ICS
ACT Inspector of Custodial Services

REVIEW OF A CRITICAL INCIDENT

by the

ACT CUSTODIAL INSPECTOR

A self-harm incident, involving a use of force at the Alexander Maconochie Centre 24 July 2025

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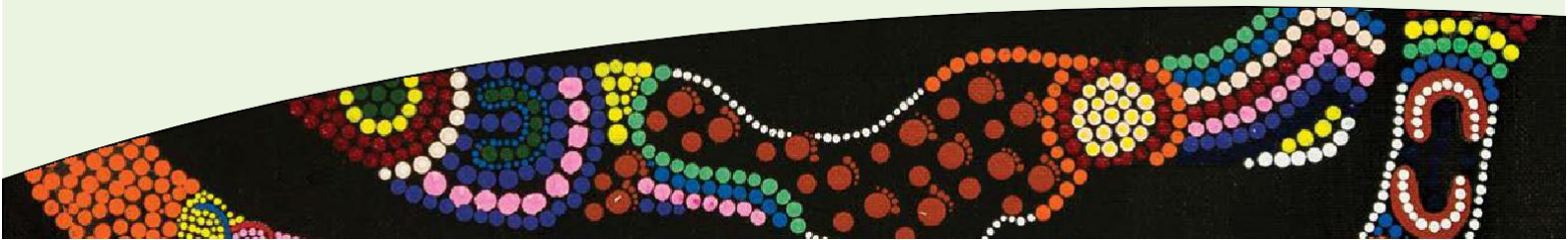

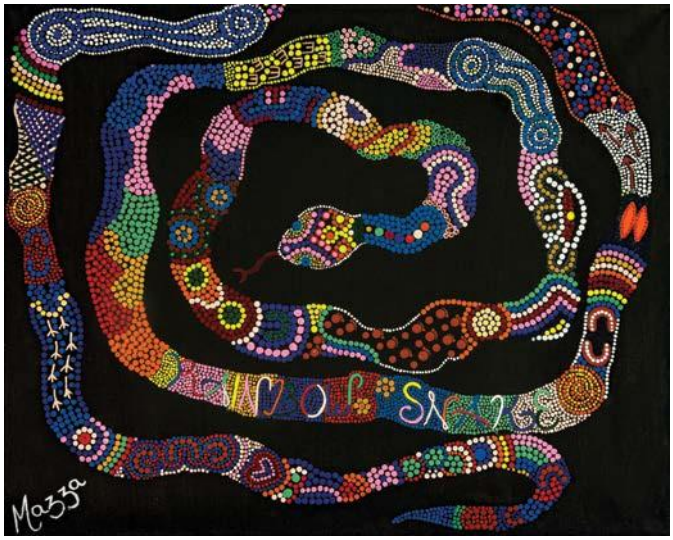

Rainbow Serpent (above and cover detail)
Marrilyn Kelly-Parkinson of the Yuin Tribe (2018)

'There are no bystanders – the standard you walk past is the standard you accept'

– Lieutenant General David Morrison, AO
Chief of Army (2014)

Content warning

Readers should be aware that this report includes information related to the treatment and conditions of Aboriginal people in places of detention, including self-harm and deaths in custody.

About this report

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ACT Custodial Inspector

We acknowledge the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region. 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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A self-harm incident, involving a use of force at the Alexander Maconochie Centre 24 July 2025

Rebecca Minty
ACT Inspector of Custodial Services
June 2026

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Glossary

Term	Meaning
ACTCS	ACT Corrective Services
ALO	Aboriginal Liaison Officer
AMC	Alexander Maconochie Centre (ACT adult prison)
ATSIEB	Aboriginal and Torres Strait Islander Elected Body
CI Act	*Custodial Inspector Act 2017* (ACT)
CM Act	*Corrections Management Act 2007* (ACT)
CO	Corrections Officer
CORIS	ACTCS information management system
CSU	Crisis Support Unit
HRAT	High Risk Assessment Team
HR Act	*Human Rights Act 2004 (ACT)*
Inspector	ACT Custodial Inspector
JHS	Justice Health Service
MCR	Master Control Room
NAIDOC	National Aborigines and Islanders Day Observance Committee
OC Spray	Oleoresin Capsicum Spray
OICS	Office of the Inspector of Custodial Services
WCC	Women's Community Centre – the women's area of the AMC
Winnunga	Winnunga Nimityjah Aboriginal Health and Community Services
WR2	Women's Remand 2 – secure cottage style women's accommodation

1. Executive Summary

Detained Person A is an Aboriginal woman in her early 30s with prior experience of youth and adult detention. She has a significant history of loss and trauma. She was detained at the Alexander Maconochie Centre (AMC) on 30 June 2025. In the weeks following she experienced significant mental health concerns including engaging in serious self-harm for which she was placed 'at-risk' in the AMC's Crisis Support Unit (CSU) on several occasions. At the time of the incident under review she was experiencing considerable mental health distress. This was compounded by an onerous discipline of 28 days separate confinement (isolation) and loss of privileges as a consequence of her climbing on a roof in protest for being unable to attend NAIDOC celebrations at the jail, an event of cultural significance.

On 24 July 2025, while separately confined to her cell, she used the cell intercom to request to join an Aboriginal art program but was advised she could not due to her disciplinary status. Shortly afterwards, she engaged in serious self-harming behaviour by tying a ligature around her neck and attempting to strangle herself.

ACT Corrective Services (ACTCS) COs responded urgently and called a Code Black (personal threat). No Code Blue (medical emergency) was activated so Justice Health staff were not alerted to respond. Two COs entered her cell and deployed Oleoresin Capsicum (OC) spray. She fell to the ground and briefly lost consciousness. Officers then restrained her, cut the ligature, and cuffed her hands behind her back. She was escorted by a significant number of officers to the CSU without prior health assessment. She was not reviewed by a Justice Health Medical Officer until the following day. No ambulance was requested at any point.

The incident had both a significant immediate physical impact on Detained Person A, as well as a (potentially longer term) traumatic impact on her mental health. The review's clinical reviewer considered this incident was a 'near miss' scenario, in that Detained Person A could have been left with catastrophic injuries to her head or neck as there was no medical assessment in the immediate aftermath of her loss of consciousness and fall, before her forcible transfer to the CSU.

The use of OC spray in these circumstances posed significant risk of physical and psychological harm and trauma. While the use of OC spray to respond to a detained person who is self-harming is not explicitly proscribed by policy or training materials, this review finds it should be. In Detained Person A's case, the ligature around her neck was compromising her airways and use of OC spray in this situation could further contribute to respiratory distress, in addition to the traumatic impact of being sprayed. The review recommends that ACTCS prohibit the use of OC spray where someone is engaging in, or threatening, self-harm and not posing a threat to anyone else. Instead, a trauma informed approach should be prioritised and articulated in policy, training and practices including de-escalation and physical intervention only to the extent required to stop the harm. This would be more consistent with ACTCS' 2025 Suicide Prevention Framework.

Detained Person A had experienced three acute mental health episodes in preceding weeks where she had been categorised as 'at risk' for serious self-harm, prompting initiation of certain procedures. This review identifies deficiencies in providing appropriate information about requisite support, including to COs responsible for her day-to-day needs, as she exited from these 'at-risk' processes. Had a multidisciplinary support plan that contained information about triggers, risk factors and protective factors been available to COs they may have been better

able to support her. This may have even led to considering whether 28 days separate confinement with loss of privileges was an appropriate discipline given her mental state. The review recommends that ACTCS and Canberra Health Services together with other relevant stakeholders consider the role of the High Risk Assessment Team (HRAT), including its prevention focus for someone exiting at-risk procedures.

The review considered the role Detained Person A's Aboriginality and gender played in this incident. We did not identify any overtly racist or directly discriminatory words, actions, or policies. However, the cumulative effect of custodial system design, institutional practices, and likely unconscious bias in decision making significantly impacted her as an Aboriginal woman, particularly given her serious and enduring mental health presentations. Examples include: overly bureaucratic grounds for refusal of her request to attend NAIDOC day celebration; a grossly disproportionate discipline punishment that removed opportunities for access to cultural and peer support; and placing her in the CSU in close proximity to men, which is culturally inappropriate. The review saw examples of some staff interpreting her distress as her 'just being difficult' or being manipulative, which was perceived as requiring a security response rather than a therapeutic one. In the Inspector's view the incident reflects systemic and institutional racism, and likely unconscious bias in decision making and should guide ACTCS in its efforts to address these factors.

The review notes some cultural support roles already exist in the jail that play a part in culturally appropriate care and support for Aboriginal and Torres Strait Islander people, but for differing reasons these had a limited role in this case. This incident should inform ACTCS' consideration of how cultural supports can be delivered, by the right entities, at the right time to fully realise their impact.

The review makes 11 findings and 4 recommendations.

2. Findings & Recommendations

Finding 1:

The gaps in available CCTV footage demonstrates persistent deficiencies in camera practices and reinforces the need to progress the *Healthy Prison Review of the AMC 2025* recommendation to implement body-worn cameras.

Finding 2:

The imposition of 28 days of separate confinement and loss of privileges for the disciplinary breach in question was grossly disproportionate and inherently harmful to Detained Person A's mental health.

Finding 3:

Consistent with the observations made in the *Healthy Prison Review of the AMC 2025*, the High Risk Assessment Team process would benefit from the participation of Winnunga Nimityjah Aboriginal Health and Community Services staff or another service that is culturally appropriate to support the effective care of Aboriginal and Torres Strait Islander detained people.

