



## **CONCLUSIONS REACHED IN THE MOSS REPORT**

### **“So Much Sadness in our Lives” - Independent Inquiry into the Treatment in Custody of Steven Freeman**

The following is a list of ‘conclusions’ contained in the Moss Report shown by paragraph number (e.g. 2.1.3). Where more than one conclusion is contained in a paragraph they are shown separately [e.g. 2.1.2 (1) and 2.1.2(2)].

#### **2.1.2 (1)**

When Steven Freeman arrived at the AMC he would have been unwell and vulnerable after a prolonged period of drug and alcohol use. The Inquiry concludes that a number of factors combined to place Steven Freeman unknowingly in harm’s way at the AMC.

#### **2.1.2 (2)**

The Inquiry concludes also that had measures and processes adopted since Steven Freeman’s assault been in place when he was admitted, including the assessment of new receptions in a separate unit generally for five days, the likelihood of his being assaulted would have been significantly reduced.

#### **2.1.3**

The Inquiry concludes further that the agencies involved in the care of detainees need to find a way to share relevant detainee-related information, yet take into account all legislative, professional and ethical obligations.

#### **2.1.13**

The Inquiry concludes there was no follow-up after 9 September 2015 regarding Steven Freeman’s head injury. Justice Health Services did not revisit early advice to ACTCS regarding the nature of his injuries. For its part, the AMC did not act upon the Justice Health Services advice that Steven Freeman had suffered a serious head injury.

#### **2.2.1**

The Inquiry concludes there is a need to reform the AMC (ACTCS) / Justice Health Services (ACT Health) relationship under contract or memorandum of understanding (MOU) to improve information sharing and to reflect the AMC responsibility and accountability for the management of detainees’ safety and wellbeing. This MOU should reflect that Justice Health Services must meet professional health standards and protect patient privacy and confidentiality.

#### 2.2.2

Recognising the significant proportion of Indigenous detainees at the AMC, the Inquiry concludes there is a need to introduce Winnunga Nimmityjah Aboriginal Health Service to provide its holistic approach to health care for Indigenous detainees at the AMC.

#### 2.2.4

The Inquiry concludes the AMC should segregate remanded and sentenced detainees, by establishing at the AMC a separate remand facility, and thereby achieve greater human rights compliance.

#### 7.2.12

The MOU covers transfer of custody and other topics including intelligence exchange, investigations, police responses to incidents at the AMC and DNA back-capture. The Inquiry notes that ACT Health is not a party to the MOU, but concludes it would also benefit from a transfer from ACT Policing of health, wellbeing and other relevant information.

#### 7.2.14

The Inquiry notes that ACT Policing's record of interview of 27 April 2015, made reference to Steven Freeman's recent illicit drug and alcohol use. The Inquiry notes also that ACT Policing did not provide this information to ACTCS until 15 March 2016, almost a year after Steven Freeman's admission to the AMC. This situation may explain why the ACTCS Court Transport Unit Risk Assessment Form records that Steven Freeman showed no signs of being under the influence of substances. The Inquiry concludes that there was a deficiency in procedure, in that ACT Policing did not being provide this information to ACTCS or ACT Health.

#### 7.2.15

Accordingly, information which ACT Policing knew regarding Steven Freeman's illicit drug and alcohol use and difficulty in answering questions was not available to ACTCS and Justice Health Services. It meant that the opportunity for appropriate assessment and treatment for Steven Freeman on his arrival at the AMC was lost. The Inquiry concludes also that a placement at AMC based on detoxification and rehabilitation would have been more appropriate.

#### 7.2.16

The Inquiry concludes further that the lack of a comprehensive approach to information sharing between ACT Policing and ACTCS was a factor in Steven Freeman's assault in April 2015.

#### 8.2.7

The Inquiry concludes youth justice information should be available to the AMC when it is assessing the accommodation placement options for new detainees.

#### 8.2.9

The Inquiry notes the AMC's induction process required Steven Freeman himself to identify detainees of concern. The assessment took place when, unknown to the ACTCS, Steven Freeman had been using illicit drugs and alcohol for a

prolonged period. The Inquiry concludes this approach placed too great an onus on Steven Freeman to identify the risk in the accommodation options.

#### 8.3.6

The Inquiry concludes that Justice Health Services failure to inform both the AMC and TCH about Steven Freeman's "significant daily ICE habit" was a deficiency.

#### 8.3.8 (1)

The Inquiry concludes also that this situation reveals an instance of inadequate information sharing in relation to Steven Freeman.

