ICS
ACT Inspector of Correctional Services

REPORT OF A REVIEW OF A CRITICAL INCIDENT

by the

ACT INSPECTOR OF CORRECTIONAL SERVICES

Assault of a detainee at the Alexander Maconochie Centre on 5 December 2019
(CIR 03/19)

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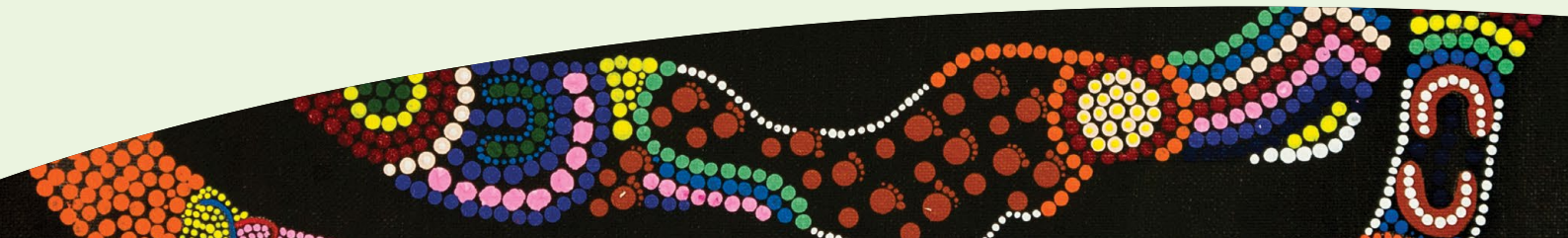

Rainbow Serpent (above and cover detail)
Marrilyn Kelly-Parkinson of the Yuin Tribe (2018)

ABOUT THIS REPORT

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ACT Inspector of Correctional Services

We acknowledge the traditional custodians of the ACT, the Ngunnawal people. We acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

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Assault of a detainee at the Alexander Maconochie Centre on 5 December 2019
(CIR 03/19)

Neil McAllister
ACT Inspector of Correctional Services
15 April 2020

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Letter of Transmittal

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Madam Speaker

I am pleased to provide you with a report entitled 'Report of a Review of a Critical Incident by the ACT Inspector of Correctional Services: Assault of a detainee at the Alexander Maconochie Centre on 5 December 2019' for tabling in the Legislative Assembly pursuant to Section 30 of the *Inspector of Correctional Services Act 2017* (ACT) (the Act).

This report was prepared pursuant to Section 17(1)(c) and (d) of the Act.

As required under Section 29 of the Act a draft copy of the review was provided to Shane Rattenbury MLA, Minister for Corrections and Justice Health and Richard Glenn, Director-General of the Justice and Community Safety Directorate, and comments have been considered.

Yours sincerely

Neil McAllister
ACT Inspector of Correctional Services
15 April 2020

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1. EXECUTIVE SUMMARY

1.1 On 5 December 2019 a male detainee (Detainee V) was assaulted in a cell by another detainee (Detainee X) at the Alexander Maconochie Centre. Detainee V suffered lacerations to his finger and face.

1.2 Corrections Officers (COs) were supervising medication dispensing and became aware of the incident when Detainee X motioned to them that he needed to be released from the cell block. COs responded to the incident in a timely manner.

1.3 There was no intelligence available to ACT Corrective Services (ACTCS) to suggest that the incident was reasonably foreseeable.

1.4 Detainee V and Detainee X were serving similar length sentences of imprisonment. The review team found that they were both appropriately classified as Medium security and that their placement in the same unit was reasonable.

1.5 Overall, the review team finds that the assault was not reasonably foreseeable by ACTCS. On the whole, the actions of ACTCS were appropriate in the circumstances, although improvements could be made in relation to evidence handling and the notification of next of kin. In addition, no staff debrief was held.

1.6 The review team was pleased to see significant improvements in ACTCS procedures for the use of investigative segregation since previous reviews conducted by the Office of the ACT Inspector of Correctional Services.

1.7 As required under s29 of the *Inspector of Correctional Services Act 2017* (ACT) a draft copy of this report was provided to the Hon Shane Rattenbury MLA, Minister for Corrections and Mr Richard Glenn, Director-General of the Justice and Community Safety Directorate. The Minister and Director-General had no comments on the draft report.