Recommendation 1:

Within 6 months, ACT Corrective Services and Canberra Health Services complete a review of the current operation of the High Risk Assessment Team against its Terms of Reference and ACT Corrective Services Suicide Prevention Framework to identify:

- opportunities to enhance a prevention-focused multidisciplinary approach to reducing self-harm and suicide risk for people transitioning out of at-risk procedures; and
- means for ensuring Correctional Officers have clear and relevant information on how to best support and engage with someone exiting from at-risk procedures, and appropriate training and support to do this.

Finding 4:

Relevant ACT Corrective Services policy and training material on the use of chemical agents do not allign with human rights based practice as they do not appropriately consider the physical and psychological impact of oleoresin capsicum (OC) spray on someone who is engaged in self harming behaviour.

Recommendation 2:

Within 6 months, ACT Corrective Services amend policy, training and practice to require that oleoresin capsicum (OC) spray is never used in response to self harm or attempted self harm (where the person's behaviour is self directed and there is no immediate threat to others for example because of a weapon).

Finding 5:

The incorrect code was called (a Code Black instead of a Code Blue) which resulted in a security response instead of a therapeutically focused response to self harm.

Finding 6:

The ongoing presence of up to 19 Corrections Officers in response to a self harm incident was not trauma informed and inconsistent with the ACT Corrective Services Suicide Prevention Framework and impacted Detained Person A's privacy and dignity.

Recommendation 3:

Within 6 months, ACT Corrective Services take active steps to enhance a trauma informed response to incidents of serious self-harm consistent with the ACT Corrective Services Suicide Prevention Framework.

This should be operationalised by:

- always calling a Code Blue;
- standing down all non-essential staff not required on the scene after an initial response;
- reinforcing trauma informed principles through training and staff meetings; and
- for each use of force involving self harm, the Use of Force Review Committee consider whether a Code Blue was called, and if staff presence at the scene was trauma informed.

Finding 7:

The decision by ACT Corrective Services staff to not call a Code Blue (medical emergency), and then move Detained Person A from her cell to the CSU risked causing her significant injury in circumstances where she had not undergone any clinical review for potential head, neck and airway injuries.

Recommendation 4:

Commencing immediately, ACT Corrective Services and Canberra Health Services work together to ensure all relevant Alexander Maconochie Centre policies, procedures and training reflect the requirement for urgent medical assistance to be sought, and a detained person to not be moved, in cases of attempted strangulation and other incidents that could result in injuries to the head, neck and spine.

Finding 8:

Contrary to policy and best practice, Detained Person A was not assessed in a timely manner by trained health practitioners for her potentially significant physical injuries after the incident. In the absence of clear records, the Inspector is left to conclude this is due to either a failure of ACT Corrective Services to properly inform Justice Health Services of the urgency and/or Justice Health Services not responding in a timely way.

Finding 9:

Despite in 2025 the ACT Supreme Court finding the circumstances of a strip search on entry to the Crisis Support Unit (CSU) was unlawful, Detained Person A was subjected to a strip search on entry to the CSU without reasonable grounds.

Finding 10:

Detained Person A's treatment in the lead up and response to her self harm show examples of systemic racism and implicit bias. These include the denial of, and conditional access to culture, the absence of appropriate cultural input at key decision points, the interpretation of her behaviour as attention seeking and manipulative and the compounding effects of disciplinary responses to deteriorating mental health.

Finding 11:

That feedback arising from the ACT Corrective Services' Use of Force Review Committee meetings is not routinely communicated to frontline staff, limiting opportunities for learning and continuous improvement.

3. Introduction

This review considers the immediate lead up and response to a serious self-harm incident involving an Aboriginal detained woman (Detained Person A), in which force was used through the deployment of Oleoresin Capsicum (OC) spray and handcuffs. She was subsequently transferred to the Alexander Maconochie Centre's (AMC) Crisis Support Unit (CSU) where she underwent decontamination from OC spray and was subjected to a strip search, before being placed in tear-proof smock. This review also considers her medical treatment and care, subsequent to the self-harm incident.

3.1 Authority for the review

The Aboriginal and Torres Strait Islander Elected Body (ATSIEB) wrote to the Custodial Inspector seeking a review of this incident following concerns raised with them by members of the broader Aboriginal and Torres Strait Islander community.

The *Custodial Inspector Act 2017* (CI Act) defines certain events in a correctional centre or in the provision of correctional services which are 'critical incidents' that the Inspector may review. This includes 'any other incident referred by the relevant Minister or Director-General'. On initial review, the Inspector formed the view that the incident referred by ATSIEB did not clearly fit within the specific incidents articulated in parts (a) – (g) of that definition but would be captured under part (h) should the Minister or Director-General identify it is a critical incident and refer it to her office.

The Inspector wrote to the Minister for Corrections, who subsequently identified this matter as a critical incident. On that basis, the Inspector exercised her discretion to review the incident.

3.2 Methodology

The Inspector undertakes critical incident reviews with a view to identifying any areas for improvement at a systems level as well as good practices.

Material considered in this review included interviews with ACTCS staff, a discussion with the relevant detained person, review of records, available CCTV, intercom recordings, and relevant ACTCS and Mental Health Justice Health Alcohol and Drug Service (MHJHADS) policies and procedures.

The review engaged two external contractors for expert advice: a cultural advisor, and a public health physician with experience in justice health.

Gaps in CCTV footage

The cell where this incident occurred is one of the few at the AMC with CCTV coverage inside the cell. ACT Corrective Services advised the Inspector that this CCTV footage was not retained because the camera was covered at the time. Detained people sometimes use items such as wet toilet paper or sticky labels to cover in-cell CCTV cameras, often for privacy reasons. However, the cameras in these cells serve an important purpose and staff are required to uncover CCTV when they are aware of it.[1] This issue has been raised previously by OICS in earlier critical incident reviews, and highlighted during a coronial inquest into a death in custody at the AMC.[2] Furthermore, regardless of whether the camera was covered at the relevant time,

[1] See *Corrections Management (Master Control Room) Operating Procedure 2025*; *Corrections Management (Night Shift) Operating Procedure 2025*.
[2] *Inquest into the Death of Luke Anthony Rich* [2024] ACTCD 3; ACT Inspector of Correctional Services, *Report of a review of a critical incident: Death in custody at the Alexander Maconochie Centre on 1 February 2022* (Report, 2022).

the footage should have been retained.

In addition, CCTV did not capture some of the transfer of Detained Person A from her cell in the Women's Remand Cottage 2 (WR2) to the CSU due to the Master Control Room (MCR) operator not directing the relevant PTZ (Pan Tilt Zoom) camera to follow movement. It has been suggested that excessive force was used to transfer Detained Person A to the CSU, but this is difficult to ascertain due to incomplete CCTV coverage and the review makes no findings on this.

The Healthy Prison Review of the AMC 2025 (HPR25) recommended the introduction of body-worn cameras for COs to enhance accountability and improve the evidentiary record of operational practices. Implementation of this recommendation would help address gaps in CCTV coverage.

Finding 1:

The gaps in available CCTV footage demonstrates persistent deficiencies in camera practices and reinforces the need to progress the *Healthy Prison Review of the AMC 2025* recommendation to implement body-worn cameras.

Impact of intergenerational trauma

Recognising the impact of colonisation and intergenerational trauma on Aboriginal and Torres Strait Islander peoples is essential to understanding the mental health challenges many face, particularly in custodial environments. As discussed in the *Bugmy Bar Book*, an evidence-based resource for courts and others about the impacts of experiences of trauma, the removal of Aboriginal children from their families, both historically and in contemporary practice, continues to generate deep and enduring impacts for individuals, families, and communities. Early separation from family, kin, and culture frequently results in placement in out of home care where risks of neglect and physical and sexual abuse are higher.

This is discussed in the *Bringing Them Home* report which notes that for many this trajectory extends into adulthood, including recurrent periods in detention, substance dependency, mental ill-health, and experiences of domestic and family violence. Intergenerational impacts are evident, as children of affected parents are frequently removed from their families, reinforcing cycles of trauma, disconnection from culture, and socioeconomic disadvantage. Research demonstrates that maltreatment in childhood leads to cognitive and neurobiological alterations, including distrust of others, hypervigilance to threat, impaired emotional regulation, and reduced responsiveness to rewards. These experiences increase vulnerability to mental illness.

The Jumbunna Institute for Indigenous Education and Research's *Independent Review into the Over-Representation of First Nations People in the ACT Criminal Justice System* identified racism, discrimination and a lack of cultural safety in the AMC. It recommended that 'the operation of the AMC should be a priority area for a systemic racism review', including the use of segregation, the use of force, recognition of cultural rights and the interaction of staff with detained people. This recommendation noted the intersections between systemic racism, gender and disability.

The long history of structural harm caused by colonisation was extensively documented by the 1991 Royal Commission into Aboriginal Deaths in Custody (RCIADIC), which concluded that the over-representation of Aboriginal people in custody was rooted not in higher criminality, but in the legacy of colonisation, systemic racism, and socioeconomic inequality. It noted that self-harm and suicide among Aboriginal people in custody could not be understood without recognising the enduring impacts of colonisation.

4. Background

4.1 Health service provision at the AMC

Health services at the AMC are provided by Justice Health Services which comprises of Justice Health Services (primary health) and Custodial Mental Health Services (mental health), as well as the Winnunga Nimmityjah Aboriginal Health and Community Services (Winnunga), an Aboriginal Community Controlled Health Organisation that provides health services to some of the Aboriginal and Torres Strait Islander detained people at the AMC.[3]

Justice Health Services also has access to a team of Aboriginal Liaison Officers (ALO) that work across ACT mental health and detention facilities and can attend the AMC as required.

At the time of this incident it appears the Detained Person A was not engaged with a Justice Health Services ALO and that she was on the waitlist to become a client of Winnunga.[4] On 7 November 2025 her healthcare was transferred from Justice Health Services to Winnunga.

