

“So Much Sadness in our Lives”

**Independent Inquiry into the Treatment in Custody of
Steven Freeman**

7 November 2016

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Inquiry website

<http://www.justice.act.gov.au/news/view/1709/title/inquiry-into-the-treatment-in>

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Mr Shane Rattenbury MLA
Minister for Corrections
ACT Legislative Assembly
London Circuit
CIVIC ACT 2601

Dear Minister

Independent Inquiry Report: "So Much Sadness in Our Lives"

I am pleased to provide you with the report of my Independent Inquiry into the treatment of Mr Steven Freeman in custody at the Alexander Maconochie Centre (AMC) in the Australian Capital Territory (ACT).

The Report's title is drawn from a comment which a leader in the ACT Aboriginal and Torres Strait Islander community made to the Inquiry. It reflects the continuing and profound sadness caused by Steven Freeman's experiences, and those of Aboriginal people in our justice system, and the wider community.

Above all else, the Inquiry acknowledges the acute sense of grief and loss which Steven Freeman's mother, Narelle King, his family and many other people are experiencing since his death. This Inquiry also recognises the support which Winnunga Nimmityjah Aboriginal Health Service, and in particular the Chief Executive Officer, Ms Julie Tongs OAM, is giving to Steven Freeman's mother and family.

When you established this Inquiry, you sought to commence the process of restoring the Aboriginal community's trust in the ACT corrective services system. In that sense, the Inquiry acknowledges that various aspects of the present system need to change in order to prevent a recurrence of Steven Freeman's experience in custody. The Inquiry notes that, if its recommendations are accepted, they ought to be implemented in Steven Freeman's name.

I wish to recognise the assistance which Inquiry team members, Mr Sean Costello, Professor Ngiare Brown and Ms Megan Sparke have given to the Inquiry and to thank them for their outstanding contribution and commitment.

Yours sincerely

A handwritten signature in black ink that reads "Philip Moss". The signature is written in a cursive, flowing style.

Mr Philip Moss AM
Independent Inquirer

7 November 2016

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Part 1. Terms of Reference

- 1.1.1 Steven Freeman died in custody at the Alexander Maconochie Centre (AMC) on 27 May 2016. In response, on 2 June 2016, the Minister for Corrections, Shane Rattenbury MLA, announced an Independent Inquiry into Steven Freeman’s treatment while in custody. The Inquiry commenced on 24 June 2016.¹
- 1.1.2 On 1 August 2016, based on feedback from the ACT Aboriginal and Torres Strait Islander community and Steven Freeman’s family, the Inquiry requested that an additional term be added to the Terms of Reference and that the reporting date be extended.
- 1.1.3 The Minister agreed to amend the Inquiry’s Terms of Reference to include:
- *“The extent of the consideration given to Aboriginal culture, traditions and beliefs in the management, care and custody of Steven Freeman;”*
- 1.1.4 The final Terms of Reference for the Inquiry are:
- the adequacy of the management, care and custody of detainee Steven Freeman at the AMC and the compliance of this care and custody with human rights obligations;
 - the overall effectiveness of the application of relevant policies and procedures in the care and custody of Steven Freeman;
 - the adequacy of induction and risk assessment policies and procedures at the AMC and how these were applied to Steven Freeman;
 - the adequacy of policies and procedures relating to separation of vulnerable detainees at the AMC and how these were applied to Steven Freeman;
 - the extent of the consideration given to Aboriginal culture, traditions and beliefs in the management, care and custody of Steven Freeman;
 - the effectiveness of information sharing arrangements between ACT Policing and ACT Corrective Services around new and remand detainees at AMC; and
 - the accessibility and appropriateness of health and other support services within the AMC for Steven Freeman;

but must not inquire into or consider the manner and cause of the death of Steven Freeman, which is the subject of an inquest by the Coroner.

Following the Inquiry, the Independent Inquirer will provide a report with any key recommendations on how to improve the management, care and supervision arrangements of detainees.

¹ The Minister for Corrections’ media release is at Appendix 1.

- 1.1.5 The Minister also agreed to extend the Inquiry's reporting date from 31 August to 31 October 2016.
- 1.1.6 On 28 October 2016, the Inquiry's deadline was extended to 7 November 2016. The Justice and Community Safety Directorate's media release announcing the extension is at Appendix 2.