#### 8.3.8 (2)

The Inquiry concludes further that the agencies involved in the care of detainees need to find a way to share relevant detainee related information, yet take into account all legislative, professional and ethical obligations.

#### 8.4.6

The Inquiry concludes that, at the AMC, the need to accommodate increasing numbers of detainees, with a wide range of categories and classifications, has been a factor in undermining the original aim of a human rights compliant prison with a focus on rehabilitation.

#### 8.4.9

The Inquiry concludes that, at the time, the AMC admission process was deficient in that it relied on Steven Freeman to provide information about his own risk factors rather than AMC-collected information from a wider range of sources (such as ACT Policing, Justice Health Services, and Youth Justice) collated with its own intelligence.

#### 8.4.11

The Inquiry concludes also that there was a deficiency in Steven Freeman's treatment at the AMC, in that the period of induction and admission was insufficient.

#### 8.4.16

The Inquiry concludes further that a number of factors, as referred to above (eg his likely being unwell and vulnerable), combined with the result that Steven Freeman was placed unknowingly in harm's way.

#### 8.4.19

The Inquiry concludes further that had these measures and processes been in place when Steven Freeman was admitted to the AMC, the likelihood of his being assaulted would have been significantly reduced.

#### 8.6.6

The Inquiry concludes the ACTCS response following Steven Freeman's assault was appropriate.

#### 8.7.2

The Inquiry concludes the Justice Health Services immediate response to Steven Freeman's assault was appropriate.

#### 9.1.6

The Inquiry concludes that the next of kin of a detainee at TCH should be provided information about the detainee's condition and prognosis, when the detainee is unconscious and cannot give consent.

#### 9.2.5

The Inquiry concludes that in future, Justice Health Services should ensure that it shares all relevant health information about a detainee who is transferred to hospital.

#### 10.1.13

The Inquiry was told that Steven Freeman originally appeared in court wearing a hospital gown, but was unable to verify this report. Nevertheless, the Inquiry concludes that ACT Health and ACTCS need to ensure detainees transferred from hospital to the courts are provided with clothes and do not appear only wearing hospital garments. In response, ACT Health told the Inquiry it will work with ACTCS to address this issue.

#### 10.1.14

The Inquiry concludes the options available to Magistrate Dingwall in considering Steven Freeman's bail application were lacking in that the Aboriginal community was not able to participate and there were limited supported accommodation options available for the magistrate to consider outside the AMC.

#### 11.1.7

The Inquiry concludes that ACTCS and ACT Policing should update their MOU to reflect changes made in August 2015 (as listed as paragraph 11.1.4), and this MOU be subject to ministerial approval.

#### 11.1.18

The Inquiry understands that the CCTV cameras in operation at the time of Steven Freeman's assault had the capability to "sweep", although they were not used in this way. The Inquiry notes that one of the cameras could be moved to observe Steven Freeman's cell door, as occurred when the Code Pink was called. The Inquiry concludes that ACTCS considering increased use of sweeping CCTV cameras regularly.

#### 11.1.20

The Inquiry concludes also that ACTCS should log all movements of CCTV cameras consistently with the requirements of the Australian Standard.

#### 11.1.22

The Inquiry concludes further that training consistent with the Australian Standard is not given to CCTV operators at the AMC.

#### 11.1.26

The Inquiry concludes further that the security of the AMC is lessened by the incorrect time being displayed on CCTV footage, which makes it unnecessarily difficult to determine the time of incidents within the AMC.

#### 11.1.28

This measure was abandoned in February 2011 due to problems with the battery life of RFID bracelets. The Inquiry concludes further the use of RFID bracelets and anklets should be explored again. The use of such bracelets at the time of Steven Freeman's assault would have identified who was in his cell.

#### 11.2.11

The Inquiry understands that ACT Policing already has a pro-arrest policy in relation to family violence matters. The Inquiry concludes that a similar pro-charge policy is required for violent incidents at the AMC.

#### 11.2.12

The Inquiry concludes also that the investigations of serious assaults at the AMC should also be given a higher priority by ACT Policing. The Inquiry notes that during Steven Freeman's bail hearings, ACT Policing gave evidence that they were not treating his assault as an attempted murder investigation.

#### 11.3.8 (1)

The Inquiry concludes that consideration should be given to how ACTCS and ACT Policing can work together in the context of investigations to achieve a coordinated, rather than serial and separate approach, to matters at the AMC.

#### 11.3.8 (2)

The Inquiry concludes also that ACTCS and ACT Policing should determine how joint investigation would enhance the response to any incident of assault at the AMC.