4.2 Detained Person A's history of mental health and self-harm

Detained Person A is a woman in her early 30s who identifies as Aboriginal. She has experienced a profoundly disadvantaged childhood and complex trauma, which has contributed to poor mental health and substance use. From a young age, she was placed in out-of-home care and exposed to multiple adverse experiences, including substance use, domestic violence, neglect and maltreatment, sexual abuse, disrupted education, and homelessness. She has prior experience in youth and adult detention. These circumstances have had a profound and lasting impact on her life. This background is noted here, in order to situate her experience of custody in a broader context (see callout box on the previous page).

In late June 2025, she was remanded in custody at the AMC. In the weeks following admission, she displayed a significant pattern of deteriorating mental health, emotional distress, repeated threats of self-harm, and several self-harm incidents, that resulted in at-risk referrals to Custodial Mental Health, and placements in the CSU.

Detained Person A had experienced multiple episodes in custody at the AMC and as a result she is known to staff. All the staff interviewed for this review were at least generally aware of her challenges with mental health, self-harm and suicidal ideation, with some working more closely with her than others. She noted she had good rapport and a level of trust and confidence in several AMC staff.

Custodial case notes indicate Detained Person A's willingness to engage with support services during this period varied, and clinical records indicate she often refused to engage with Justice Health nursing staff immediately following a self-harm incident. Nonetheless, custodial case notes indicate that Justice Health nursing staff continued to attempt to engage with her, and continued to offer her prescribed and PRN (as needed) medication.

[3] Even when a detained person is a Winnunga client, some health services in AMC are only provided by Justice Health Services including responding to Code Blue (medical emergency) and examining a detained person after a use of force or self harm.

[4] At the time of this review there were approximately 150 Aboriginal and Torres Strait Islander detained people at the AMC, and Winnunga had a maximum case load of 50 detained people. Referrals take some time to be progressed, they are triaged with priority given to women and detained people with longer sentences. After approval the wait time to become a Winnunga client is between four weeks to 12 months. The Healthy Prison Review of the AMC 2025 (HPR25) highlighted that Winnunga would be open to having a larger case load however barriers such as staff resources and the physical size of the health facility at AMC exist.

In the week prior to the incident, Detained Person A was accommodated in the CSU after a self-harm incident. On 22 July, two days before the incident, she was moved to WR2 cottage in the Women's Community Centre (WCC) on a 28 day separate confinement order imposed earlier. This penalty was imposed because on 15 July she briefly climbed onto the roof of the WCC building in protest at being denied access to a NAIDOC Day event. On 23 July, Detained Person A met with Custodial Mental Health staff for a welfare review. Clinical notes from this review suggest that she reported feeling angry and frustrated about her treatment while on separate confinement, including late administration of medications, access to food and time out of her cell. She also felt she was receiving unfair treatment and inconsistency from COs in relation to her discipline.

Custodial case notes indicate that the ACTCS ALOs also attempted to engage with her on a number of occasions during this period, including by visiting her when she was in CSU following various incidents. During a number of these engagements Detained Person A declined to speak with the ALOs, and on one occasion sighted 'personal reasons' for not wanting to engage (discussed further below).

4.3 The incident and response

This review is primarily focussed on an incident which occurred on 24 July 2025. On that date, Detained Person A engaged in serious self-harm in her cell by tying a ligature around her neck and attempting to strangle herself. ACT Corrective Services staff were in close proximity and responded with appropriate urgency.

Prior to the incident, at 8:00AM, she used the cell intercom to contact the WCC officers' station to enquire when her prescribed mental health medication would arrive. She had concerns that her medication had not been arriving on time recently, and its administration was time-critical (the timing of this medication dose should be adhered to for the best therapeutic outcome). Corrections Officers told her that they were 'looking into it'.

At 9:20AM she had not had a response regarding her mental health medications and again contacted the officers' station via the intercom to enquire if she was able to attend the Aboriginal Cultural Art Program, expressing her need for cultural and mental health support. Approximately 15 minutes later a CO told her that as she was on separate confinement for disciplinary reasons she would not be permitted to attend any programs.

She responded that she wished to be transferred to the CSU and to be placed 'at risk'.[5] Minutes later two COs attended the unit and attempted to communicate with her through the cell hatch. One officer's incident report states that at this time she was being verbally abusive towards staff and refusing to engage in de-escalation attempts. As a result, a CO called over the radio for security team support. Corrections Officers continued to speak to her through the cell door hatch, and soon after a CO called a 'Code Black' over the radio.

Detained Person A then pushed her mattress against the cell door, obstructing the COs' view through the door's observation window and hatch. Corrections Officers reported hearing sheets being torn up which Detained Person A then fashioned into a ligature, wrapping it around her neck. Due to the obstructed view, a third CO was sent outside the accommodation block to observe through the external cell window.

[5] 'At risk' refers to a detained person being at risk of suicide or self-harm, requiring immediate care and support.

As Detained Person A was not responding to verbal directions to cease self-harming, a CO then opened the hatch and considered deploying OC spray to try to get her to stop self-harming. However, as the hatch was obstructed, they assessed OC spray was unlikely to have been effective and so did not proceed at that point.

Shortly after, a CO opened the cell door and entered, directing Detained Person A to cease self-harming, closely followed by another CO. One officer deployed OC spray in the direction of Detained Person A, who had turned to face the wall. The OC spray made contact with the back of her head and neck. The other officer then deployed their OC spray.

The use of OC spray did not immediately result in Detained Person A ceasing self-harm. She fell backward onto the floor and continued to tighten the ligature around her neck. Based on officer reports it appears she briefly lost consciousness at some point. Two COs then physically restrained her, with one CO applying mechanical restraints (handcuffs) behind her back while the other cut the ligature from around her neck with their Hoffman knife.[6] During this time a significant number of COs arrived in WR2 including the security team and designated Incident Response Officers (who attend incidents from various locations across the AMC). The women's accommodation area was locked down at this point.

Figure 1: Hoffman (safety) knife

Detained Person A was then escorted to the CSU by at least 13 COs. She stated that she 'came to' during the escort and became increasingly agitated, including having difficulty breathing. She said she was confused about what was happening and was scared. She sought the assistance of a particular CO who she trusted, and this officer reassured her throughout the escort.

Upon arrival in CSU she was having difficulty standing and COs assisted her to the floor at the entry to the unit and placed her in the recovery position. Incident reports include reference to her stating 'I can't breathe', and her appearing to lose consciousness again. Handcuffs were then removed and water was provided to her.

When able to stand up she was transferred to the bathroom in the CSU where three female COs assisted her decontamination from OC spray exposure in the shower. The female COs then conducted a strip search. She was provided a tear-proof smock and placed in a cell that had minutes before been occupied by a male detained person. The cell was not cleaned between occupants.

While in cell 1 Detained Person A can be seen on CCTV moving between lying on the concrete bed and lying face down on the cell floor. She appears distressed, constantly moving and patting the back of her neck and shoulders in what may be an attempt to calm the discomfort from the OC spray. A female CO was stationed outside the cell maintaining constant observations.

According to custodial case notes, Justice Health nursing staff attended the CSU at 10:10AM to conduct a health assessment of Detained Person A, but she refused to engage. This attempted review is not recorded in her clinical health notes. Clinical notes indicate that she

[6] A Hoffman knife is designed to safely and effectively assist in the removal of ligatures in custodial settings.

spoke with Custodial Mental Health nursing staff at 10:30AM and agreed to a brief mental health review, but was not willing to engage in a full assessment due to feeling upset and frustrated by her treatment by COs that morning.

Detained Person A remained in the CSU until 28 July 2025, after which she was transferred back to WR2. Following this incident, some supports were put in place to assist her ongoing mental health needs. These included access to the Aboriginal Official Visitor, visits from a kinship support person within the prison, and engagement from a senior staff member from the ACTCS Aboriginal and Torres Strait Islander Services Unit, who undertook to provide additional support and assist in establishing a working relationship between her and the ALO team.

5. Matters arising from this incident

5.1 Discipline penalty and impact of isolation

Nine days prior to this incident, Detained Person A received a 28-day separate confinement order as a disciplinary penalty for climbing on a roof as a protest. She was protesting the refusal of her request to attend the AMC NAIDOC Day event. Her attendance was refused on the grounds she had not been in custody long enough for her behaviour to be assessed. She found the refusal particularly frustrating as prior to her coming into custody she had been approved to attend the same event as a visitor of an incarcerated family member.

"NAIDOC" is a national celebration recognising the history, culture and achievements of Aboriginal and Torres Strait Islander peoples.
See: www.naidoc.org.au

In determining a suitable penalty for a breach, relevant policy[7] requires the decision maker to consider factors including the circumstances and seriousness of the breach, if the detained person admitted to the conduct, as well as any mental health condition 'which may be impacted by the proposed penalty'. There is no documentation to indicate what factors (if any) the decision maker (a CO) considered in determining Detainee A's penalty, including that Detained Person A admitted to the breach.

ACT Corrective Services Schedule of Penalties Policy guides disciplinary sanctions, noting sanctions should be chosen strategically with the aim of correcting behaviour rather than punishment being an end in itself. For the relevant offence of 'being in a prohibited area', guidance as to appropriate penalties indicates a reprimand for the first offence, and up to 7 and 14 days loss of privileges for subsequent offences. There is no suggestion of the imposition of separate confinement:

Being in a prohibited area

First offence-	reprimand noted on case file
Second offence-	7 days general loss of privilege
Subsequent offence-	14 days general loss of privilege

Figure 2: Extract from Corrections Management (Schedule of Penalties) Policy 2012

The penalty imposed on Detainee A was

- 28 days loss of privileges; and
- 28 days separate confinement.

