 on 15 November. Their judgement was that the fire had been significant because of the extent of the smoke damage and the acrid smell of the burnt plastic.

The officers advised the CO3 Area Manager that, in their opinion, SC2 was uninhabitable. At about 1:15pm the 28 detainees were moved from SC2 to other accommodation.

Over the following days Facilities Management completed a more thorough examination of the damage, which revealed:

- The fire had entered the roof void around the skylight, between the ceiling sheeting and the Colorbond roof sheeting
- The entire roof void for the foyer compartment was charred
- Metal purloins in the roof were all blackened
- The foil backing in the ceiling was blackened and burnt
- The cabling in the ceiling had melted, exposing bare wires
- There was fire / heat damage to Pod A/B/C and D doors
- There was significant water damage to the floor coverings in the foyer area
- A thorough inspection of each Pod was also conducted and no smoke (or fire) damage was evident. The Director Facilities Management believes that the rubber seals around each Pod door- door frame had prevented any smoke accessing the Pods.

The AMC contracted a forensic cleaning company to clean the foyer/stairwell area on 15 and 16 November 2020.

5.2 Staff safety

The three officers who went directly into the fire scene wearing breathing apparatus were dressed in their normal uniform. OICS notes that COs daily uniform consists of cotton-type material that is not suitable for heavy-duty use such as fighting fires or responding to other hazardous situations.[7]

Further, when the officers discarded their breathing apparatus to return to their normal duties, they remained in their uniforms for the rest of the night shift, notwithstanding that their clothes had been exposed to heavy smoke and fire extinguisher chemicals.

Whilst onsite the reviewer sighted firefighting protective clothing in Operations, comprising fire retardant jackets and trousers. The reviewer was advised that whilst this protective clothing is available, it was not used in this fire incident, that it had never been used, nor is it included in any fire training.

Recommendation 1:

That ACT Corrective Services explore options for providing staff with appropriate "heavy-duty" clothing that they can access quickly and change into, or put over their normal uniform, to provide better protection against heat, fire and chemicals.

5.3 Detainee welfare

Officers reported speaking to detainees during and after the incident. They asked detainees whether there was any fire or smoke in the Pods and if any detainees needed assistance from staff. However, due to limited night shift staff numbers it was not safe to enter the Pods. Consequently, there was no visual check of detainees in SC2 to identify whether any detainee had any injuries as a result of the fire either just after the incident or at any other time for the remainder of the night shift.

A count was conducted sometime between 7am and 8am on 15 November by having the detainees stand in each of the secure veranda of their Pod. Whilst the detainees could be counted, the veranda security grill and mesh did not allow any clear observation of a detainee's condition. OICS understands that none of the Pods were entered by staff prior to the detainees being moved at about 1pm.

Finding 3:

That a visual check of each detainee and assessment of the condition of each Pod should have occurred shortly after the start of the day shift, when there would have been sufficient staff to ensure security requirements.

7 This clothing issue was also raised in the OICS' review report on the riot and fires in Accommodation Unit-North on 10 November 2020.

5.4 Training issues

The reviewer examined the fire training of the four COs who engaged the fire and was advised that the last attendance at Fire (Refresher) Training for the four officers was:

- CO 'A' 17 June 2019
- CO 'B' 24 June 2019
- CO 'C' 29 April 2019
- CO 'D' 26 August 2019

All four officer's Fire Refresher Training had lapsed. It is an ACTCS requirement that they receive Fire Refresher Training every 12 months. The reviewer was also advised that:

CO 'A' Cancelled from the breathing apparatus training refresher on 26 August 2020 due to 'swap in shift'

CO 'B' Cancelled from breathing apparatus refresher on 26 August 2020 due to 'operational requirements'

There does not appear to be any scheduling of Fire Refresher Training for the four officers, including refresher training on the proper use of breathing apparatus.

Recommendation 2:

That ACT Corrective Services ensure that Fire Refresher Training (including Breathing Apparatus) for all relevant staff is brought up to date as a matter of urgency and review processes are implemented to ensure that mandatory training is provided when it is required to maintain currency.

5.6 Establishment of a crime scene

The *Corrections Management (Code Red (Fire)) Operating Procedure 2020* states: 'where the cause of the fire is the result of suspicious circumstances or is unknown, the OIC or delegate must secure the site as a crime scene as per the *Management of Evidence Operating Procedure*.'

No crime scene was established at SC2. However, it is important to note that the *Management of Evidence Operating Procedure* states 'the preservation of life outweighs any preservation of evidence procedures'.