2. FINDINGS & RECOMMENDATIONS

Finding 1:	That AMC staff responded in a timely manner to the incident
Finding 2:	That AMC staff could have better complied with the *Corrections Management (Management of Evidence) Procedure 2018*.
Finding 3:	That contrary to the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019*, no 'hot' debrief was reported to have occurred after the incident.
Finding 4:	That Detainee V and Detainee X were appropriately classified as Medium security.
Finding 5:	That there were no active intelligence notes that would indicate that the incident was reasonably foreseeable.
Finding 6:	There were no failings of security procedures or practices that contributed to the assault on Detainee V.
Finding 7:	That notifications of the incident were made in accordance with policies and procedures.
Finding 8:	That the record keeping around next of kin notification was inadequate.
Recommendation 1:	That ACTCS implement the use of an Incident Checklist to ensure that all notifications are made and recorded, including the time of successful notification.
Finding 9:	That Detainee X's segregation was reviewed in accordance with the *Corrections Management Act 2007* (ACT), though the incorrect timing of the review was communicated to Detainee X.

3. INTRODUCTION

3.1 Authority to conduct a review of a critical incident

Section 18(1)(c) of the *Inspector of Correctional Services Act 2017* (ACT) (the Act) provides that the Inspector *'may review a critical incident on the inspector's own initiative or as requested by a relevant Minister or relevant director-general.'* This review was conducted at my own initiative.

3.2 What is a 'critical incident'?

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

(g) an assault or use of force that results in a person being admitted to a hospital;

This review concerns an event relevant to s17(2)(g) in that it was an assault resulting in the victim being admitted to The Canberra Hospital (TCH).

3.3 What must the Inspector report on?

Section 27 of the Act requires that the Inspector include certain things in a report of a review. In a previous report the Inspector noted that this section was directed towards the content of 'examinations and reviews' of correctional centres and correctional services but was ambiguous in relation to the content of reviews of critical incidents.[1] This report, like the previous critical incident reports tabled in the Legislative Assembly, has been structured to capture the spirit and intent of s27 but without specific reference to some of the topics.

3.4 Public interest considerations relating to this report

Section 28(1) of the Act provides that *'the inspector must consider whether any part of the report must be kept confidential because—*

(a) *there are public interest considerations against disclosure; and*

(b) *those considerations outweigh the public interest in favour of disclosure.'*

Section 28(2) details grounds of public interest against disclosure. In accordance with s28(2)(d), certain information that might reveal the identities of detainees and staff involved in the incident has been withheld in this report.

3.5 The Review Team

The review team comprised:

- Holly Fredericksen, Assistant Inspector of Correctional Services.

1 ACT Inspector of Correctional Services (2018), *Report of a review of an assault of a detainee at the Alexander Maconochie Centre on 23 May 2018,* OICS, Canberra, 6.

4. FORM OF THE REVIEW

4.1 The Act does not specify what form a review must take. In order to take a consistent approach to the review of critical incidents, the Office of the ACT Inspector of Correctional Services (OICS) has devised two types of reviews that may be conducted.

4.2 The first is a "desk-top" review of documents and reports, including audio/visual records if applicable, provided by ACT Corrective Services (ACTCS) and other agencies e.g. ACT Health. A desk-top review does not involve OICS in direct action such as interviewing staff or detainees and is more likely to be conducted where the circumstances of an incident are reasonably self-evident.

4.3 The second form of a review is one carried out by OICS utilising if necessary, the full powers of the Inspector under the Act. This type of review could be conducted following or instead of a desk-top review and is more likely to be conducted in response to very serious or problematic incidents such as an escape from secure custody.

4.4 In the case of the incident that is the subject of this report, I decided to conduct a desk-top review because I was of the opinion that the CCTV recording and officer reports were such that further inquiries were not warranted.

5. THE REVIEW

5.1 How, when and where the incident occurred

5.1.1 The incident occurred at approximately 9:30am on 5 December 2019 in a cell block housing male detainees at the Alexander Maconochie Centre (AMC). Corrections Officers (COs) were supervising medication dispensing in an adjoining cell block when they noticed activity in the block where the incident occurred. They observed that Detainee X (alleged perpetrator) had isolated himself in the external recreation yard. He appeared distressed, had a significant amount of blood on his clothing and was motioning to be released from the cell block into the internal corridor connecting the cell blocks. The COs opened the door to allow this.