[7] *Corrections Management (Detainee Discipline) Policy 2023.*

The specific separate confinement regime is listed at Figure 3. It included 1 hour out of cell per day (during which time she was to be cuffed and escorted to the fully fenced tennis court), 1 phone call per week, no cultural/kinship or internal visits, and access to programs and education only if they were delivered in the WCC area.

Separate Confinement Regime		
Activity	**Yes / No**	**Conditions (e.g. escorted, in cell)**
Out of cell hours	☒ Yes ☐ No	1 hour per day secured in WCC tennis court, CSU external yard or MU external depending on housing location
Personal visits	☒ Yes ☐ No	Zoom only
Professional visits	☒ Yes ☐ No	
Buy-Ups and Canteen	☐ Yes ☒ No	Toiletries only
Personal phone calls	☒ Yes ☐ No	1x phone call every 7 days
Library	☐ Yes ☒ No	Librarian attends Management unit, WCC or CSU
Education	☐ Yes ☒ No	Unless facilitated in MU, WCC or CSU
Programs	☐ Yes ☒ No	Unless facilitated in MU, WCC, or CSU
Newsagency services	☐ Yes ☒ No	
Exercise	☒ Yes ☐ No	As per 'out of cell hours'
Work	☐ Yes ☒ No	
Religion	☒ Yes ☐ No	To be facilitated in MU, WCC or CSU
Television and computer access	☒ Yes ☐ No	TV only
In cell property	☐ Yes ☒ No	
Internal visits	☐ Yes ☒ No	
Cultural/kinship	☐ Yes ☒ No	

Figure 3: Extract from ACTCS Separate Confinement Authority Form (Form D3.F2)

The basis for Detained Person A being disciplined for being in a prohibited area is not disputed. However, in the Inspector's view, the penalty she received was grossly disproportionate to the breach according to ACTCS' own policy guidance.

There is no evidence that Detained Person A's significant mental health condition was considered by the CO who determined the penalty, nor any protective factors for managing her mental health.

Solitary confinement (defined as being isolated for 22 hours or more per day without meaningful human contact)[8] is widely recognised as a practice that can cause profound psychological harm, and its impacts are especially severe for people with pre-existing mental health conditions. Prolonged solitary confinement, defined as more than 15 consecutive days of solitary confinement, has been linked to irreversible psychological harm, making it particularly dangerous for people already living with mental illness and mental ill-health.

Detained Person A was accommodated in the CSU at the time she learned of this sanction. Custodial case notes indicate she asked if she could see a kinship support person at that time, but this was denied.

Given her known mental health vulnerabilities, the conditions of confinement predictably and substantially exacerbated her psychological distress, compounding the punitive impact of the penalty and causing avoidable harm to her mental health. The blanket denial of access to cultural/kinship connection unreasonably limited her access to cultural rights under the *Human Rights Act 2004* (ACT) (HR Act).

This was not a failure in policy or procedure, but in decision making that did not give sufficient regard to policy and procedure, which allowed flexibility to respond to Detained Person A's attributes and circumstances.

[8] Juan E. Méndez, *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN DOC A/66/268, 66th Session (5 August 2011).

Finding 2:

The imposition of 28 days of separate confinement and loss of privileges for the disciplinary breach in question was grossly disproportionate and inherently harmful to Detained Person A's mental health.

5.2 Policy and operational approach to suicide and self harm, and opportunities for prevention

The management of suicide and self-harm in custody is governed by several interrelated frameworks and policies. These involve the intersection of health, custodial, and other detainee services.

The ACT Corrective Services Suicide Prevention Framework (2025) was developed in response to recommendations in a previous OICS review and coronial inquest.[9] It seeks to provide a whole-of-system approach, around six focus areas: creating a safe, secure and caring environment; ensuring timely identification and support; promoting collaboration; maintaining continuity of care; managing incidents effectively; and embedding trauma-informed practice. The *Corrections Management (Detainees at Risk of Suicide or Self-harm) Policy 2022* establishes operational requirements including the 'Person at Risk' and interim risk management requirements, High Risk Assessment Team (HRAT) processes, accommodation and observation arrangements, and planning for detained people exiting the 'at risk' process. Clinical responsibilities are governed by the Canberra Health Services *Suicide Prevention and Intervention at the Alexander Maconochie Centre and ACT Court Cells* (2024) policy which defines clinical roles, suicide risk ratings, High Risk Assessment Team (HRAT) processes, and treatment planning.

Taken together, these instruments require a multidisciplinary and collaborative approach to suicide and self-harm prevention, rather than a model that is solely custodial or solely clinical. There are important questions as to whether these worked as intended in this case.

Role of the High Risk Assessment Team

When a detained person is categorised as 'at-risk' they come under the scope of the High Risk Assessment Team (HRAT). The HRAT is a decision and intervention planning team that coordinates the immediate care of detained people at risk of suicide or self-harm. The HRAT meets daily on business days, is chaired by ACTCS and membership includes COs, Custodial Mental Health, and Justice Health staff. ACT Corrective Services policy indicates membership can also include the ACTCS Supports and Interventions Unit (responsible for sub-acute mental health matters, which are not dealt with by Custodial Mental Health), and the Aboriginal and Torres Strait Islander Services Unit. The role of HRAT includes amongst other things, to facilitate information sharing between ACTCS, Justice Health and Custodial Mental Health regarding detained people at risk of suicide or self-harm, developing Risk Management Plans, making recommendations regarding overall case management and accommodation placements, developing exit plans for exiting the CSU, and recommending broader strategies to address potential suicide and self-harm risks. Policy requires HRAT to collaborate with the

[9] In a 2022 critical incident review into the death in custody of Mr Luke Rich at the AMC, OICS recommended that ACT Corrective Services, Canberra Health Services, and Winnunga Nimmityjah Aboriginal Health and Community Services consider whether an overarching suicide prevention framework was required, and if so to jointly develop one within a year. A similar recommendation was made by the ACT Coroner in relation to the same death in custody. ACT Government agreed to this recommendation.

ACTCS Supports and Interventions Unit regarding exit plans. All plans and records developed must be stored in a detained person's electronic record.

During the relevant custody episode, Detained Person A was triaged by Custodial Mental Health and considered at multiple HRAT meetings in response to ongoing at-risk referrals and repeated self-harm incidents. Meeting minutes indicate that discussions predominantly centred on accommodation placement and appropriate observation levels. Given Detained Person A's repeated cycling through the CSU and her ongoing mental health crises, the absence of Winnunga or other appropriate cultural representation at HRAT meetings meant that cultural safety considerations were not embedded in the decision-making process. As previously recommended by OICS, ensuring culturally informed input at HRAT meetings would strengthen the management and support of at-risk Aboriginal and Torres Strait Islander detained people and help ensure that culturally appropriate perspectives guide risk mitigation strategies.

Finding 3:

Consistent with the observations made in the *Healthy Prison Review of the AMC 2025*, the High Risk Assessment Team process would benefit from the participation of Winnunga Nimityjah Aboriginal Health and Community Services staff or another service that is culturally appropriate to support the effective care of Aboriginal and Torres Strait Islander detained people.

Custodial Mental Health Services

When a detained person is placed 'at-risk', Canberra Health Services policy refers to Custodial Mental Health convening a multidisciplinary team meeting to consider presentation, treatment and management planning. Where this cannot occur, the matter must be discussed with senior staff and documented in the detained person's Digital Health Record. Outcomes may include ongoing Custodial Mental Health intervention, referral to an alternative pathway, or a decision that no further engagement is required. Interventions are typically brief and psychosocial in nature, focused on managing immediate needs and building skills to prevent or respond to future crises, with psychiatric review as required. One option is referral to the Brief Intervention Clinic, a four-session program aimed at crisis containment, strengthening coping strategies and identifying ongoing supports in custody and the community. A collaborative safety plan must be developed.

Detained Person A's engagement

In the 24 days that Detained Person A was in custody prior to this incident, she went 'at-risk' three times, with three admissions to the CSU for a total of 10 days. She was considered by nine meetings of the HRAT.

Records show three Risk Management Plans were developed by the HRAT, one for each time she was in the CSU prior to this incident. These plans were completed on one-page templates with prompts relating to accommodation, observations, daily activities, custodial and other support, proposed treatment plan, relevant significant issues, and recommendations. Two of these plans are brief, with responses such as 'as required' 'as indicated' or 'as per ACTCS'. The third one had more information such as recommending one point of communication with her to avoid inconsistent messages. The 'treatment plan' section of each of these plans do not detail any treatment but refer to Custodial Mental Health ongoing input and review (this

information is not documented in a way that COs may access). There was no involvement from the ACTCS Supports and Interventions Unit or any cultural support staff (eg custodial or health ALOs).

Custodial Mental Health developed a care plan as part of the Brief Intervention Clinic engagement for Detained Person A, prior to this incident. This contained information such as triggers, warning signs that her mental health may be deteriorating and suggested protective factors and support people. As this is health information, due to patient confidentiality it would not normally be shared with COs without the patient's consent other than in exceptional circumstances such as imminent risk of harm. Detained Person A did not initially consent to sharing this plan with ACTCS staff but did so after this incident.

The HRAT is established as a multi-disciplinary collaborative forum to address immediate risk of suicide and self harm. Membership includes roles that could provide ongoing support to detained people including the ACTCS Supports and Interventions Unit,[10] 'Indigenous Services Staff or health provider', or ALOs. All of these roles within AMC could have potentially engaged in a discussion about supporting Detained Person A based on her Risk Management Plan, but none attended the relevant HRAT meetings, nor signed off on her various Risk Management Plans. This was a missed opportunity for identifying culturally appropriate and other supports for Detained Person A after exiting the CSU.