In our opinion it would not have been practical to preserve the foyer as a crime scene as it was the only way for staff to access the detainees in the upper level Pods had that been necessary during the night. Further, once established, only ACTP can release a crime scene.

5.7 Notification to police

Notification to ACTP of the incident did not occur until 08:08am on 15 November 2020, nine hours after the commencement of the incident. As noted earlier, ACTP did not attend the AMC in response to that notification.

The *Code Red Operating Procedure* does not require ACTP to be notified of fires. However, under the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2020*, 'Divisional Executives are responsible for ensuring that ACT Policing are immediately notified of any serious incident…'. In the case of the SC2 fire, the extent of the damage, and the possible involvement of detainees in lighting the fire, was not known until the morning of 15 November.

5.8 ACTFR vehicle access to SC2

The ACTFR attended the AMC at 11:15pm on 14 November 2020, in response to the call from MCR. A CO escorted ACTFR, via the ring road gates, arriving at SC2 at about 11:50pm.

The time taken for the ACTFR to attend the fire scene after their arrival at the AMC, some 35 minutes, was identified as a concern at the Hot Debrief. The issue was that different keys were required to open various gates in the AMC, and it took time to identify the correct keys. The Hot Debrief minutes record that the responsibility for rectifying this situation (to prevent any delays in the future) was 'Maintenance' and this action was required to be completed as soon as possible.

In our opinion this access delay could have cost lives in other circumstances.

Recommendation 3:

That ACT Corrective Services take urgent action to ensure that the Alexander Maconochie Centre ring road gates are keyed alike.

5.9 Evacuation of detainees from cottages

The bottom two Pods (A and B) in the Sentenced Cottages have a gate built into the security screening of each veranda. This gives officers at the ground level the ability to evacuate detainees from Pods A and B directly outside instead of via the foyer within the Cottage. However, there is only the one exit for those detainees accommodated in Pods C and D (the upper level). That exit is via the foyer central stairwell where the fire occurred on 14 November.

While the 14 November fire did not affect the integrity of the Pods, a more substantial fire may have necessitated a complete evacuation of the unit.

There may be engineering solutions that could address this evacuation problem from the upper levels (e.g. external fire escapes). ACTFR and/or WorkSafe ACT may be able to advise on this matter.

Recommendation 4:

That ACT Corrective Services investigate engineering options for the safe evacuation of detainees from upper level Pods in all Cottages in the Alexander Maconochie Centre.

APPENDICES

Appendix 1: Review methodology

The methodology adopted for this review comprised:

The review team

The timing of this incident, just four days after the riot in Accommodation Unit-North, meant that OICS did not have the staffing capacity to conduct the review with our own staff. Therefore, the Inspector engaged the services of Mr Russell Ford ("the reviewer") who had assisted OICS on the AMC Healthy Prison Review in 2019.

The Inspector (Neil McAllister) acted as "Review Manager". Deputy Inspector (Rebecca Minty) and the Assistant Inspector (Holly Fredericksen) acted as "Critical Friend" for the report.

Interviews

The reviewer conducted in-person interviews at the AMC with:

- Senior Director Operations AMC
- Senior Director Accommodation AMC (Duty Manager for the incident)
- A/Senior Director Detainee Services AMC
- Director Facilities Management AMC
- Four Corrections Officers who responded to the incident

Documentation from ACTCS

We requested a large volume of documents from ACTCS including intelligence reports, policies and procedures and officer reports. All requests were met in a timely manner.

Site inspection

The reviewer attended the AMC for two days in early December 2020 to inspect SC2 and conduct interviews.

Draft report

Section 29 of the *Inspector of Correctional Services Act 2017* requires that:

(1) The inspector must give a draft copy of a report prepared under section 27 to the relevant Minister and relevant director-general at least 6 weeks before giving the report to the Legislative Assembly.

(2) The relevant Minister and relevant director-general may provide comments in relation to the draft report to the inspector within the 6-week period.

(3) The inspector—

(a) must consider any comments made under subsection (2); and

(b) may include the comments provided by the relevant Minister and relevant director-general as an attachment to the report; and

(c) may, if the inspector is satisfied that amendment is an appropriate response to the comments, amend the draft report.

The draft report was provided to the Minister for Corrections and Director-General, Justice and Community Safety Directorate on 25 February 2021. Comments received were considered in the preparation of the final report.

Appendix 2: Security-sensitive matters

COMMENTS ON SECURITY MATTERS

[This appendix has been fully redacted in the tabled version of this report pursuant to s 28 of *the Inspector of Correctional Services Act 2017* (ACT)]

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