Part 2. Executive Summary

2.1 Key Events in the Treatment in Custody of Steven Freeman

Assault at the Alexander Maconochie Centre (AMC)

- 2.1.1 On 28 April 2015, within hours of his arrival at the AMC, Steven Freeman was seriously assaulted in Sentenced Unit 1.
- 2.1.2 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. 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 notes that Steven Freeman was likely still withdrawing from his multi-substance use, throughout his time at The Canberra Hospital and on return to the AMC. 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.
- 2.1.4 The Inquiry could not conclude the reason and persons responsible for this assault, but did pass on new information to ACT Policing regarding who may have been involved.

Health care at The Canberra Hospital (TCH)

- 2.1.5 On 28 April 2015, Steven Freeman was taken to TCH by ambulance, where he spent nine days. He suffered severe head injuries from his assault and spent time in an induced coma.
- 2.1.6 On 6 May 2015, hospital staff members called a "Code Black" in relation to Steven Freeman's behaviour in the neurosurgical ward. A "Code Black" is an Australian Standard defined hospital emergency response code to deal with incidences of violence or aggression.
- 2.1.7 The Inquiry notes that TCH did not seek to determine why Steven Freeman behaved uncharacteristically that resulted in a Code Black being called. The Inquiry notes also that this Code Black was not considered in the decision to discharge Steven Freeman.
- 2.1.8 Steven Freeman was discharged from TCH on 7 May 2015, and appeared in court later that day seeking bail.

Return to the AMC

- 2.1.9 Steven Freeman's bail was considered over several weeks in two separate bail applications. During these hearings, Steven Freeman's safety in the community, protection at AMC and the mixing of remanded and sentenced detainees were discussed. Bail was denied on both occasions.
- 2.1.10 The Inquiry understands that the ACT Government is in the process of developing a bail support service. In formulating this model, the Government should consider what role a Aboriginal-led organisation could have in providing bail support and advice to the Court.
- 2.1.11 On 7 May 2015, after his initial bail application was refused, Steven Freeman returned to the AMC as a remanded detainee. He remained there until his death on 27 May 2016.

Health care at the AMC, providing by Justice Health Services

- 2.1.12 In the weeks after his return to the AMC, Justice Health Services and AMC staff members undertook a range of welfare and medical assessments of Steven Freeman. According to the clinical records, Steven Freeman was not seen personally after 20 May 2015 by a Justice Health Services medical officer.
- 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.

Lack of rehabilitation at the AMC

- 2.1.14 Steven Freeman spent 395 days at the AMC. He was a remanded detainee for all but 52 days, when in February and March he became a sentenced detainee following convictions. The Inquiry notes a deficiency in that ACTCS failed to develop a case plan for Steven Freeman's rehabilitation in this time. The AMC also did not assess Steven Freeman for any affect to his cognitive functions following his head injury. It is unknown if Steven Freeman suffered any such disability after his head injury. Discovering whether there was any long term impact of the head injury and trauma Steven Freeman suffered while in custody at the AMC does not appear to have featured prominently in the ongoing management of Steven Freeman. The Inquiry notes also this deficiency.
- 2.1.15 Steven Freeman reported being bored during his time at the AMC. The Inquiry notes that the lack of rehabilitative opportunities and a structured day for detainees has been identified by several reports concerning the AMC.
- 2.1.16 Rather than the originally intended 30 hours per week, detainees told the Inquiry that they would have up to 1 to 2 hours of programs, education or employment a week. The Inquiry notes that the lack of a structured day inevitably leads to boredom, which invites the possibility and added risk of detainees using illegal drugs.

2.2 Key Features of the Corrective Services System in the Treatment in Custody of Steven Freeman

Reform the AMC (ACTCS) / Justice Health Services (ACT Health) Relationship

- 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.

Introduction of Winnunga Nimmityjah Aboriginal Health Service

- 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.
- 2.2.3 The greater involvement of Winnunga Nimmityjah would establish and achieve the aim of reflecting in AMC procedure and practice greater awareness of, and sensitivity to, Indigenous culture.

Separation of Remand and Sentenced Detainees

- 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.