Furthermore, protective factors identified on Detained Person A's Custodial Mental Health support plan (developed as part of the Brief Intervention Clinic) may have assisted COs working with her on a day-to-day basis in the Women's accommodation area and included information directly relevant to the incident on 24 July. For example, Detained Person A notes that attending Cultural Art Program was something that helped her manage her mental health and that being isolated and receiving her mental health medication late were significant risk factors for her. Corrections Officers being aware of likely triggers and potential supports would inform de-escalation strategies. Detained Person A did not consent to this plan being shared with ACTCS prior to the incident, and there is no interdisciplinary forum for considering this sort of information once a detained person is no longer 'at-risk' and considered at the HRAT forum.

All the COs the review team spoke to knew Detained Person A as she had been in custody on many occasions previously and were aware to varying degrees of her mental health challenges and previous self-harming behaviour. However, COs are not trained mental health professionals and a prevention focused plan with multidisciplinary input would have assisted COs in their interactions with her. Detained Person A noted to the review team she had good rapport with some officers, including some regularly posted to the WCC area In interviews some COs spoke with empathy of how Detained Person A experiences custody and faced mental health challenges, while others told the review team they considered her self-harming behaviours were a manipulative attempt to 'get her way'.

The 1991 *Royal Commission into Aboriginal Deaths in Custody* noted the need for key information to be shared between medical and corrections staff to prevent suicide and self-harm:

[10] Referred to using its previous name of Specialist Communities and Specialist Interventions.

> A major deficiency noted in the cases investigated was the failure, or absence, of a system for communication of information relevant to the care of a prisoner, not only between medical and corrections staff (and I include here, communications from corrections to medical staff) but also between corrections staff.[11]

The ACTCS Suicide Prevention Framework adopts a 'person centred approach' and refers to 'cultural responsiveness'. Relevant focus areas include: 'timely identification and support' (to be aware of the warning signs when a client needs help, knowledge of how and when to provide help, and support for clients to access help); and 'collaboration' (for all relevant stakeholders to work together to provide the best possible individualised care, for the client to manage suicidal behaviours and promote wellbeing').

The HRAT Standing Committee's Terms of Reference (2021) pre-dates this strategy. It is timely to review how HRAT is working in practice including against the new Suicide Prevention Framework, to maximise opportunities for reducing risks of self harm.

Recommendation 1:

Within 6 months, ACT Corrective Services and Canberra Health Services complete a review of the current operation of the High Risk Assessment Team against its Terms of Reference and ACT Corrective Services Suicide Prevention Framework to identify:

- opportunities to enhance a prevention-focused multidisciplinary approach to reducing self-harm and suicide risk for people transitioning out of at-risk procedures; and
- means for ensuring Correctional Officers have clear and relevant information on how to best support and engage with someone exiting from at-risk procedure, and appropriate training and support to do this.

5.3 Use of OC spray on someone engaging in self-harm

The review finds that use of OC spray in the circumstances posed significant risk of physical and psychological harm and trauma. While the use of OC spray to respond to a detained person who is self-harming is not explicitly proscribed by policy or training materials, this review finds it should be.

Oleoresin Capsicum (OC) spray, a form of chemical agent, has been available to COs at the AMC since 2020. All trained ACTCS COs carry Mark 4 OC spray as part of their personal issued equipment while on shift at the AMC. Mark 4 OC spray is a handheld aerosol device that delivers a controlled stream of capsaicin-based gel to temporarily incapacitate a person through intense eye, skin, and respiratory irritation.

Figure 4: Mark 4 oleoresin capsicum spray

Legal framework

The authority to use force, including chemical agents, carries significant power and demands the highest level of responsibility, accountability, and professional judgement.

[11] *Royal Commission into Aboriginal Deaths in Custody* (Report, 1991) vol 3, 24.4.38.

Section 138 of the *Corrections Management Act 2007* authorises a CO to use force that is necessary and reasonable, including to prevent a detained person from inflicting self-harm. Under s 138(2) (and the *Corrections Management* (*Use of Force and Restraint) Policy 2024*), an officer may only use force if the officer believes, on reasonable grounds, that the purpose for which force may be used cannot be achieved in another way under the circumstances. This is consistent with the HR Act requirement for proportionality to guide decision making.

All reasonable efforts must be made to de-escalate and resolve a situation through effective verbal and non-verbal communication and without the use of force. The staff member must take into consideration the consequences of the detained person's non-compliance and the risk to the detained person or anyone else. Policy requires that chemical agents must only be used where the circumstances are sufficiently serious to justify the use and the use must be proportionate to the circumstances.

OC Spray Training material

The ACTCS Use of Force training manual provides:

> In general, the most proportionate type of force is the one that establishes control of the detainee with the least potential for injury, or the lower potential for injury for the detainee and officers.[12]

The training materials note that 'OC has no long-lasting side effects or after effects', but may cause a range of short term symptoms including 'immediate respiratory inflammation, which causes uncontrollable coughing, retching, shortness of breath and gasping for air with a gagging sensation in the throat' 'intense burning sensation' of the eyes or 'severe twitching or spasmodic contraction of the eyelids to involuntary closing of the eyes' and 'immediate burning sensation of the skin and mucous membranes inside the nose and mouth'.

The training materials outline operational and tactical benefits of chemical agents such as timeliness, effectiveness, and reduced physical contact between COs and detained people. It is noted that the 'inward focus on pain' caused to the detained person means 'they may give in quickly'. No specific guidance is provided for staff responding to circumstances where detained people are self harming or attempting suicide except to say:

> Special consideration should be given to those at risk of self-harm or suicide, and those with physical or known psychological vulnerabilities such as being victims of torture and trauma.

There is no guidance on 'special consideration'.

The training manual lists contraindications for the use of OC spray (that is, the circumstances it should **not** be used). The circumstances of a detained person is harming themselves or attempting suicide is not listed as a contraindication, although it is arguable that a detained person with a ligature around their neck would come within the first point below.

[12] ACT Corrective Services, Operating Skills and Safety Training: Use of Force Theory Version 5 (30 October 2023).

Extract of ACTCS training guidance on contraindication for use of OC spray

Chemical agents are contraindicated:

- where the possibility of exposure to chemical agents will increase the risk of harm, for example … [a]n officer is being choked by a detainee and another officer come to assist. **The use of a chemical agent may increase the difficulty in breathing the officer is already experiencing**.[emphasis added]
- pregnant detainees
- frail or elderly detainees
- detainees who are effectively restrained by mechanical restraints or by effective control holds
- inside a moving vehicle
- where medical staff provide advise that the person has a medical condition that may be affected by the chemical agent
- a detainee who is known to have undergone LASIK or eye surgery in the last 6 months.
- detainees who are restricted by illness or injury
- detainees armed with a firearm
- detainees who cannot be continually observed
- detainees who are barricaded and entry cannot be made after chemical agent deployment.

Source: Version 5 (30 October 2023) of the ACT Corrective Services Operating Skills and Safety Training: Use of Force Theory, Section 14 – Contraindications.

Staff perspective on use of chemical agents

Staff responses to the HPR25 staff survey indicate a high degree of confidence in their training in use of force and use of OC spray. For example, 86% indicated they felt adequately trained in use of force generally and 91% indicated they felt adequately trained in use of chemical agents. For this review, OICS spoke to six of the COs involved in the response to the incident. Most indicated that other than avoiding its use on a pregnant person they were not aware of any significant contraindications for the use of OC spray.

Several officers said they were unsure why this incident in particular was being reviewed by OICS, implying a perception that the gravity of this incident was not as high as other incidents. This did not align with the gravity of the incident as felt by Detained Person A.

Detained Person A's experience of the OC spray

Although Detained Person A had spent significant time in custody, this was the first time she had been subjected to OC spray. She told the review team she found the experience extremely distressing. She found the decontamination to be ineffective and stated she could feel the effects of the chemical agent on her skin and in her hair for a number of days following the incident. The decontamination process that occurred in the CSU bathroom took less than 8 minutes, far short of the required minimum of 15 minutes access to fresh running water.[13] Her behaviour in the CSU cell after the decontamination suggests she was still feeling the irritant effects of the OC spray, indicated by her rubbing her neck and shoulders and appearing agitated.

[13] *Corrections Management (Use of Chemical Agents – First Aid and Cleaning) Operating Procedure 2024*

Detained Person A described feeling completely powerless, frightened, and unheard in the lead-up to the incident, including her attempts to request transfer to the CSU because she feared she would harm herself. Her experience after the use of OC spray, including the prolonged physical discomfort, and shame and distress of being forcibly transferred from the WR2 accommodation unit while distressed and disorientated in view of other detained women, has had an impact on her self-esteem and mental health. She shared with us that although she had experienced many episodes of serious mental health crisis before involving self-harm, that on this occasion she felt like she was not going to survive.

Conclusion

In summary, under current policy and procedure, arguably the use of OC spray on a detained person engaging in self-harm is lawful **if** it can be considered 'necessary' and 'reasonable' (or 'proportionate' under human rights legislation). Nonetheless, training materials emphasise the tactical benefits of OC spray but provide limited consideration of the negative impacts including distress and trauma particularly for someone engaging in self-harm. Viewed through a gender and cultural lens the impact may be manifold. This incident demonstrates that the stress of exposure is prolonged due to after effects of OC spray and need for adequate decontamination.

It is reasonable to conclude that in the circumstances, officers believed that there was an imminent risk to Detained Person A's life. They were also generally aware of her mental health concerns and history of self-harm. Entry to the cell and staff physically restraining her to remove the ligature were a reasonable response to preserve her life. However, there is no information before the review team to suggest that the use of OC spray in these circumstances was necessary or reasonable. Further, on multiple previous occasions while in custody, including in the weeks prior to this incident Detained Person A engaged in similar self-harming behaviour but OC spray was not deployed. Instead, alternative interventions were utilised by COs.

