ICS
ACT Inspector of Correctional Services

REPORT OF A REVIEW OF A CRITICAL INCIDENT

by the

ACT INSPECTOR OF CORRECTIONAL SERVICES

Escape of a detainee from a secure escort on 9 July 2021
(CIR 04/21)

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

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

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

ABOUT THIS REPORT

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ACT Inspector of Correctional Services

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

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Escape of a detainee from a secure escort on 9 July 2021
(CIR 04/21)

Neil McAllister
ACT Inspector of Correctional Services
November 2021

CONTENTS

GLOSSARY

Term	Meaning
ACTCS	ACT Corrective Services
ACTP	ACT Policing (AFP)
AMC	Alexander Maconochie Centre (ACT adult prison)
CTU	ACTCS Court Transport Unit
CM Act	*Corrections Management Act 2007* (ACT)
CO	Corrections Officer ("prison officer")
EMF	ACTCS Emergency Management Framework 2018 (restricted publication)
ICS Act	*Inspector of Correctional Services Act 2017* (ACT)
Inspector	ACT Inspector of Correctional Services
OICS	Office of the Inspector of Correctional Services
DCCO	ACTCS Deputy Commissioner Custodial Operations – responsible for the CTU
AMCTU	Area Manager, CTU
CTU Review	ACT Inspector of Correctional Services (2020), *Report of a review of the ACT Corrective Services Court Transport Unit*, Canberra
Detainee Z	Escapee
Person A	Alleged driver of Jeep that rammed ACTCS escort vehicle
Person B	Alleged passenger in Jeep that rammed ACTCS escort vehicle
TCH	The Canberra Hospital
CSU	Crisis Support Unit (at AMC)

1. EXECUTIVE SUMMARY

At about 2pm on 9 July 2021, a detainee attended the Alexander Maconochie Centre (AMC) Hume Health Centre and told staff that he had swallowed a damaged battery. A duty Doctor contacted The Canberra Hospital (TCH) and was advised that the detainee needed to attend TCH for assessment due to the risk of harm if the battery leaked. A three-officer escort was arranged, which departed AMC for TCH at 4pm in an AMC Toyota Camry. The detainee was handcuffed in the rear seat with an officer on either side of him. The escort officers were unarmed in accordance with usual practice.

As the vehicle was approaching the Hindmarsh Drive/Mugga Lane intersection from the east it was rammed in the rear by a white Jeep with a bull bar. Officers first thought that it was a simple traffic accident, however the Jeep rammed the escort Camry a second and then a third time, the last of which caused the Camry to spin around facing in the opposite direction towards Fyshwick. Fearing that the attackers in the Jeep may be armed, the escort decided to drive to the AFP offices in Barton via back streets to minimise risks to the public. The Jeep followed the escort and continued to ram it until the escort vehicle was forced to stop in Oxley Street, Griffith when a tyre (or tyres) deflated. Although now stationary, the Camry was rammed again by the Jeep which caused the escort team to exit the vehicle with the detainee. An officer had hold of the detainee's handcuffs but was forced to let go when the detainee ran towards and jumped into the Jeep which sped off.

The three escort officers involved in this violent incident conducted themselves with absolute professionalism and are deserving of commendation for their actions on the day

The review concludes that while the escape was not reasonably foreseeable by ACT Corrective Services (ACTCS) there are matters that need to be addressed by ACTCS to minimise the likelihood of incidents of this type occurring in the future.

Firstly, the report notes that prior concerns raised by OICS about the use of Camry sedans as secure escort vehicles in our CTU Review were not heeded by ACTCS.

Recommendation 1:

That ACT Corrective Services ensure that secure vehicles are used to transport detainees unless there are exceptional circumstances that make an unsecure vehicle a more appropriate choice (for example, detainees with particular medical conditions, attending funerals, low security detainees engaged in pre-release programs etc). If an unsecure vehicle is used, a full risk assessment must be completed and approved in advance (note Recommendation 5 of this review).

The review found that staff were unclear about what the ACTCS required response was for an escape from an external escort. Further as this incident unfolded, a number of staff attended the scene without specific authorisation to do so. In OICS view this was due to a lack of clear direction from ACTCS to staff (delivered through training, policies, procedures, etc) about how to respond in this sort of situation. There are too many sources of information for staff to consult in the event of an incident involving an external escort.