5.1.2 At this time, other detainees in the cell block alerted staff that Detainee V (the victim) required medical attention. Detainee V was holding a towel to his face and had blood present on his face and body. The COs removed Detainee V from the cell block and all other detainees were secured in their cells.

5.1.3 A review of the CCTV footage revealed that Detainee X approached Detainee V in the external recreation yard then they both walked towards a cell. While entering the cell Detainee X removed an object from the front of his pants. It is alleged that that object was an improvised weapon ("shiv"). The cell door is closed with both detainees inside, and there is no CCTV coverage inside the cell. It is alleged that at this time Detainee X used the shiv to inflict lacerations to Detainee V's face and finger.

5.1.4 A short time later, Detainee X can be seen scrambling from the cell with Detainee V attempting to grab hold of him. Detainee X moved through the common area of the cell block towards the external recreation yard. Another detainee (Detainee Y) then attempts to approach Detainee X but is held back by another detainee (Detainee Z). Detainee X then held the door to the recreation yard closed from the outside.

5.1.5 After Detainee X moved away from the door, Detainee V entered the recreation yard but is prevented from approaching Detainee X by Detainee Z. COs then released Detainee X from the recreation yard into the internal corridor. Detainee X walked over to the entrance to an adjoining cell block where he yells through the glass something to the effect of "I got him. I got him."[2]

5.1.6 Detainee X was then escorted to the Hume Health Centre (HHC) where he was assessed by health staff. Here he voluntarily handed the shiv to COs.[3] Detainee X was then escorted to Admissions where COs conducted a strip search and his clothing, shoes and the weapon were bagged as evidence. He was then escorted to the Management Unit.

5.1.7 Detainee V was removed from the unit and escorted to the HHC. While at the HHC, photos were taken of Detainee V's injuries and his clothes were bagged as evidence. After his injuries were assessed by a registered nurse, he was escorted to TCH. He returned to the AMC at approximately 6pm the next day. Detainee V reported to an AMC staff member that he received 54 stitches.[4]

5.1.8 Detainee V stated to COs that he thought the incident was in retaliation for his statement to detainees that he did not want weapons present in the unit. However, other intelligence information received after the event suggests that Detainee V was engaged in "stand-over"[5] behaviour in relation to other detainees and the incident was in retaliation for this.

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

5.2.1 Corrections Officers responded to the incident when Detainee X alerted them of his need to be released from the external recreation yard. They called a Code Purple (Detainees Fighting) and then a Code Pink (Medical Emergency). Staff responded in a timely manner to these codes.

Finding 1:

That AMC staff responded in a timely manner to the incident.

5.2.2 When escorting Detainee V from the unit building, he saw Detainee X on the walkway and attempted to push past the COs to approach him. Minimal use of force on Detainee V was required to prevent this. However, it may have been possible to avoid this by ensuring Detainee X was no longer visible, or at least through the next secure gate, before releasing Detainee V from the unit.

Evidence Handling

5.2.3 The cell where the incident had occurred was secured shortly after the incident. After all detainees in that cell block had been secured, the common areas were also secured. A CO attended HHC to photograph Detainee V's injuries, which Detainee V consented to. The whole cell block remained secured until police arrived at approximately 11am.

5.2.4 However, both Detainees V and X were escorted to other areas of the centre prior to their clothing and shoes being collected, placed and stored in appropriate evidence bags. Section 2.5 of the *Corrections Management (Management of Evidence) Procedure 2018* states: 'Bodily fluids associated with the crime scene must be retained at the crime scene, where possible until ACT Policing have attended.' Both

2 Reports from Corrections Officers.
3 Reports from Corrections Officers.
4 Not confirmed with Justice Health.
5 Detainee-on-detainee threatening behaviour to gain something.

detainees had blood on their clothing and so these items should have been removed from the detainees before they were escorted from the unit.

5.2.5 According to officer reports, Detainee X was assessed at HHC as having no injuries. It was as this point that he voluntarily surrendered the weapon. The CO who it was handed to then handed it to another CO, and it was not until after they had escorted Detainee X to Admissions that the weapon was bagged as evidence. This is contrary to s2.4 of the *Management of Evidence Procedure* which states 'The handling of evidence must be kept to a minimum.'