More broadly, the Inspector is deeply concerned about the use of OC spray on a detained person in mental health crisis, particularly when engaging in self-harm with a ligature. This review concludes some physical use of force was necessary to ensure Detained Person A ceased the self-harming behaviour, particularly to release the ligature from around her neck. However, after reviewing all relevant documentary material, and talking to involved parties, it is not clear what additional benefit the OC spray deployment brought in this situation. Instead, it heightened the traumatic nature of the incident.

Relevant ACTCS policy[14] and training materials do not clearly proscribe the deployment of OC spray on someone who is self-harming. Further, in the review team's view, training materials place insufficient weight on the traumatic impact and risks associated with the deployment of OC spray in these circumstances and focus heavily on tactical benefits more suited to situations where harm is directed by a detained person towards others or they are resisting directions.

Several jurisdictions have provided more explicit guidance and proscriptions around the use of chemical agents than exists in the ACT. For example, in the United Kingdom the equivalent to OC Spray (PAVA) is not used at all in women's prisons. In relation to men's prisons, the HM Prison & Probation Service Use of Force Policy Framework emphasises PAVA should only be used as a **defensive technique** to protect against an immediate threat of harm, where no safer option is available, and only when the response is proportionate to the risk. It specifically refers

[14] *Corrections Management (Use of Force and Restraint) Policy 2024*.

to its use when detained people are presenting a serious risk of harm to themselves or others, noting in particular that there must be serious risks to staff in physically intervening:

PAVA must never be used to manage such incidents unless:

i. there is a serious and imminent risk to the life of the prisoner who may also be threatening others; **and**

ii. intervention is required immediately to prevent that risk; **and**

iii. there are serious risks to staff in physically intervening; and

iv. no other reasonable options are judged to be appropriate.[15]

In the United States' jurisdiction of New York State, a Department of Corrections and Community Supervision staff member may only use a weapon other than a firearm (including OC spray) when the staff member reasonably believes it is necessary for self-defence, to prevent a serious assault or gross destruction of property, to quell a disturbance, to make a lawful arrest or to prevent an escape.[16] In a report for the New Zealand Human Rights Commission, Dr Sharon Shalev concluded the use of chemical agents in prisons is not justified to prevent self-harm.[17]

Avoiding use of chemical agents supports a therapeutic approach which promotes de-escalation and a health response (eg attendance by health professionals), and reduces traumatic impacts arising from the incident. The Inspector therefore recommends that ACTCS prohibit the use of OC spray in response to self harm where the person's behaviour is self directed and there is no immediate threat to others.

Finding 4:

Relevant ACT Corrective Services policy and training material on the use of oleoresin capsicum (OC) spray do not allign with human rights based practice as they do not appropriately consider the physical and psychological impact of oleoresin capsicum (OC) spray on someone who is engaged in self harming behaviour.

Recommendation 2:

Within 6 months, ACT Corrective Services amend policy, training and practice to require that oleoresin capsicum (OC) spray is never used in response to self harm or attempted self harm (where the person's behaviour is self directed and there is no immediate threat to others for example because of a weapon).

5.4 Security response to a mental health crisis

Codes are pre-defined emergency response classifications used inside custodial facilities to communicate critical incidents quickly and to trigger a coordinated, lawful, and proportionate response by staff.

[15] See, eg United Kingdom Ministry of Justice, *HM Prison & Probation Service - 'Use of Force Policy Framework'* (11 September 2025) [12.4, 12.7].
[16] New York State Department of Corrections and Community Supervision, *Use of Physical Force* (Directive, 28 April 2023) 4.
[17] New Zealand Human Rights Commission, *First, Do No Harm: Segregation, restraint and pepper spray use in women's prisons in New Zealand* (Report, 2021) <https://tikatangata.org.nz/cms/assets/Documents/Reports-and-Inquiry/First-Do-No-Harm-Segregation-restraint-and-pepper-spray-use-in-womens-prisons-in-New-Zealand-v2.pdf>

- A **Code Black** is used to signal a threat or actual assault on a staff member or detained person, detained people fighting or a hostage situation.[18] After calling this code, a situation report should immediately be provided including all relevant information such as the location of the incident, if weapons are involved, and if medical assistance is required.
- A **Code Blue** is used for alerting a response to a situation requiring medical assistance, from a minor health issue to life threatening incidents.

Custodial staff told the review team it was at the discretion of the CO calling the code to determine the most appropriate code to call during an incident. Several noted that a Code Black was preferable in a situation such as this, as it provides a timelier response. It was also suggested that due to the more dispersed physical environment of WCC with three cottages (as opposed to a cell block), it is difficult to know the nature of the situation they will be faced with and would feel safer with a more robust response that comes with calling a Code Black.

Figure 5: 12 Corrections Officers outside the cell in WR2,
4 Corrections Officers and Detained Person A are inside the cell at this time

Relevant ACTCS policy requires that the most senior officer should ensure all nonessential personnel are removed from the area. Further, the ACTCS Suicide Prevention Framework's focus area of 'incident management' aspires to 'appropriately manage suicide and attempted suicide and identify areas for continuous improvement', noting that an indicator for success might include 'non-punitive responses to incidents of self-harm'. An excessive staff presence is likely to be perceived as punitive (particularly the presence of the security team wearing personal protective equipment) and may escalate the person's distress. The presence of excess officers can also reflect or reinforce a custodial culture that defaults to command and control approaches rather than therapeutic or person centred care and indicates a gap between stated trauma informed values and actual operational practice.

At least 19 COs responded to the Code Black. This included the security team, and designated Incident Response Officers.[19] The level of response was unnecessary. A follow up radio call should have been made to clarify the nature of the incident and calibrated staff presence accordingly. The level of staff presence further contributed to an already overwhelming and distressing environment for Detained Person A.

Because a Code Blue was not called, Justice Health nurses did not attend, where urgent medical assessment was required. The ACTCS Use of Force Review Committee concluded this incident should have been called as a Code Blue. This review concurs with that opinion.

[18] *Corrections Management (Code Black – Personal Threat) Operating Procedure 2024.*
[19] There is one IRO rostered to each accommodation area each shift.

Finding 5:

The incorrect code was called (a Code Black instead of a Code Blue) which resulted in a security response instead of a therapeutically focused response to self harm.

Finding 6:

The ongoing presence of up to 19 Corrections Officers in response to a self harm incident was not trauma informed and inconsistent with the ACT Corrective Services Suicide Prevention Framework and impacted Detained Person A's privacy and dignity.

Recommendation 3:

Within 6 months, ACT Corrective Services take active steps to enhance a trauma informed response to incidents of serious self-harm consistent with the ACT Corrective Services Suicide Prevention Framwork.

This should be operationalised by:

- always calling a Code Blue;
- standing down all non-essential staff not required on the scene after an initial response;
- reinforcing trauma informed principles through training and staff meetings; and
- for each use of force involving self harm, the Use of Force Review Committee consider whether a Code Blue was called, and if staff presence at the scene was trauma informed.

5.5 Health assessment of Detained Person A's injuries

The failure to inform Justice Health of the emergency

Justice Health Services was not immediately alerted to the incident or any potential physical injury sustained by Detained Person A. A Code Blue would have notified Justice Health staff that their presence was required at a medical emergency, in accordance with the Canberra Health Services policy.[20] Even with the calling of a Code Black, notification to Justice Health was an option, but not one that appears to have been taken. ACT Ambulance Services was not called to attend.

The clinical reviewer considered that an evolving injury to the head and neck was possible and therefore her cervical, vascular and respiratory systems needed to be assessed and protected as a matter of urgency. They were not. In the view of OICS' clinical reviewer, it was likely, given the potential that Detained Person A may have sustained injuries to her neck and throat, coupled with her loss of consciousness, that had Justice Health nurses been called, they would have advised an ambulance was needed on an emergency basis. According to well-known protocols for suspected head and neck injuries, Justice Health nurses would also have likely "sand-bagged' the head and neck regions of Detained Person A to prevent movements of those

[20] Canberra Health Services, *Code Blue Response in Alexander Maconochie Centre (AMC) and Bimberi Youth Justice Centre (BYJC)* (Procedure, 2025).

regions until the ACT Ambulance Service were present with specialist braces and restrictive backboards.

Lack of urgent in situ medical attention was compounded by the decision to transfer Detained Person A to CSU. She had a risk of potential injuries to her head and neck, which that movement could have exacerbated. She was transferred to CSU with her hands cuffed behind her back and COs escorting her with their hands on her arms and shoulders. Although not all CCTV is available, an officer can be seen on the available CCTV applying additional force to the back of her head and neck in response to her resisting against the force being used on her.[21] Detained Person A told the Review Team:

> "I came to it at the gate near the office, I went to move my head and they used excessive force on me and they dragged me like I was a piece of shit."

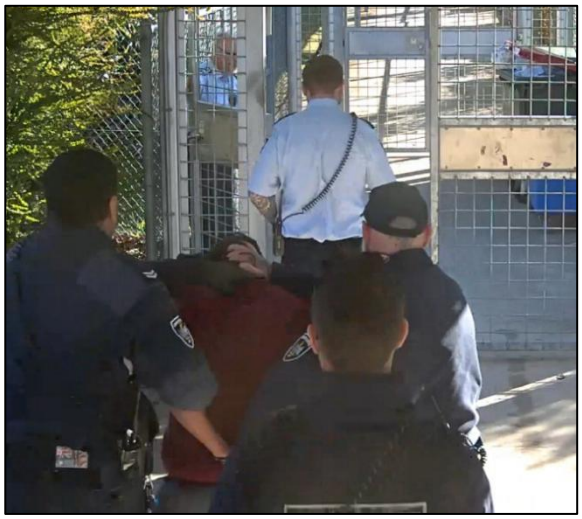

Figure 6: Staff escorting Detained Person A to the CSU

In the view of OICS' clinical reviewer, had Detained Person A sustained a cervical spinal injury during the application of the ligature, this transfer procedure could have converted a trivial injury into a catastrophic one. The Inspector is aware of other critical incidents involving possible head and neck injuries where detained people have had to walk out of their cells. In one case a detained person was later confirmed to have cracked vertebrae. This is a matter of significant concern to the Inspector.