Changes to Policy and Technical Initiatives

- 2.2.5 The Inquiry notes the need to improve detainee safety through a range of policy reform and technical initiatives.
- 2.2.6 In relation to policy changes, the Inquiry recommends that ACT Policing accord a higher priority to the investigation of assault at the AMC, and that relevant agencies in the justice system adopt pro-charge and pro-prosecution policies in relation to such assaults.
- 2.2.7 The Inquiry also recommends that the ACT Ombudsman should have the role of reviewing all critical incidents at the AMC, including serious assaults.
- 2.2.8 The Inquiry recommends that technical initiatives include ACTCS conducting a survey of electronic surveillance at the AMC.

Part 3. Recommendations

Recommendation 1: That ACT Corrective Services (ACTCS) conduct a survey of electronic surveillance at the Alexander Maconochie Centre (AMC) to ensure best practice protection for, and the security of, detainees including:

- training for AMC custodial officers operating CCTV cameras; and
- developing protocols relating to camera settings, movement and recording.

Recommendation 2: That ACT Policing accord a higher priority to the investigation of any assault at the AMC.

Recommendation 3: That ACT Policing, ACTCS and ACT Director of Public Prosecutions develop and adopt pro-charge and pro-prosecution policies in relation to assaults at the AMC.

Recommendation 4: That the arrangements for the provision of health care at the Alexander Maconochie Centre be established, under contract or memorandum of understanding, to reflect the respective responsibilities of AMC (ACTCS) and Justice Health Services (ACT Health).

Recommendation 5: That Winnunga Nimmityjah Aboriginal Health Service be integrated into the provision of health care at the AMC, in order to introduce its holistic model of care to Indigenous detainees.

Recommendation 6: That ACTCS establish a separate remand prison within the AMC to ensure remanded detainees are segregated from sentenced detainees.

Recommendation 7: That the Health Services Commissioner (of the ACT Human Rights Commission) conduct an own-initiative investigation into the prescription of methadone to detainees at the AMC.

Recommendation 8: That the ACT Ombudsman have the role of reviewing the response to all critical incidents at the AMC, including serious assaults.

Recommendation 9: That the Inquiry's conclusions, which provide detail of various aspects of the treatment in custody of Steven Freeman that were deficient, be addressed with a view to implementing change and bringing about improvement. All conclusions are bolded throughout the Report.

Part 4. Introduction

4.1 Background

- 4.1.1 There have been five deaths of detainees in Australian Capital Territory Corrective Services (ACTCS) custody since the AMC commenced accepting detainees on 30 March 2009. Steven Freeman's death is the second instance of an Aboriginal detainee dying in custody.²
- 4.1.2 In a tragic coincidence, Steven Freeman died on the same day as the Sorry Day Bridge Walk over Commonwealth Avenue Bridge in Canberra, and just weeks after the twenty-fifth anniversary of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC).
- 4.1.3 Steven Freeman's experience as an Aboriginal young person and adult has brought a focus on aspects of the operation of the ACT justice and corrections system.

4.2 Brief Outline of Steven Freeman's Experience in Custody and Detention

- 4.2.1 Steven Freeman had prior contact with youth justice and ACT Policing since the age of 12.
- 4.2.2 On 27 April 2015, Steven Freeman was arrested, charged with various offences. He was held overnight in the police Watchhouse. The next day, 28 April 2015, Steven Freeman appeared before the ACT Magistrates Court where he was represented by the Aboriginal Legal Service. Steven Freeman's application for bail was refused and he was remanded in custody.
- 4.2.3 Within four hours of his arrival at the ACT's prison - the Alexander Maconochie Centre (AMC) - Steven Freeman was seriously assaulted, in his cell, by other detainees.
- 4.2.4 Steven Freeman was taken by ambulance to The Canberra Hospital (TCH) where he was admitted to the Intensive Care Unit. After four days, Steven Freeman was transferred to the Neurosurgical Ward where he remained for five more days. Steven Freeman stayed in TCH for a total of nine days. During that period, Steven Freeman was in ACTCS custody, and two custodial officers attended him.
- 4.2.5 After being discharged from TCH on 7 May 2015, Steven Freeman was taken to the ACT Magistrates Court, where he appeared before Chief Magistrate Lorraine Walker, and sought bail. During the hearing, Steven Freeman's mother, Narelle King, gave evidence expressing her concern about Steven Freeman's safety at the AMC. Bail was refused and Steven Freeman returned to the AMC that day.