Finding 2:

That AMC staff could have better complied with the *Corrections Management (Management of Evidence) Procedure 2018.*

Staff debrief

5.2.6 This assault constituted an 'incident' under the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019*. Under this policy a 'hot' debrief should occur immediately after every incident and a report on this debrief should be completed and emailed by the appropriate manager. No debrief was held.

Finding 3:

That contrary to the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2019*, no 'hot' debrief was reported to have occurred after the incident.

5.3 Assessment, classification and accommodation of the detainees

5.3.1 Detainee V is a medium security detainee serving a moderately long sentence for a violent theft-related offence. He has been in the AMC since early 2019 and is in his mid-twenties. He has a short and mixed criminal history.

5.3.2 Detainee X is a medium security detainee serving a moderately long sentence for violent theft-related offences. He is in his early twenties, has been in the AMC since early 2019 and has a criminal history beginning as a young person that includes numerous violent and theft-related offences.

5.3.3 Neither detainee identifies as Aboriginal or Torres Strait Islander.

5.3.4 The *Corrections Management (AMC Detainee Classification) Policy 2012* sets out the factors that must be considered in determining a detainee's security classification and the effects of detainee classification on accommodation placements. Medium security is the default classification for new receptions to custody where high levels of risk are not identified.

5.3.5 Having reviewed the criminal histories and related materials the review team is satisfied that Detainee V and Detainee X were appropriately classified as Medium security.

Finding 4:

That Detainee V and Detainee X were appropriately classified as Medium security.

5.4 Whether there was any intelligence or other information in existence prior to the incident which might have indicated that the incident was reasonably foreseeable

5.4.1 The review team examined ACTCS intelligence notes made on the "named" detainees. There are no relevant notes on either Detainee V or Detainee X made before the incident.

5.4.2 Detainee V has been involved in a number of violent and aggressive incidents in the AMC, where he was often identified as the perpetrator. Detainee X has also been disciplined for violent incidents in the AMC, including assaults on other detainees.

5.4.3 There are credible previous reports indicating that Detainee X and Detainee V had joined together in assaults on other detainees. With the benefit of hindsight, this suggests that they had a recent falling-out over some unknown matter(s). It is not reasonable to suggest that ACTCS intelligence staff should have been aware of this falling-out.

Finding 5:

That there were no active intelligence notes that would indicate that the incident was reasonably foreseeable.

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

5.5.1 The cell block where the incident occurred is not subject to constant staff presence. COs monitor the cell block by "line-of-sight" from the central officers' station and via CCTV. They also enter the cell block to conduct musters[6] regularly during un-lock hours, to conduct cell and general inspections, undertake searches when required and to interact with detainees to facilitate daily activities.

5.5.2 The incident occurred when COs were supervising medication dispensing in the area external to the cell block. While this means there were fewer COs who were able to observe the cell block, it is unlikely that this contributed to the assault as COs could have still entered the area at any time.

Finding 6:

There were no failings of security procedures or practices that contributed to the assault on Detainee V.

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

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

5.6.2 Both the policy and the operating procedure require that ACT Policing be notified of incidents that may require their attendance (e.g. alleged assault). ACT Policing was advised of the assault on Detainee V shortly after it occurred and attended the AMC at approximately 11am the same day.

5.6.3 The *Incident Reporting, Notifications and Debriefs Policy* also requires that ACTCS notify the detainee's next-of-kin as soon as practicable 'where the detainee has experienced a serious injury or illness and been admitted to a health facility'.

6 The process of COs accounting for detainees by sight.

In addition, '[a]ll attempted and completed notifications to a detainee's next of kin must be recorded on the detainee's electronic record system'.

5.6.4 An email from the Area Manager at approximately 4pm confirms Detainee V's admission to hospital and states 'We are currently in the process of informing his chosen next of kin.' There is no record made of whether this notification was successful. Issues with ACTCS' notification of detainees' next of kin have also been noted in previous critical incident reviews conducted by OICS.[7]

5.6.4 The *Incident Reporting, Notifications and Debriefs Policy* deals with notification of critical incidents to the Inspector of Correctional Services.[8] More detailed arrangements concerning critical incidents are set out in a Memorandum of Understanding (MOU) between the Inspector and ACTCS (dated August 2018).[9] With regard to this incident, oral and written notifications were provided to the Inspector in accordance with the MOU.

Finding 7:

That notifications of the incident were made in accordance with policies and procedures.