Finding 7:

The decision by ACT Corrective Services staff to not call a Code Blue (medical emergency), and then move Detained Person A from her cell to the CSU risked causing her significant injury in circumstances where she had not undergone any clinical review for potential head, neck and airway injuries.

Recommendation 4:

Commencing immediately, ACT Corrective Services and Canberra Health Services work together to ensure all relevant Alexander Maconochie Centre policies, procedures and training reflect the requirement for urgent medical assistance to be sought, and a detained person to not be moved, in cases of attempted strangulation and other incidents that could result in injuries to the head, neck and spine.

[21] Additional footage is not available due to the PTZ camera not being pointed in the right direction to capture the transfer.

The subsequent health assessments of Detained Person A

It remains unclear when and how Justice Health were alerted of the need to assess Detained Person A for physical injuries following this incident. The ACTCS *Use of Force and Restraint Policy 2024* requires that a detained person subject to a use of force should be examined by a Justice Health Doctor or Registered Nurse within two hours of a use of force, or as soon as practicable.[22] Both ACTCS and CHS record keeping systems provide scant detail of when and how Justice Health was advised of Detained A's injuries and the need to assess her physical health.

There are no clinical records of Justice Health's engagement with Detained Person A on the day of this incident. A note in the ACTCS custodial information system CORIS implies that two Justice Health nurses attempted to see her in the CSU shortly after she was transferred there and that she refused to engage with them. In the absence of any further custodial or clinical records, the review team was unable to ascertain why Detained Person A was not assessed by a Justice Health physician for her potentially significant injuries on the day of this incident. Clinical records indicate that Custodial Mental Health did engage in a brief assessment of her in the CSU, approximately 45 minutes after the incident. It is the view of the OICS' clinical reviewer that records maintained by Justice Health are deficient. The reviewer nonetheless notes that clinical notes by Custodial Mental Health nurses on the afternoon of 24 and 25 July were informative – in the presence of minimal other clinical information.

Clinical records also indicate that a medical officer (doctor) eventually assessed Detained Person A on the afternoon of the following day, 25 July. It is unclear why this occurred more than 24 hours after the incident. It is also unclear when and if she was assessed for potential injuries to her spine or airways. The records suggest that the attendance was due to her losing consciousness on the previous day and was requested by COs. This suggests at some point ACTCS did notify Justice Health of the nature of the incident, or were concerned about Detained Person A's physical health after the incident.

It appears that appropriate hospital-based imaging was never considered, or if it was, there is no written evidence of it. No baseline assessment of physical injury was documented, and no plan for follow-up examination to detect potential evolving injuries was documented.

The lack of a timely primary health assessment and contemporaneous clinical records relating to the incident occurred in the context of a detained person with a known history of complex behaviours and self-harm. Given the ligature injury, exposure to a use of force and OC spray, the risk of head/neck injury, the transfer from WCC to CSU prior to assessment, and the likelihood that the detained person experienced a loss of consciousness, the clinical reviewer concluded that the primary health care provided was sub-optimal. This conclusion is adopted by the Inspector.

[22] In accordance with the *Use of Force and Restraint Operating Procedure 2024*.

Finding 8:

Contrary to policy and best practice, Detained Person A was not assessed in a timely manner by trained health practitioners for her potentially significant physical injuries after the incident. In the absence of clear records, the Inspector is left to conclude this is due to either a failure of ACT Corrective Services to properly inform Justice Health Services of the urgency and/or Justice Health Services not responding in a timely way.

5.6 The Crisis Support Unit (CSU)

The CSU is staffed by COs and was designed to provide short-term accommodation, support, and treatment for detained people who are acutely mentally unwell and at significant risk of suicide or self-harm. However, in recent years it has been used for a range of purposes, including placement of people with complex behaviours, those returning from a hospital stay or those suspected of internally secreting contraband. Men and women are both accommodated in the unit with limited aural and visual privacy. It can be an incredibly challenging work environment for COs, who do not receive any specialised training for working on this post. It is not currently a fit for purpose therapeutic environment to support detained people experiencing mental health crisis. Concerns about the CSU have previously been raised by the Inspector including in HPR25 as well as by other oversight agencies.

Figure 7: Crisis Support Unit cell

Limitations of the CSU for this incident

During this incident, the CSU's limitations in accommodating a woman experiencing mental health crisis were evident. To accommodate Detained Person A in the unit, a detained man had to be relocated from cell 1 to another cell. Correctional Officers were able to quickly remove rubbish left in cell 1, flip the mattress up against the wall and provide a pillow, however the cell was not otherwise cleaned or sanitised prior to Detained Person A being placed there. Despite this, at least one other detained man (and likely others) remained in adjacent cells throughout this incident, compromising privacy and psychological safety of Detained Person A. This issue was also raised by OICS in a 2021 critical incident review of a use of force and strip search on an Aboriginal woman in the CSU, which found:

> [O]ther male detainees in the CSU could not view the use of force or strip search but it is likely that it was clear to some of them what was going on because they could hear the incident and some engaged verbally in the incident from their own cells.[23]

It is important to recognise that, for Aboriginal people, this kind of treatment cannot be viewed in isolation. Witnessing the treatment of an Aboriginal woman, who is also a mother, a sister, an aunty and so much more, in this way is deeply distressing. To see an Aboriginal woman already in crisis treated in a way that strips her of dignity, denies her appropriate care, and places her in degrading conditions is both confronting and harmful. It reflects a broader pattern of responses that lack cultural safety, understanding and compassion, and contributes to the ongoing dehumanisation of Aboriginal women. This is not an isolated incident, but part of systemic practices that continue to disproportionately harm Aboriginal women.

Strip searching upon entry to CSU

The strip search of Detained Person A upon entry to the CSU raises significant concerns about operational practice, which have been highlighted by OICS in previous critical incident reviews,[24] and found by the ACT Supreme Court to be incompatible with human rights (based on the particular circumstances of that case).[25] The *Corrections Management (Detainees at Risk of Self Harm and Suicide) Policy 2022* only states that detained people **may** be searched on entry, in that a detained person in the CSU may be x-ray body scanned or strip searched if there is reasonable suspicion or belief that the detained person has a seizable item concealed on them. The policy also says that the psychological state and risk ratings of the detained person must be considered in determining the appropriate search to avoid unnecessary distress to detained people in crisis.

There was no evidence that any CO held a reasonable suspicion or belief that Detained Person A had any items on her that could be used to harm herself or others. Furthermore, there is no documentation to suggest COs considered a body scan instead of a strip search as a less restrictive option. There is also no documentation that anyone considered the psychological state of Detained Person A and attempted to avoid unnecessary distress to her.

Interviews with COs suggest that some hold the view that all detained people must be searched on entry to the CSU, as it is a 'sterile' environment. This is incorrect.

The Inspector reiterates the concerns raised in earlier reviews regarding the legality, necessity, and potential harm associated with strip searching detained people experiencing mental health crisis, particularly on a routine basis without reasonable suspicion or belief that they have a seizable item in their possession.

Finding 9:

Despite in 2025 the ACT Supreme Court finding the circumstances of a strip search on entry to the Crisis Support Unit (CSU) was unlawful, Detained Person A was subjected to a strip search on entry to the CSU without reasonable grounds.

[23] ACT Inspector of Correctional Services, *Review of a critical incident: Use of force to conduct a strip search at the Alexander Maconochie Centre on 11 January 2021* (Report, 2021).
[24] ACT Inspector of Correctional Services, *Review of a critical incident: Use of force to conduct a strip search at the Alexander Maconochie Centre on 11 January 2021* (Report, 2021).
[25] *Williams v Director-General of the Justice and Community Safety Directorate* [2025] ACTSC 396.

Cultural Safety and the Structural Limits of Custodial Environments

Cultural safety for Aboriginal and Torres Strait Islander peoples refers to environments where individuals feel respected, valued, and free to express their cultural identity without fear of discrimination. It requires recognition and redress of power imbalances, acknowledgment of historical and ongoing trauma, and service delivery that respects cultural identity. Critically, cultural safety is determined by the lived experience of the person receiving the service, not by the intentions of the provider. Prisons are structurally and historically culturally unsafe for Aboriginal and Torres Strait Islander peoples because they are inherently built on control, surveillance, and coercion, which conflict with Aboriginal and Torres Strait Islander values of connection to land, kinship, community, and self-determination. Given the impacts of colonisation, over-incarceration, and intergenerational trauma, it is argued that custodial settings can at best aim to provide culturally aware and responsive services, including informed practice, staff education, and partnerships with Aboriginal Community Controlled Organisations.

It is positive that the ACT has an Aboriginal Community Controlled Health Organisation, Winnunga Nimmityjah Aboriginal Health and Community Services providing health services in the AMC.