Recommendation 2:

That ACTCS review the *Corrections Management (Escort) Policy and Operating Procedure 2017 (No 2)* to provide clear directions to staff about responses to incidents involving external escorts, including but not limited to, which staff positions at AMC and/or the Court Transport Unit may be required to respond to the scene of the incident.

This incident exposed some problems with the AMC Master Control Room (MCR) concerning communications within AMC and with the escort team.

Recommendation 3:

That ACT Corrective Services review and document the roles, staffing, management and operation of the AMC Master Control Room and any special training requirements for staff rostered in the Master Control Room.

Management of the incident by AMC Operations staff was somewhat impeded by having to deal with telephone calls from family and friends of staff and off-duty staff making enquiries about the incident.

Recommendation 4:

That ACT Corrective Services issues a clear directive to all staff that only staff who are specifically authorised to do so are permitted to disclose the occurrence of an incident to a member of the public or an off-duty staff member.

The review also found that there are fundamental problems with the ACT Corrective Services external escort Security Risk Assessment and Removal Authority (SRARA) tool. We note that while this issue was not a causal factor in this escape, it nonetheless needs to be addressed as a matter of urgency.

Recommendation 5:

That ACT Corrective Services review the process by which external escort security arrangements are determined with the aim of simplifying the decision making along the lines of the Queensland Corrective Services' *Custodial Operations Practice Direction, Movement and Transfers.*

AMC staff do not receive any special training in the conduct of external escorts. In practice, any rostered officer could be assigned to an escort team with little notice, regardless of their level of experience.

Concerning the transport of detainees, the review found that there is scope for better use of the CTU to conduct AMC secure escorts (as it has in the past) but the current arrangement of the CTU reporting to the Deputy Commissioner Custodial Operations inhibits AMC from tasking the CTU even if the CTU could assist.

Recommendation 6:

That ACT Corrective Services put in place arrangements that would allow the General Manager, AMC to request escort assistance direct to the Court Transport Unit and for the Court Transport Unit to provide such assistance where its operational commitments to the courts can be accommodated without detriment to its primary functions.

As we noted at the opening of this Executive Summary, the three escort officers involved in this incident conducted themselves in an exemplary manner while, as they told us, being in fear of their lives. The officers expressed gratitude for the support they had received from their peers and an external support agency based in Victoria. However, all three felt that the services provided by the Employee Assistance Program (EAP) were generic rather than specific to the trauma they experienced during the incident.

For some staff involved in traumatic incidents[1] a combination of support services may be sufficient to help them through the post-incident period and move forward. However, some may require longer term specialist assistance (e.g. psychologist) to help them deal with the trauma they have experienced.

Recommendation 9:

That ACT Corrective Services provide for the psychological support of staff involved in traumatic incidents through the provision of post incident debriefing with qualified professional providers and ongoing psychological treatment where such ongoing treatment is medically assessed to be in the best interests of a staff member. This ongoing support should not be dependent on the outcome of a worker's compensation claim.

There were two security-related matters that we are not able to detail in this public report but are the subject of recommendations:

Recommendation 7:

That ACT Corrective Services enhance the tracking facility of all Operations vehicles in the AMC and Court Transport Unit fleets to ensure that they can be accurately located at all times.

Recommendation 8:

That ACT Corrective Services and ACT Policing develop and implement a "duress system" for all Operations vehicles in the AMC and Court Transport Unit fleets to provide for direct access to ACT Policing in the event of an emergency i.e. a system which does not involve the use of the public "000" phone number.

1 Traumatic incidents should be broadly defined to include incidents such as assaults on staff, riots, deaths in custody, etc.

2. CONTEXT, SCOPE AND METHODOLOGY

2.1 Authority to conduct a review of a critical incident

Section 18(1)(c) of the *Inspector of Correctional Services Act 2017* (ACT) (ICS Act) provides that the Inspector '***may*** *review a critical incident on the inspector's own initiative or as requested by a relevant Minister or relevant director-general*' (emphasis added). However, the ICS Act does not provide guidance as what the Inspector should consider when deciding whether to review a critical incident, noting that we have elected not to review some relatively low-level ACTCS' incidents in the past (detailed in our annual reports). In order to provide some clarity around this decision making process, we have developed and published an operating procedure on our website.

We determined that this incident met our review criteria (see the procedure) of:

- seriousness;
- public reporting considerations; and
- prevention considerations.

Under the 'prevention considerations' we note that to the best of our understanding, this is the first escape from an ACTCS secure escort and thus the potential for lessons learned for ACTCS are significant.

