2019

THE LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

GOVERNMENT RESPONSE TO THE 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 16 DECEMBER 2018

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INTRODUCTION

The ACT Government welcomes the Inspector of Correctional Services' *Report of a Review of a Critical Incident, Assault of a detainee at the Alexander Maconochie Centre on 16 December 2018* (the Report), provided to the Speaker of the ACT Legislative Assembly on 5 June 2019.

In recognition of the unique make-up of the ACT's correctional system and increasing population pressures, the ACT Government committed to establishing an external and independent Inspectorate of Correctional Services, intended to strengthen and improve existing oversight arrangements.

On 30 November 2017, the ACT Legislative Assembly passed the *Inspector of Correctional Services Act 2017* (the Act). This legislation established the independent Inspector, tasked with conducting biennial reviews of ACT adult corrections facilities. It also provides the Inspector with powers to visit a corrections place at any time, review records, and talk to both detainees and staff. Section 18 (1)(c) of the Act makes provisions for the Inspector to review a critical incident.

This review of a critical incident was conducted on the Inspector's own initiative following an assault, and the subsequent hospitalisation, of an Alexander Maconochie Centre (AMC) detainee on 16 December 2018. The detainee was assaulted in his unit by up to two detainees. This resulted in significant head injuries and led to his admission to the intensive care unit of the Canberra Hospital.

The assault occurred in the detainee's cell therefore was not directly captured on CCTV. However, ACT Corrective Services (ACTCS) staff were able to quickly identify possible perpetrators by viewing CCTV to ascertain who entered the cell at the time of the assault. ACTCS reported the incident to ACT Policing for further investigation.

In summary, the Report found that the incident was not reasonably foreseeable by ACTCS. It makes four findings that provide the ACT community assurance that ACTCS responded to this critical incident efficiently. Two findings identify areas for improvement in practice in relation to ensuring internal incident review practices align with written procedure; and timely updating of detainee records relating to next of kin. The Report also made one recommendation that ACTCS ensure that victims and secondary victims involved in traumatic events are offered support after the event, and that these offers are documented.

RESPONSE TO RECOMMENDATION AND FINDINGS

Recommendation 1

That ACTCS ensure that victims and secondary victims of traumatic events in correctional centres are offered appropriate support from mental health professionals or counsellors as soon as possible after the event. Such offers of support and responses from detainees must be recorded on relevant files.

Government Response to the Recommendation: **Agree in Principle**

At the time of the review Corrections Psychological and Support Services (CPSS) were, when requested, responsible for providing post incident debriefing and support to detainees. ACTCS will continue to provide post incident debriefing for detainees on request, and seek to offer appropriate support from mental health professionals or counsellors as soon as possible after the event where practicable.

In accordance with the *Incident Response Policy 2014 (No 1)* (RESTRICTED), debriefing may be provided to individual or groups of detainees depending on the circumstances of the incident.

ACTCS staff in the course of their duties may observe the behaviour of detainees who may have witnessed or been involved in a traumatic incident, and will be encouraged to proactively engage with detainees on options to seek support if required. ACTCS will also discuss these issues with Canberra Health Services (Justice Health) to ensure that all opportunities to consider detainees welfare needs are being acted upon.

ACTCS will consider how referrals can be provided to support services for detainees who have been exposed to traumatic incidents, so that they receive the necessary support and how these offers and responses can be recorded.

Finding 1

That proper adherence to detainee muster procedure by ACTCS staff ensured the timely discovery of the victim after the assault, limiting the potential severity of his injury.

Finding 2

That the detainees involved in the incident were appropriately classified in each instance.

Finding 3

That there was no intelligence information on ACTCS systems to indicate that the victim was at risk of assault by anyone in the unit, including the actual suspected assailants.

Finding 4

That there were no failings of security procedures or practices that contributed to the assault on the victim.

Government Response to the findings: **Noted**

It is positive to hear that ACTCS' adherence to muster procedures and other security procedures or practices resulted in the timely discovery of the victim and appropriate management of the incident.

It is also reassuring that the AMC's procedures for detainee classification and accommodation placement were appropriate in this instance. ACTCS is currently

conducting a security classification review of all detainees at the AMC, and this will provide further assurance of appropriate allocation of detainee classifications.

Finding 5

That Detainee V's next of kin details should have been updated following the death of his previously nominated next of kin.

Government Response to Finding 5: **Noted**

It is standard practice that detainees be given the opportunity to nominate a next of kin upon admission to the AMC. After this, it is the responsibility of the detainee to inform ACTCS should they wish to change their nominated next of kin or update their details.

The detainee's next of kin had only recently passed away at the time of the incident. ACTCS took appropriate steps to ensure another family member was informed of the incident after the nominated next of kin could not be contacted.

Nominated next of kin are contacted following an incident in accordance with the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2018.* The ACT Government is satisfied that the current ACTCS practice for notifying next of kin when a serious incident or illness occurs is appropriate for all detainees at this time.

Finding 6

That the operational practice around conducting an internal written review of the incident did not fully align with the relevant procedure for a formal debrief.

Government Response to Finding 6: **Agreed**

ACTCS agrees that the relevant policy (*Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2018)* and procedure (*Corrections Management (Incident Reporting) Operating Procedure 2018 (No 2))* for a formal debrief were not followed.

The internal written review conducted after the incident was not intended to be a formal debrief and therefore did not fully align with the relevant policy and procedure for a formal debrief. The internal written review focused on outcomes resulting from the incident, however it did not 'identify any opportunities to improve responses' or 'identify and address and concerns' from the incident. These are both headings in the *Corrections Management (Incident Reporting) Operating Procedure 2018 (No 2)*.

ACTCS has implemented a formal debrief template, and will ensure formal debriefs are conducted in line with the policy in the future.

CONFIDENTIAL APPENDIX

The Report also contained a confidential appendix that was not made public, however, was provided to the Minister for Corrections and Justice Health and the Director-General of the Justice and Community Safety Directorate. The Inspector decided against full disclosure of

the contents of the appendix as it may reveal the identities of detainees and would not be in the public interest to release it. The confidential appendix has been noted.

CONCLUSION

The ACT Government recognises that effective independent oversight provided by the Inspector of Correctional Services is important to build and maintain public confidence in the ACT's corrections system.

The ACT Government welcomes this review, its findings and recommendation, which will further assist to inform best practice in the care, treatment and safety of all detainees in the ACT's correctional facilities.

ACTCS continues to strive to maintain correctional facilities where detainee and staff safety is paramount, detainees are treated with respect and dignity, and where human rights are maintained at all times. However, within all correctional centres there remains risk for conflict amongst detainees. In order to manage this risk, ACTCS has bolstered its security operations and is constantly evolving its security practices to align with international best practice in corrections management. The positive findings of this Report are evidence that this work is progressing well.