#### 12.2.21

TCH discharge procedure is for a discussion to be held with the patient's carers. This discussion includes the need for vigilance about post-concussive or post-traumatic brain injury syndrome. The symptoms that need to be monitored include any alteration of sleep patterns, increased irritability, impaired concentration, and potential for ongoing headaches which may last for many months after a significant head injury. The Inquiry notes that this discussion is not documented in Steven Freeman's clinical record or discharge summary from TCH. The Inquiry concludes this lack of documentation is a deficiency in record keeping.

#### 12.2.24

The Inquiry concludes also there was no follow-up after 9 September 2015 regarding Steven Freeman's head injury. Justice Health Services did not revisit its 7 May 2015 advice to ACTCS. For its part, AMC staff members did not act upon the Justice Health Services advice of 7 May 2015, for example assessing whether Steven Freeman had impaired learning or cognitive function.

12.2.27

The Inquiry concludes further that the standard of Justice Health Services record keeping and documentation is minimal, if not at times inadequate.

12.2.28

The AMC relies on information from Justice Health Services to manage detainees both collectively and individually. Accordingly, the Inquiry concludes further that poor clinical record keeping may have an adverse affect on the AMC's ability to make proper provision for any given detainee.

12.2.36 (1)

The Inquiry concludes that the monitoring of Steven Freeman following his head injury was not adequate. Justice Health Services advised the AMC on 20 May 2015, to cease the observation regime with no information about potential symptoms of concern.

12.2.36 (2)

The Inquiry concludes also that the AMC was not alerted to the need to monitor Steven Freeman for certain behaviour or issues of concern, particularly in relation to his head injury.

12.2.40

The Inquiry notes the five-month delay in Steven Freeman receiving a dental appointment, and concludes that this delay in obtaining treatment indicates a deficiency in the provision of dental care.

12.2.47

The Inquiry concludes that the involvement of Winnunga Nimmityjah's holistic model of health care would enhance the provision of mental health and counselling services at the AMC (see paragraph 12.2.59 for a discussion).

12.2.53

The Inquiry concludes that there would be considerable benefit for Aboriginal and Torres Strait Islander detainees if Winnunga Nimmityjah Aboriginal Health Service's holistic approach was integrated into the health care which Justice Health Services provides.

12.2.57

Steven Freeman's experience at the AMC indicates that inadequate information sharing was a factor in the deficiencies evident in his treatment. Accordingly, the Inquiry concludes that, if AMC management is to have overall responsibility for outcomes and incidents relating to detainees, it must have access, to the extent possible, to all relevant information.

12.2.60

The Inquiry concludes also that a significant role for Winnunga Nimmityjah Aboriginal Health Service is necessary, given the need to enhance the care available to Indigenous detainees in the AMC. The present limited involvement of

Aboriginal-led health services in an institution with a detainee population of twenty-five per cent Aboriginal and Torres Strait Islander peoples is not acceptable.

12.2.61

In light of the RCIADIC recommendations, the Inquiry concludes further that ACTCS and ACT Health work with Winnunga Nimmityjah Aboriginal Health Service to fund and embed its holistic health model for Aboriginal and Torres Strait Islander clients. There are several benefits to this approach, including enhanced throughcare for detainees leaving the AMC.

12.2.62

In proposing this approach, the Inquiry notes that there will need to be a mechanism to ensure that the arrangements established under contract or MOU are workable at the operational level and that issues of concerns can be resolved as they arise. Accordingly, the Inquiry concludes further that a coordinating committee needs to be established. The committee would comprise representatives of the AMC, Justice Health Services and Winnunga Nimmityjah Aboriginal Health Service.

12.2.66

The Inquiry notes that these conclusions are not a reflection on the provision of service provided by Justice Health Services. The Inquiry concludes further that it is wholly professional. The proposed new framework seeks to improvement the care and custody of Indigenous detainees in the light of Steven Freeman's experience. The aim is also to prevent serious assault and death in custody.

12.2.68

The Inquiry concludes further that the new framework proposed for the provision of health services at the AMC requires resources for the enhanced role for Winnunga Nimmityjah Aboriginal Health Service.

12.3.7

The Inquiry notes the inconsistency in the legislation on the question of whether remanded detainees should have individual case plans. Given the long periods of time a detainee sometimes spends on remand at the AMC, the Inquiry concludes that individual case management plans should be in place for remanded detainees too.

12.3.24

The Inquiry concludes that the lack of a structured day at the AMC inevitably leads to boredom, which invites the possibility and added risk of detainees using illegal drugs.

12.3.28

The Inquiry concludes that if a separate remand prison were established AMC, there were improvements in a number of areas, including rehabilitation services, human rights compliance and personal safety of remanded detainees.