2.2 What is a 'critical incident'?

Section 17(2) of the Act provides a list of events that are critical incidents, including at part (c), 'an escape from custody'.

This review concerns an event relevant to section 17(2)(c) in that a detainee escaped from ACT Corrective Services custody whilst being escorted to The Canberra Hospital.

2.3 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.[2] This report, like the previous critical incident reports tabled in the Legislative Assembly, has been structured to capture the spirit and intent of section 27 but without specific reference to some of the topics.

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

2.4 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 section 28(2)(b) certain information that may assist escape or attempted escape has been withheld, and in accordance with section 28(2)(d), certain information that might reveal the identities of detainees and staff involved in the incident has been withheld in this report.

2.5 The review team

The review team comprised:

- Neil McAllister, Inspector of Correctional Services
- Rebecca Minty, Deputy Inspector of Correctional Services
- Pip Courtney-Bailey, Assistant Inspector of Correctional Services

2.6 Form of the review

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

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

The second form of a review is one carried out by 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.

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

3. HOW, WHEN AND WHERE THE INCIDENT OCCURRED

3.1 Background on those involved in the incident

3.1.1 Detainee Z

Detainee Z[3] is a 29 year old male serving a 14 year sentence imposed in NSW, which commenced in 2015. He is eligible for parole in 2024. Detainee Z's NSW offences were of a serious nature involving aggravated break and enter, assault and firearms charges. Detainee Z was transferred to the ACT in March 2020 on compassionate grounds. He had previously served a short sentence in AMC in 2012 after breaching a good behaviour order related to a number of traffic offences.

Detainee Z was classified as Medium Security at his most recent classification review on 8 July 2021. His classification score was at the higher end of the Medium range. OICS considers that the classification was appropriate.

3.1.2 Person A

Person A is a 28 year old female with a history of motor vehicle and stolen property-type offences in the ACT. The matters were dealt with without the imposition of custodial sentences, and in some cases, with no conviction recorded.

Person A had visited Detainee A in AMC previously but was refused entry to AMC to visit him in March 2021 after she had a positive response from a drug detection dog. Person A was listed as a visitor, email and telephone contact for Detainee Z.

3.1.3 Person B

Person B (female) is believed to be a friend of Person A. Person B was not listed as a visitor, email or phone contact for Detainee Z.

3.2 The incident

At about 2pm on 9 July 2021, Detainee Z attended the AMC's Hume Health Centre and told staff that he had swallowed a damaged battery. A duty Doctor contacted TCH and was advised that Detainee Z needed to attend TCH for assessment due to the risk of harm if the battery leaked. A three-officer escort was arranged, which departed AMC for TCH at 4pm in an AMC Toyota Camry. Detainee Z was handcuffed in the rear seat with an officer on either side of him. The escort officers were unarmed in accordance with usual practice.

As the vehicle was approaching the Hindmarsh Drive/Mugga Lane intersection from the east it was rammed in the rear by a white Jeep with a bull bar. Officers first thought that it was a simple traffic accident, however the Jeep rammed the escort Camry a second and then a third time, the last of which caused the Camry to spin around facing in the opposite direction towards Fyshwick. Fearing that the attackers in the Jeep may be armed, the escort decided to drive to the AFP Head Quarters/training centre in Barton via back streets to minimise risks to the public.

3 Whilst the identities of Detainee Z and Person A have been widely reported in the media, it has been OICS' practice not to name staff, detainees or other people mentioned in reports.

The Jeep followed the escort and continued to ram it until the escort vehicle was forced to stop in Oxley Street, Griffith when a tyre (or tyres) deflated. Although now stationary, the Camry was rammed again by the Jeep which caused the escort team to exit the vehicle with Detainee Z. An officer had hold of the detainee's handcuffs but was forced to let go when the detainee ran towards and jumped into the Jeep which sped off.

The driver of the Jeep was heard to say, "(name) get in".

Shortly before the escort entered Oxley Street a female (believed to be Person B) was seen exiting the Jeep and then walking off in the direction of Manuka.

At various times during the chase, Detainee Z reportedly said things like "they are here to kill me', "she is going to fucken kill me", "she is going to shoot me", "she is going to shoot us".

After the first ram attack on Hindmarsh Drive, the escort officers called a Code Blue[4] on their radio but this was mis-heard in the AMC Master Control Room (MCR) as a Code Blue in the AMC Women's Community Centre (WCC). This initial confusion was clarified, and support officers were despatched to the scene from AMC. At about the same time, an escort officer called "000" on an AMC issued mobile phone for police assistance. An MCR operator also called "000". By the time AMC officers reached Oxley Street, police crews were already on-site.