² ACT Health and ACTCS informed the Inquiry that the other death of an indigenous detainee occurred in The Canberra Hospital (TCH) of natural causes.

- 4.2.6 Steven Freeman sought a review of the decision to refuse bail, which Magistrate Peter Dingwall heard over a period of several weeks. On 10 June 2015, bail was again refused, and Steven Freeman remained a remanded detainee at the AMC.
- 4.2.7 Just over 12 months later, Steven Freeman died in his cell at the AMC on 27 May 2016.

4.3 Conduct of the Inquiry

- 4.3.1 In his Closing the Gap speech, on 10 February 2016 the Prime Minister said:

“It is equally important we listen to Aboriginal and Torres Strait Islander people when they tell us what is working and what needs to change. It’s our role as government to provide an environment that enables Indigenous leaders to develop local solutions. Again, Mr Speaker, it is time for Governments to ‘do things with Aboriginal people, not do things to them.’”³

- 4.3.2 Through consultation, the Inquiry sought to appreciate the Indigenous perspective of Steven Freeman’s treatment in custody. As one Aboriginal community leader expressed it, “we know how the system isn’t working for our people”.
- 4.3.3 The Inquiry had regular meetings with Steven Freeman’s mother, Narelle King, and other family members.
- 4.3.4 The Inquiry invited Steven Freeman’s family to pose questions they wanted answered in order to assist them make sense of Steven Freeman’s treatment in custody. These questions are at Appendix 4. Some of these questions relate to the manner and cause of death, which are beyond the Inquiry’s Terms of Reference and the subject of an inquest by the Coroner.
- 4.3.5 The Inquiry consulted with the ACT Aboriginal and Torres Strait Islander community through its leadership forums, including the United Ngunnawal Elders Council, the ACT Aboriginal and Torres Strait Islander Elected Body, through Indigenous organisations including Winnunga Nimmityjah Aboriginal Health Service, Gudan Gulwan Youth Aboriginal Youth Corporation and the Aboriginal Legal Service, and through key individuals.
- 4.3.6 Because the Coroner’s inquest will be held in December 2016, the Inquiry was completed before the manner and cause of Steven Freeman’s death is known. This Report is written without that knowledge.
- 4.3.7 The Inquiry notes that the AMC has been reviewed from time to time. These reviews, which were undertaken at considerable effort and cost, are listed at Appendix 3.
- 4.3.8 The Inquiry took the following steps in addressing its Terms of Reference, and:
- wrote to 33 organisations and individuals inviting their participation;

³ Commonwealth, *Parliamentary Debates*, House of Representatives, 10 February 2016, 1173 (The Hon Malcolm Turnbull MP, Prime Minister)

- received six written submissions, of which five were posted on Tuesday, 18 October 2016 and Wednesday 19 October 2016 to the Inquiry's website (<http://www.justice.act.gov.au/news/view/1709/title/inquiry-into-the-treatment-in>);
- met face to face with 106 people including Aboriginal detainees at the AMC and elsewhere, ACTCS and ACT Health staff members, and oversight agencies (Official Visitors, the ACT Ombudsman and the ACT Human Rights Commission);
- visited the AMC on eight occasions;
- advertised on the ACT Justice and Community Safety Directorate's website and publicised via media release from the Minister; and
- perused the extensive electronic and written material which ACTCS, ACT Health and ACT Policing provided, including policies, procedures, internal management reviews, recorded phone calls, emails and CCTV footage.

4.3.9 In the time frame available to it, the Inquiry was not able to speak to as many AMC custodial officers and detainees as it would have liked to.

4.3.10 The Inquiry notes the professionalism of the custodial officers it met, and the responsiveness of ACTCS/AMC management and officers in providing information to the Inquiry and responding to requests for assistance.