#### 12.4.3

The Inquiry concludes it was a breach of the ACTCS Drug Testing Policy that Steven Freeman was not drug tested at admission.

#### 12.4.6

The Inquiry concludes also it was a deficiency in Steven Freeman's treatment in custody that he was not referred to a therapeutic program, such as the Solaris Therapeutic Community.

#### 12.4.11

The Inquiry concludes that the solely punitive response to Steven Freeman under the 2015 ACT Drug Testing Policy was inappropriate.

#### 12.4.12

The Inquiry concludes also that a more appropriate response would have included therapeutic treatment, which would have assessed Steven Freeman, in order to understand the reason(s) for the renewed drug use, including a consideration of whether that drug use was a form of "self-medication" for one reason or another.

#### 12.7.6 (1)

The Inquiry concludes that this level of training is inadequate, both in terms of the proportion of staff members who have undertake the program and the method of training.

#### 12.7.6 (2)

The Inquiry concludes also that all Justice Health Services staff should undertake cultural awareness training, on commencement at the AMC, and on a refresher basis thereafter. This training is particularly important while the ACT continues to have a significant number and proportion of Aboriginal and Torres Strait Islander persons in custody.

#### 12.7.11

The Inquiry concludes that ACTCS should not undertake cultural activities without consulting with the relevant family. If the family cannot be contacted, ACTCS should consult with Aboriginal organisations supporting the family.

#### 12.8.11

The Inquiry concludes that it is inappropriate for the AMC to have to rely on "exceptional circumstances" to breach the human right of a remanded detainee to be segregated. In reaching this conclusion, the Inquiry acknowledges that, as a one institution corrective services system with limited accommodation options, the AMC management regards the personal safety of detainees as its highest priority.

#### 12.8.12

The Inquiry concludes also that AMC management needs to be able to achieve both obligations of detainee safety and human rights.



#### 12.8.16

The Inquiry notes further that, while both Official Visitors are female, until very recently, all Aboriginal case managers and Indigenous liaison officers at the AMC were male. Accordingly, female Aboriginal and Torres Strait Islander detainees could not be supported by equivalent Indigenous female staff. The Inquiry concludes further that this situation was inappropriate. Moreover, an Indigenous leadership forum told the Inquiry that this situation may also have been culturally inappropriate. Having passed on these observations to ACTCS, the Inquiry notes that, with effect from 2 November 2016, the AMC has seconded a female Aboriginal case manager.

#### 12.8.19

The Inquiry concludes further that, the claim so commonly made about the AMC being human rights compliant cannot be made in good faith. Until such time as male and female detainees are in separate facilities, and remanded detainees are segregated from sentenced detainees, the AMC cannot be said to be a human rights compliant correctional facility.

#### 12.10.8

The Inquiry concludes that for each member agency to respond more effectively to detainee issues, there is a need for them to be as informed as possible about the AMC. Oversight can only be effective if information from and about detainees is available.

#### 12.10.9

Noting the role the Inquiry proposes for the Winnunga Nimmityjah Aboriginal Health Service at the AMC (to introduce its holistic approach to health care) the Inquiry concludes also that it would be desirable for Winnunga Nimmityjah to be included in this forum.

#### 12.10.14

The Inquiry notes the concerns of Narelle King, her family and the broader community about the lack of information about Steven Freeman's assault, and the manner and cause of his death in custody. Two submissions to this Inquiry also raised concerns about the lack of transparency into that matter and other critical incidents at the AMC. The Inquiry concludes that, in order for trust to be restored and maintained in the ACT's corrections system, independent reviews are required for all critical incidents at the AMC. In the Inquiry's view, a critical incident would include any serious assault.

#### 12.10.16

The Inquiry concludes also that ACT Ombudsman should be resourced to undertake regular administrative and procedural inspections of the AMC to provide early warning of systemic issues and assurance that policies and procedures are in place and implemented effectively.

#### 12.11.8

The Inquiry concludes that any detainee concerns about the arrangements for visits at AMC is a matter for the ACT Ombudsman, ACT Human Rights Commission and Official Visitors.

12.12.9 (1)

The Inquiry concludes that the current system of notification regarding deaths in custody by ACT Policing is inappropriate, particularly for Aboriginal and Torres Strait Islander peoples. The Inquiry notes that ACT Policing treat all deaths in custody as a criminal investigation, and so must be involved in notification to the family.

12.12.9 (2)

The Inquiry concludes also that ACTCS should attempt to attend with ACT Policing when they notify the detainee's family, preferably an ACTCS Indigenous Liaison Officer.

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