The escort officers were treated at the scene then taken to TCH for further assessment.

3.2.1 Prelude to the incident

Suspicions were raised on 9 July 2021 when Detainee Z reported swallowing a damaged battery as this would quite likely involve him being taken for X-rays at TCH. Acting on intelligence information[5], ACTCS alerted TCH security as to the possible location of a "package" at TCH near the imaging department. TCH security conducted a search and found a package containing contraband.

Detainee Z was informed about the finding of the package and asked, in effect, if he still needed to go to hospital. He strenuously denied any knowledge of the package and asked to go back to his cell where he would "pass" the battery naturally. When told if he did not consent to going to TCH he would have to go to the AMC Crisis Support Unit (CSU) under observations, Detainee Z changed his mind and agreed to go to TCH.

OICS notes that notwithstanding that Detainee Z was monitored closely by ACTCS intelligence staff, there were no indications of him planning an escape that would have been apparent without the benefit of hindsight.

Finding 1:

That the escape was not reasonably foreseeable by ACT Corrective Services.

4 Staff Member Assaulted / Under Threat of Assault.

5 Known to OICS but which can't be detailed publicly in this report.

3.2.2 *Planning the escape?*

Detainee Z rang Person A at 10:47am on 9 July 2021 but the phone was answered by another woman.

Detainee Z rang Person A again at 1:30pm on 9 July 2021. They had a conversation about Person A getting a car, ensuring that it was fuelled and asking/confirming if everything was ready. In this call, Person A states the car is 'the best one I could have picked'[6]. There is a vague conversation about dinner arrangements that night for Detainee Z's mother[7]. Detainee Z talks about going up to 'health' and possibly going to hospital and that he will call Person A before he goes up to health[8].

With the value of hindsight, this conversation was about the escape but that would not have been obvious to a listener at the time, noting that while calls are recorded, they are not necessarily monitored in real time (live). The details of the escape may have been discussed during one of Person A's visits to Detainee Z[9] with this telephone conversation being the culmination of the plan.

However, it is not known how Person A knew when Detainee Z left AMC or what vehicle he was travelling in. The CCTV footage from the AMC car park does not show the escort vehicle being followed by a white Jeep or other unknown vehicle. Further, Detainee Z would not have known exactly when the escort was departing or in what specific vehicle. However, hospital escorts almost always follow the most direct route to TCH in one of AMC's Camry cars, fitted with ACT government number plates.

3.2.3 *The Camry escort vehicle*

In our CTU Review we noted:

> During the review, the CTU received a Toyota Camry to replace their eight-seat Toyota HiAce van (Romeo 1). ACTCS advised the review that the vehicle was 'purchased specifically for detainees at risk of suicide or self-harm…' and that 'the seating configuration is driver, and two staff in the back seat on either side of the detainee.'[10]
>
> The *Corrections Management (Escort) Policy and Procedure 2017* specifies that detainees at-risk 'due to suicide or self-harm concerns must be escorted in a sedan or station wagon'. However, CTU officers believe the Toyota Camry is too small in situations where staff need to wear bulky personal protection equipment (PPE), such as body pads, on escorts of potentially violent detainees. One officer described it as 'unfit for purpose'.
>
> In reality, and even leaving aside the PPE issue, a Toyota Camry is a mid-sized family car with a back seat that would be a tight squeeze for three average size adults. It is unclear to us why an at-risk detainee could not be transported safely in a larger-seat capacity vehicle that would provide more room for the detainee and safe-distancing of staff. Further, as the Camry is unsuitable as a general-use escort vehicle it may end up being underutilised and poor value for money.

While the Camry used to transport Detainee Z was not the CTU Camry, it was nonetheless a basic family sedan.

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6 It is alleged by ACTP that the vehicle was a white Jeep Wrangler stolen from a car dealer on the morning of 09/07/21.

7 May have been "code talk".

8 No record of such a call from an official prison phone.

9 Recent visits were 2 and 4 July 2021. Note that conversations during visits are not intentionally overheard by staff.

10 Email from ACTCS on 22/05/20.

Source: ACTCS 2021

Detainee Z was a handcuffed, medium-security detainee under a three-officer escort, in recognition of his lengthy and serious criminal history and his suspected involvement in a contraband plant at TCH.