Aboriginal and Torres Strait Islander peoples continue to experience significant harm in custody due to unconscious bias and systemic racism embedded across the justice system. The Jumbunna Institute's Independent Review into the Over-Representation of First Nations People in the ACT Criminal Justice System identified widespread systemic racism across policing, corrections, and government agencies, noting inadequate cultural recognition and disproportionate exposure to traumatic practices such as use of force and strip searching. Healthy Prison Review of the AMC 2025 data, found Aboriginal and Torres Strait Islander men were involved in 36% of use of force incidents despite comprising 30% of detained men(women were involved in 31% of use of force incidents but made up 39% of detained people). Aboriginal and Torres Strait Islander women accounted for 48% of all strip searches of women, and men for 31% of strip searches of men. Strip searching, use of force and use of OC compound trauma and undermine safety, dignity, and rehabilitation outcomes for Aboriginal and Torres Strait Islander people in custody.

5.7 Cultural safety and supports

In reviewing this incident, the structural limitations of custodial environments in providing culturally safe and responsive services and supports for Aboriginal and Torres Strait Islander detained people must be considered. Both the Jumbunna Review and HPR25 acknowledged that while ACTCS has made policy commitments to cultural safety and cultural competency through *Be the Change We Seek: Aboriginal and Torres Strait Islander Framework,* there remains gaps between intent and practice. The Jumbunna Review found limited evidence of how cultural safety is operationalised at the AMC and recommended the development of an AMC specific Cultural Safety Action Plan to translate these commitments into concrete programs, procedures and staff training. OICS supported this recommendation and continues to encourage the ACT Government to implement this recommendation to ensure culturally responsive, trauma-informed care for Aboriginal and Torres Strait Islander people in custody.

Access to culture for Aboriginal and Torres Strait Islander people in prison is essential to maintaining connection to identity, kin, and community, and serves as a critical protective factor against trauma, supporting emotional wellbeing, self-regulation, and rehabilitation in an inherently disempowering environment. During this period of custody, Detained Person A's access to culture was at times restricted either through overly bureaucratic processes or as a

punitive response to incidents linked to her mental health presentations. As discussed in section 5.1 of this report, approval for her to attend the AMC NAIDOC Day event was denied for reasons that are not clearly documented in her custodial file. A case note from the ACTCS ALO suggests the decision related to her not being in custody during the application period, while Detained Person A advised the review team that she was told the refusal was due to insufficient time in custody to assess her behaviour. It was perplexing to her that she had been approved as an external visitor to that event, but this approval had been withdrawn due to her incarceration.

Her act of protest against a rejection of an opportunity to exercise her cultural rights and attend NAIDOC day celebrations resulted in the imposition of a disciplinary penalty which further limited her access to culture and supports. The compounding response isolated her for 28 days, restricted her access to cultural art programs and seeing kin, and limited her contact with family in the community to one phone call and visit per week. The RCIADIC identified isolation and segregation as having particularly harmful impacts on Aboriginal people in custody, and stated that such practices are "undesirable in the highest degree." Recommendation 181 emphasises that segregation should be avoided wherever possible for Aboriginal people in custody and, where it is used, mandates strict minimum standards and continued access to visitors and supports to mitigate harm. Detained Person A described the period around the incident as an extremely distressing time for her, and she was deeply impacted by having limited access to her family and support networks.

Given the significant power held by decision-makers in determining the treatment and care of people in detention, it is essential that culturally informed input is embedded at all key stages of decision-making. This includes meaningful involvement from identified Aboriginal roles and organisations to the greatest extent possible, including the ACTCS Aboriginal and Torres Strait Islander Services Unit, Aboriginal Community Controlled Organisations and Aboriginal Community Controlled Health Services and the Aboriginal Official Visitor to ensure decisions are culturally informed, trauma-informed, and representative of Aboriginal perspectives. There were notable gaps in this instance, with no cultural input or consideration evident in decision-making relating to discipline, or managing her mental health. After the incident, the Use of Force Review Committee where this incident was considered included cultural representation which is appropriate and important although minutes do not reflect any discussions of cultural considerations.

OICS acknowledges some of the cultural supports available at the AMC, including Winnunga, ACTCS and JHS ALOs, the Aboriginal Official Visitor, and some programs delivered by community organisations including ACCOs. However many of these services are constrained by limited resources and competing priorities. This reduces their capacity to meet the needs of the Aboriginal and Torres Strait Islander population at the AMC. Managing the expectations placed on these services by ACTCS, detained people, and the broader Aboriginal community further compounds the challenges in meeting demand. It is critical these services are appropriately supported, resourced and sustainably funded, particularly given that Aboriginal and Torres Strait Islander people comprise more than one-third of all detained people at the AMC.

In HPR25, OICS identified ongoing capacity challenges within the ACTCS Aboriginal and Torres Strait Islander Services Unit, particularly workload pressures and limits on detained people's access to ALOs. The review noted that ALOs carry a broad and competing set of responsibilities, restricting their ability to provide regular and proactive contact with all Aboriginal and Torres

Strait Islander detained people at the AMC. Their cultural support role is also not always well understood by staff or detained people, leading to misaligned expectations about their function.

These issues were evident in this incident. Detained Person A reported experiencing a lack of cultural support from ACTCS ALOs during a period of acute need and subsequently disengaged from the service. Custodial case notes indicate that ALOs attempted to engage with her but explained their limited capacity and focus on 'cultural matters'. This misalignment between expectations and service capacity reflects the broader systemic issues identified in HPR25 (Finding 29).

Access to culturally appropriate healthcare was further limited by Detained Person A being on the waitlist for Winnunga at the time of the incident. While having health services delivered directly by an ACCHO, represents best practice for culturally responsive healthcare in prison, OICS has previously noted that capacity constraints often result in lengthy wait times, meaning Detained Person A was unable to access culturally safe healthcare when needed. This was compounded by limited visibility and availability of Canberra Health Services ALOs at the AMC, with Detained Person A stating she was unaware such support existed until after the incident.

Although Detained Person A did access cultural supports during her time in custody, much of this occurred after the incident. This included support from the Aboriginal Official Visitor and efforts were made to facilitate kinship visits; however, these visits were inconsistent, often dependent on individual staff approval and operational requirements, limiting their reliability as a source of ongoing support.

Taken together, the circumstances surrounding this incident reflect the ways in which systemic racism and unconscious bias affect custodial decision-making. Structural constraints, overly bureaucratic processes, and restricted access to cultural supports disproportionately impacted Detained Person A as an Aboriginal woman. Several aspects of her time in custody illustrate how systems not designed with the needs of Aboriginal and Torres Strait Islander people in mind inadvertently cause harm. These include the denial of, and conditional access to culture, the absence of appropriate cultural input at key decision points, the interpretation of her behaviour as attention seeking and manipulative and the compounding effects of disciplinary responses to deteriorating mental health.

While the review team did not identify any overtly racist actions, policies or procedures that alone explain the outcome of this incident, the cumulative effect of these factors and likely unconscious bias demonstrate how entrenched systemic issues continue to undermine culturally responsive, trauma-informed care for Aboriginal and Torres Strait Islander people in custody.

In response to a draft of the report, the government noted that the incident "show[ed] areas where cultural considerations should/could have been made and the impact not taking the appropriate considerations can have / had but they do not show systemic racism, unconscious bias or likely unconscious bias. It is difficult to demonstrate systemic issues in a single event even where the issues are broad". Nonetheless the Inspector maintains the view that rather than a single event, this was a cascading series of decisions and circumstances that in sum demonstrate systemic racism and implicit bias.

In 2025, the Jumbunna Institute (University of Technology Sydney) conducted an Independent Review into Over-Representation of First Nations People in the ACT Criminal Justice System. The Inspector again endorses the recommendations of that Review, and encourages the Government to implement them as a priority.

Finding 10:

Detained Person A's treatment in the lead up and response to her self harm show examples of systemic racism and implicit bias. These include the denial of, and conditional access to culture, the absence of appropriate cultural input at key decision points, the interpretation of her behaviour as attention seeking and manipulative and the compounding effects of disciplinary responses to deteriorating mental health.

5.8 Reflective practice and continual improvement

Use of Force Review Committee

The ACTCS Use of Force Review Committee (the Committee) is responsible for the timely and structured reviews of uses of force.[26] The Committee considers CCTV footage and incident reports and refers matters of particular concern to the Commissioner.

The Committee has recently updated its Terms of Reference in early 2026, aiming to strengthen oversight of use-of-force incidents and supporting more consistent and accountable decision-making. This is to be commended.

The inclusion of the Senior Director of Cultural Services — an identified Aboriginal position — as a member of the Committee is a positive feature, supporting culturally informed reflective practice of incidents and consideration of the impacts of use of force on Aboriginal people. As identified in HPR25, Aboriginal and Torres Strait Islander people are overrepresented in the AMC detainee population compared to the community. To maximise the benefit of this role and avoid siloed approaches, the Inspector suggests this position also be included in reviews of uses of force involving non-Aboriginal detained people. This would reinforce shared accountability and support consistent organisational learning across all cohorts.

In relation to this incident, the Committee identified several concerns that align with the findings and recommendations of this review. This included that a Code Blue (Medical Emergency) should have been called. In relation to the excessive number of COs who responded to the incident, the Committee noted that the senior CO present (a CO3) should have instructed unnecessary staff to return to their posts and retained only those essential for managing the situation.

During interviews with OICS, staff interviewed told OICS they had not received any feedback from the review of the incident by the Committee on this incident. Some commented that in their experience feedback from the Committee is rarely communicated back to frontline officers.

[26] The Committee meets weekly for most incidents, or within two days where OC spray is used.

The Terms of Reference for the Committee do not specify how findings and feedback will be communicated to frontline staff. Without effective feedback loops, an opportunity is missed to maximise organisational learning and the impact of the Committee's work. Consideration should be given to addressing this issue as part of the terms of reference review.

Finding 11:

That feedback arising from the ACT Corrective Services' Use of Force Review Committee meetings is not routinely communicated to frontline staff, limiting opportunities for learning and continuous improvement.