Finding 8:

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

Recommendation 1:

That ACTCS implement the use of an Incident Checklist to ensure that all notifications are made and recorded, including the time of successful notification.

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

5.11.1 The review team notes that this incident involving detainee on detainee violence potentially engages a number of rights in the *Human Rights Act 2004* (ACT) (HR Act). Of most relevance to Detainee V as the victim of the assault is the right to protection from cruel, inhuman or degrading treatment in s10(1)(b), and the right to humane treatment when deprived of liberty in s19 of the HR Act.

5.11.2 These human rights provisions require ACTCS to take positive steps to protect detainees from violence and ill-treatment by other detainees, including by implementing measures such as security screening and risk assessment in accommodation placement, searching and confiscation of weapons. In this case, the review team's opinion is that appropriate positive steps were taken by ACTCS and that the assault was not reasonably foreseeable.

7 ACT Inspector of Correctional Services (2019), *Report of a review of an assault of a detainee at the Alexander Maconochie Centre on 15 April 2019) (CIR02/19)*, Canberra; ACT Inspector of Correctional Services (2019), *Report of a review of an assault of a detainee at the Alexander Maconochie Centre on 1 January 2019 (CIR 01/19)*, Canberra; ACT Inspector of Correctional Services (2019), *Report of a review of an assault of a detainee at the Alexander Maconochie Centre on 16 December 2018*, Canberra.

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

9 The MOU is appended to an earlier report, ACT Inspector of Correctional Services (2018), *Report of a review of an assault of a detainee at the Alexander Maconochie Centre on 23 May 2018, Canberra.*

5.11.3 The weapon used in the incident was made from everyday items used by detainees. Unfortunately, it is not feasible to remove all possible items that could be used to make a weapon from the AMC. Noting this, ACTCS does take positive steps to find and confiscate weapons, such as through cell searches. The review team's opinion is that there were no further steps that ACTCS should have taken to prevent the alleged use of this weapon.

Post incident segregation

5.11.3 Detainee X was placed on investigative segregation (under s160(1) of the *Corrections Management Act 2007* (ACT)(CM Act)) in the Management Unit immediately after the incident. In a previous critical incident review conducted by OICS,[10] significant shortcomings were identified in the AMC's use of investigative segregation. A recommendation in that report was 'That segregation orders pinpoint the legal authority in the *Corrections Management Act*'.

5.11.4 It is pleasing to see that significant improvements have been made in this regard. The updated Initial Segregation Form contains a tick-box section for the authority to segregate under the CM Act. It also contains sections for both the context of the incident and detailed reasons for the segregation. This form was properly completed for the segregation of Detainee X.

5.11.5 The updated Segregation Review Form is also a significant improvement. It requires the reviewer to thoroughly consider the need to continue segregation, including by commenting on 'the status of the risk relating to the initial segregation' and considering how these risks can be mitigated. This form was completed for Detainee X and signed by the Head of Security and General Manager of Custodial Operations to revoke the segregation direction on 10 December 2019 at approximately 3:30pm. The timeliness of this review and sign off is good practice. It is curious that the reviewer's statement on this form that the offence was 'out of character with his incarceration history' is not supported by Detainee X's custodial record.

5.11.6 Under the *Corrections Management (Management of Segregation and Separate Confinement) Policy 2019,* a review of investigative segregation must occur within three business days after the direction is approved. Detainee X was segregated on Thursday 5 December at 4pm. Under the policy, his segregation had to be reviewed before 4pm on Tuesday 10 December.

5.11.7 However, the notification provided to Detainee X stated that his segregation would be reviewed on Sunday 8 December 2019. At approximately 8pm that evening, Detainee X contacted the CO on duty asking if his segregation finished today. That CO told Detainee X to ask officers in the morning as they were unable to give details of his segregation.

5.11.8 While the timing of the review of Detainee X's segregation was consistent with the policy (and the CM Act), care needs to be taken to ensure that detainees are informed of the correct date of the review of their segregation.

Finding 9:

That Detainee X's segregation was reviewed in accordance with the *Corrections Management Act 2007* (ACT), though the incorrect timing of the review was communicated to Detainee X.

10 ACT Inspector of Correctional Services (2019), *Report of a review of an assault of a detainee at the Alexander Maconochie Centre on 1 January 2019 (CIR 01/19).*

6. OTHER MATTERS ARISING FROM THE REVIEW

6.1 There were no other matters arising from the review.

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