Had Detainee Z been transported in a secure CTU vehicle such as Romeo 3 (photo below), he would have been secured in a locked pod in the rear of the vehicle, separate from the escort officers.

Source: ACTCS 2019

Recommendation 1:

That ACT Corrective Services ensure that secure vehicles are used to transport detainees unless there are exceptional circumstances that make an unsecure vehicle a more appropriate choice (for example, detainees with particular medical conditions, attending funerals, low security detainees engaged in pre-release programs etc). If an unsecure vehicle is used, a full risk assessment must be completed and approved in advance (note Recommendation 5 of this review).

4. POLICIES AND PROCEDURES

The following ACTCS policies and procedures are relevant to an escape from an escort:

- *Corrections Management (Escape or Attempted Escape from Escort) Procedure 2011*
- *Corrections Management (Escort) Policy and Operating Procedure 2017 (No 2)*
- *Corrections Management (Incident Response) Operating Procedure 2020*
- *Corrections Management (Code Green – Escape or Attempted Escape) Procedure 2014 (No 1)*
- *Corrections Management (Code Blue – Staff Member Assaulted) Procedure 2014*
- *Corrections Management ACTCS Emergency Management Framework (EMF) 2018* (RESTRICTED)

4.1 Response to an escape from an escort

The EMF states that 'The Master Control Room will initiate a response in accordance with the *Corrections Management (Incident Response) Policy 2014* and the *Corrections Management (AMC Incident Response) Procedure 2011',* which was revoked and superseded by the *Corrections Management (Incident Response) Operating Procedure 2020.*

The *Incident Response Operating Procedure 2020* states that 'Only those officers **directed to respond** will attend an incident in order to ensure capacity to respond to secondary incidents' (emphasis added). The procedure also stipulates a number of specific positions within AMC who are to respond to incidents as the First Response and Second Response. However, the procedure does not provide any direction as to responses to an off-site (e.g. escort escape) incident.

The *Corrections Management* (*Escape or Attempted Escape from Escort) Procedure 2011* states that 'The Master Control Room will initiate a response in accordance with the [revoked] *Incident Response Policy and Procedure.*' The procedure requires that 'Once an escape or attempted escape has been discovered, the Senior Escort Officer is to liaise with the Master Control Room at the AMC/CTU (depending on where the escort initiated from, and the time of day) regarding the appropriate response.'

The *Corrections Management* (*Code Blue – Staff Member Assaulted) Procedure 2014* states that 'The Control Room will initiate a response in accordance with the [revoked] Incident Response Policy and Procedure.' The *Code Blue – Staff Member Assaulted Procedure 2014* appears to be directed only at incidents within AMC i.e. it does not mention off-site incidents.

The *Corrections Management (Escort) Policy and Operating Procedure 2017 (No 2)* states that 'In the instance of an escape or attempted escape, refer to the *Escape or Attempted Escape from Escort Procedure* (2011) and the [revoked] *Incident Response Policy and Procedure.*' The procedure provides no other directions as to responses to an escape incident.

Taking the relevant policies, procedures and the EMF together, there is no clear guidance to AMC or CTU staff about how they should respond to an escape from an off-site escort. This may explain why the response to the escape of Detainee Z appears to have been somewhat ad hoc (see below).

Finding 2:

That ACTCS did not have any clear guidance about how staff were expected to respond to an escape from an external escort.

4.2 How ACTCS responded to the escape

At about 4:10pm on 9 July 2021, AMC was alerted by a radio call from the Detainee Z escort that the escort required assistance (Code Blue call). The AMC Officer in Charge (OiC) was CO3 A who directed CO3 B and a CO1 dog handler[11] (CO1 C) to attend the scene of the incident. CO3 B directed CO1 D to join the response, and the three officers departed AMC in a dog (K9) unit vehicle. At that time the OiC was of the understanding that an "incident" of some type had occurred at TCH and deployed the officers as back-up. On learning of the escape, the OiC redirected the response team and deployed two further officers (I & J) to the crash scene.

At about this time, four other COs also responded to the scene in one of the officer's private car.

A CO from the CTU also attended the scene on hearing about the incident on their way home after completing their shift at the CTU.

It seems that 10 officers attended the scene of the incident, all of whom arrived after police had secured the scene.

While OICS understands the motivation of staff to go to the aid of their colleagues in a serious situation, only five of the responders were actually directed to do so. As the local Incident Controller, CO3 B was best placed to decide what, if any, additional support was required from AMC or CTU.

'Upon our arrival there were multiple police cars and staff already on site'

CO responder from AMC

This partially uncoordinated ACTCS' response was, in our opinion, due to the inadequacies of the relevant policies, procedures and the EMF. Further, there are too many sources of information for staff to consult in the event of an incident involving an external escort.

Recommendation 2:

That ACTCS review the *Corrections Management (Escort) Policy and Operating Procedure 2017 (No 2)* to provide clear directions to staff about responses to incidents involving external escorts, including but not limited to, which staff positions at AMC and/or the Court Transport Unit may be required to respond to the scene of the incident.

11 The dog was not deployed.

5. COMMUNICATIONS PROBLEMS

OICS was told by one of the escort officers that the radio fitted in the Camry was not working so they had to rely on their personal radios. We were also told by a senior CO that in their experience none of the fitted radios in the AMC Camrys had ever worked.

While the reasons are unclear, the radio communications from the escort were not understood by the AMC MCR which, as noted earlier, resulted in the MCR calling a 'Code Blue' in the AMC WCC to which staff responded, then the AMC Special Care Centre (SCC) then back to the WCC. These responses generated a great deal of sometimes unnecessary and ill-disciplined radio traffic within AMC which made it difficult for the OiC to oversight/monitor the escape incident[12].

OICS notes:

> MCR officers have responsibility for the conduct of the radio network. All staff must follow the directions of an MCR officer.[13]
>
> Where the MCR has been alerted to an incident, they must immediately advise that all non-incident or emergency radio traffic is to cease until further notice.[14]

Further discussion of the MCR follows.

6. MASTER CONTROL ROOM – NERVE CENTRE OF THE AMC

The MCR performs a number of vital roles at AMC including movement control, alarms and CCTV monitoring, radio traffic control, incident response and after-hours detainee emergency communications. MCRs can be very busy places with often concurrent demands having to be managed promptly and efficiently to ensure the smooth running of the centre. In that regard it is surprising that AMC does not have a document which sets out the roles, staffing, management and operation of the MCR or any special training requirements for staff rostered in the MCR.

Master Control Room staff require special training

Concerning the training issue, it is not reasonable to treat the MCR as just another "post" at AMC because no other post carries the range of responsibilities of a MCR officer.

Recommendation 3:

That ACT Corrective Services review and document the roles, staffing, management and operation of the AMC Master Control Room and any special training requirements for staff rostered in the Master Control Room.

12 Interview with the OiC, 23/08/21.

13 *Corrections Management (Radio) Policy 2019.*

14 *Corrections Management (Incident Response) Operating Procedure 2020.*

7. STAFF PHONING HOME

As the incident unfolded a number of staff apparently rang loved-ones and friends to tell them about the incident, which resulted in a large number of calls to the AMC with callers asking about the incident generally or seeking information about whether their friend/loved-one was involved, injured, etc. While concern about the incident was understandable, taking numerous phone calls from the public and off-duty staff was an unnecessary distraction and burden for Operations staff who were dealing with an active, serious incident.

Recommendation 4:

That ACT Corrective Services issues a clear directive to all staff that only staff who are specifically authorised to do so are permitted to disclose the occurrence of an incident to a member of the public or an off-duty staff member.

8. ESCORT SECURITY ARRANGEMENTS

8.1 ACTCS practice

ACTCS requires that a Security Risk Assessment and Removal Authority (SRARA) must be completed for most detainees going on escorts.[15] The SRARA is a complicated form which requires the assessor to answer numerous questions about the detainee, including some that appear odd e.g. 'Length of sentence', 'Recent property damage?' 'Inappropriate sexual behaviour?'. Having addressed all the questions, the assessor must refer to a Risk Rating Table which sets out the Likelihood (e.g. Likely, Possible, Unlikely) of something happening against the Consequences (e.g. Minor, Moderate, Major) of something happening and then translates the answers into a Risk Assessment Tool – matrix comprising nine risks measured against Likelihood and Consequence, resulting in a Risk Rating of Low, Medium, High or Extreme.

OICS notes that there is no guidance as to how a risk rating (e.g. Medium) translates to the five decisions (e.g. Staff level) that a senior manager is required to make for an escort. A senior CO told us that staff completing risk assessments, and the senior decision makers, find the process overly complicated and feel it leaves them exposed if something goes wrong.

15 For reasons which are unclear, the SRARA does not apply to escorts 'to/from a court, Tribunal or the Sentence Administration Board'.

By comparison, Queensland Corrective Services has security standards for external escorts which are set out in its *Custodial Operations Practice Direction (COPD), Movement and Transfers*. The COPD specifies restraints (handcuffs, body belt, legcuffs), number and type of escort staff (e.g. inclusion of a K9 team), and weapons and restricted items (e.g. firearms, OC spray, batons) that must be applied based on the *security classification* of the prisoner. There is another category of prisoners who, regardless of classification, have prescribed escort requirements e.g. those identified as an escape risk. The COPD also provides staff with directions about variations that can be applied in certain circumstances e.g. removal of restraints for a prisoner placed in a secure holding cell.

The clear benefits of the QCS approach are consistency and ease of application for escort planners and escort team members. However, there should be sufficient flexibility to take into account an individual's circumstances such as medical conditions and disabilities, which might lessen the security risk of an escort.

Finding 3:

That there are fundamental problems with the ACT Corrective Services external escort Security Risk Assessment and Removal Authority tool. We note that while this issue was not a causal factor in this escape, it nonetheless needs to be addressed as a matter of urgency.

Recommendation 5:

That ACT Corrective Services review the process by which external escort security arrangements are determined with the aim of simplifying the decision making along the lines of the Queensland Corrective Services' *Custodial Operations Practice Direction, Movement and Transfers.*

8.2 The escort of Detainee Z

On 9 July 2021, Detainee Z was assessed as Medium risk against each of the nine risks in the Risk Assessment Tool completed by a CO3. It was then left to the AMC Duty Manager (CO3) to decide on 'Restraints and accoutrements', Staff level', 'Vehicle', 'Searching' and 'Staff dress' for the escort. The Duty Manager decided (respectively) on handcuffs, three officers, unsecure vehicle, strip search and ACTCS uniform[16].

In an interview with OICS[17] one of the escort officers expressed strong concern that they (escort team) were not briefed on the serious, violent nature of Detainee Z's criminal history in the context of what appeared to be a contrived visit to TCH in an unsecure vehicle.

8.3 Training of AMC staff to conduct escorts

AMC staff do not receive any special training in the conduct of external escorts. In practice, any rostered officer could be assigned to an escort team with little notice, regardless of their level of experience. A senior AMC officer opined that the AMC Security team are the best qualified to conduct secure escorts and should be the first choice whenever possible.

16 The Duty Manager advised OICS that two escort officers would have been "normal" for the Detainee Z escort but there was concern about the contraband package found earlier at TCH. The Duty Manager also noted that AMC did not have a secure vehicle for the escort i.e. only a Camry. Following the escape, AMC was provided with a secure vehicle from the CTU fleet.

17 Interview on 15/9/21.

8.4 Why doesn't the Court Transport Unit conduct AMC external escorts?

The CTU conducts numerous escorts of detainees, young detainees and police watchhouse prisoners in secure vehicles (CTU Review). However, as the CTU is geared around court sittings its operations are limited to normal business hours Monday to Friday and a few hours for bail hearings on Saturdays.

It should be noted that the CTU reports to the Deputy Commissioner Custodial Operations (DCCO)[18] rather the General Manager (GM) AMC.[19]

In that regard, the GM cannot task the CTU to conduct an escort even if the CTU was able to do so. Senior AMC and CTU officers told us that the two agencies operate quite independently of each other despite both being staffed by Corrections Officers, including AMC staff rostered at the CTU at times, and both operating under the CM Act. This *separation* means that AMC would not normally consider calling on the CTU to assist with escorts.

Recommendation 6:

That ACT Corrective Services put in place arrangements that would allow the General Manager, AMC to request escort assistance direct to the Court Transport Unit and for the Court Transport Unit to provide such assistance where its operational commitments to the courts can be accommodated without detriment to its primary functions.

8.5 Incident formal debrief

A formal ("cold") debrief was conducted on 26 July 2021. Some of the matters aired at the debrief were security-sensitive, and as such, are not appropriate to be repeated in this public report. In general terms, the debrief noted problems with:

- identifying the location of the escort vehicle during the incident
- contacting police from the escort vehicle during the incident
- self-defence of escort staff
- operation of the AMC MCR during the incident
- the current emergency procedures for escapes from escorts

Various staff were tasked to examine and report back on these issues by 21 December 2021.

While OICS supports the initiative of ACTCS to conduct an internal review of the matters of concern raised at the debrief, it was surprising that there was no mention made of the unauthorised response of five staff to the incident scene (section 4.2 of this report) or the problem of telephone calls to AMC during the incident (section 7 of this report).

Recommendation 7:

That ACT Corrective Services enhance the tracking facility of all Operations vehicles in the AMC and Court Transport Unit fleets to ensure that they can be accurately located at all times.

18 DCCO position established in ACTCS head office in 2020.

19 Prior to 2020, the CTU reported to the AMC GM (then called GM Custodial Operations).

Recommendation 8:

That ACT Corrective Services and ACT Policing develop and implement a "duress system" for all Operations vehicles in the AMC and Court Transport Unit fleets to provide for direct access to ACT Policing in the event of an emergency i.e. a system which does not involve the use of the public "000" phone number.

8.6 Support for staff involved in major incidents

The three escort officers involved in the incident expressed gratitude for the support they had received from their peers. However, all three felt that the services provided by the Employee Assistance Program (EAP) were generic rather than specific to the trauma they experienced during the incident. They had also received counselling support from a private organisation, Let's Talk Differently Pty Ltd ('LTD') which is based in Victoria. LTD provides services to ACTCS on a fee-for-service basis either in-person or via video link and has extensive experience in supporting prison officers in Victoria over a number of years. The officers involved in the escape incident spoke highly of their interactions with LTD. In conversation with OICS,[20] the CEO of LTD emphasised that while LTD provides a corrections-aware counselling service they do not provide treatments for clients with diagnosed psychological conditions. He also noted that unlike EAP services, LTD does not provide a 24/7 service as it is not modelled around a first response role.

In summary:

- while peer support provides a valuable "service" for officers involved in traumatic incidents, the peer supporters are not professionally qualified counsellors or psychologists.
- although EAP is available 24/7, it is not necessarily staffed by trauma-experienced counsellors who have any knowledge of the corrections environment or the work performed by Corrections Officers.
- Let's Talk Differently provides a "corrections-informed" counselling service, which is well regarded by staff. However, LTD does not provide a 24/7 service and does not offer treatment services.

For some staff involved in traumatic incidents[21] a combination of support services (peer support, EAP, LTD) may be sufficient to help them through the post-incident period and move forward. However, some may require specialist assistance (e.g. psychologist) to help them deal with the trauma they have experienced.

Recommendation 9:

That ACT Corrective Services provide for the psychological support of staff involved in traumatic incidents through the provision of post incident debriefing with qualified professional providers and ongoing psychological treatment where such ongoing treatment is medically assessed to be in the best interests of a staff member. This ongoing support should not be dependent on the outcome of a worker's compensation claim.

20 Telephone conversation, 21/09/21.

21 Traumatic incidents should be broadly defined to include incidents such as assaults on staff, riots, deaths in custody, etc.

9. OTHER MATTERS

9.1 Emergency Management Framework (EMF)

The EMF is an internal ACTCS document, which is intended to provide staff with detailed instructions about dealing with a range of possible custodial incidents. However, unlike ACTCS policies and procedures, it is not a Notified Instrument (NI) on the ACT Legislation Register. This means that the legal status of the EMF is unclear, possibly leaving staff exposed if they follow EMF instructions that may not be consistent with a notified policy or procedure (NI's). This is an issue that OICS raised in our *Report of a review of a critical incident: Riot and serious fires at the Alexander Maconochie Centre on 10 November 2020,* where we noted:

- there is an inconsistency between the *Emergency Management Policy* and the EMF about who is responsible for activating the AMC Incident Command Suite.
- the Major Fire plan in the EMF makes no mention of calling the ACTFR, although this is clearly stated in the *Corrections Management (Code Red (Fire)) Operating Procedure 2020*.
- the EMF Major Fire plan requires that the ACTP be advised, but this is not mentioned in the *Code Red (Fire) Operating Procedure*.

In the case of the 9 July 2021 escape, the EMF referred staff to a revoked policy and procedure. In OICS' opinion, there are significant benefits[22] of the EMF provided it is kept up to date to ensure consistency with NI's. However, it must not create new obligations i.e. impose requirements on staff that are not provided for under the CM Act or NI's.

Finding 4:

That while the ACT Corrective Services' Emergency Management Framework is a useful document it is also potentially confusing in situations where it provides directions on matters that are inconsistent with, or outside, the *Corrections Management Act 2007* or notified policies and procedures.

22 As a "one-stop-shop" for information and directions rather than staff having to access and interpret (sometimes multiple) policies and procedures.

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