4.3.11 The Inquiry notes also the preparedness of the Community and Public Sector Union to provide its support.

Part 5. About Steven Freeman

- 5.1.1 Steven Freeman was an Aboriginal man, who died in custody at the AMC on Friday, 27 May 2016. He was 25 years of age.
- 5.1.2 From an early age, Steven Freeman reportedly took pride in his appearance and was described to the Inquiry by friends and family as youthful, good-looking and cheeky. As an Aboriginal person, Steven Freeman maintained regular contact with his family, particularly his mother, Narelle King, who is a Bundjalung woman, originally from Lismore, and his two brothers, two sisters and niece.
- 5.1.3 Steven Freeman's plans for his future involved his young daughter who was described as being 'his whole world'. He was fond of writing music, particularly hip hop, and thought being a performer would be his dream job. Steven Freeman had an affinity with cars and motorbikes.
- 5.1.4 As a young child, Steven Freeman contracted meningitis. When he was six, he was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). There is common agreement that Steven Freeman, by nature, was not a violent person.
- 5.1.5 Narelle King raised her family as a single parent, and the Inquiry received information about how strongly and consistently she supported and stood up for Steven Freeman and her other children.
- 5.1.6 At various points in his life, Steven Freeman had contact with law enforcement authorities and the justice system, as both a juvenile and an adult.
- 5.1.7 As a young person, Steven Freeman first appeared in the ACT Childrens Court when he was 12 years of age, in 2003, the same year his elder sister died of a heroin overdose. Her death had a significant impact on her mother Narelle King, Steven Freeman and the whole family. Court transcripts indicate that Steven Freeman commenced drinking alcohol at this age and smoked cannabis from the age of 16.
- 5.1.8 Steven Freeman was charged with 47 offences as a juvenile and spent significant time in youth detention. Steven Freeman left school in year eight and had been employed as a retail assistant, youth worker and labourer.
- 5.1.9 During 2010-11, Steven Freeman channelled this energy into employment. After attending an Aboriginal rehabilitation centre in Nowra, he reportedly looked happy and healthy. On returning to Canberra, he commenced a traineeship with a car dealer. The Inquiry notes that ACT Policing members and non-government organisations supported Steven Freeman to attend work. The Inquiry was told that this time was a particularly positive one in Steven Freeman's life.
- 5.1.10 Steven Freeman also completed 160 hours of community service on 20 September 2011 arising from his offences as a young person.

- 5.1.11 Prior to his admission to the AMC in April 2015, Steven Freeman had been in custody on remand, as an adult at the AMC twice. On both occasions, he was held in Remand Unit 1 with a mainstream classification.
- Remanded for 5 days from 19 June 2010 to 23 June 2010; and
 - Remanded for 4 days from 16 August 2010 to 19 August 2010.
- 5.1.12 Steven Freeman appeared before the Galambany Circle Sentencing Court in relation to some of his offences, which involves Aboriginal elders in the sentencing process. Steven Freeman was regarded as one of the success stories of this model of justice.
- 5.1.13 As told to the Inquiry, Steven Freeman's traineeship with a car dealer ended when his employer became aware of his criminal record. Steven Freeman then gained employment at a supermarket. The routine of working and raising his young daughter were positive influences on Steven Freeman.
- 5.1.14 In late 2014, the direction of Steven Freeman's life changed. He left his job and went on an overseas holiday. On his return, Steven Freeman began offending and once again came to the attention of ACT Policing.
- 5.1.15 In the months leading up to his arrest and incarceration in April 2015, Steven Freeman disclosed to ACT Policing and friends that he was using illicit drugs, including methamphetamine (ICE). Chief Magistrate Walker, during a bail hearing on 7 May 2015, summarised the prosecution's description of him as a "one-man crime wave". Steven Freeman was charged with approximately 30 charges, involving motor vehicle offences, theft, burglary, escape and weapons offences.
- 5.1.16 At the time of his arrest in April 2015, Steven Freeman was struggling with significant personal matters.
- 5.1.17 Steven Freeman spent 13 months in custody from 28 April 2015 to 27 May 2016, when he died. He was held on remand initially, but was sentenced for several offences in February and March 2016. Because he spent a significant period of time on remand, these sentences were largely already served. He was a sentenced detainee for 52 days.
- 5.1.18 Figure 1 shows the proportion of Steven Freeman's time in custody as a detainee on remand and as a sentenced detainee. At the time of his assault in April 2015, and death in May 2016, Steven Freeman was on remand (and at law, presumed innocent of the charges he was facing).

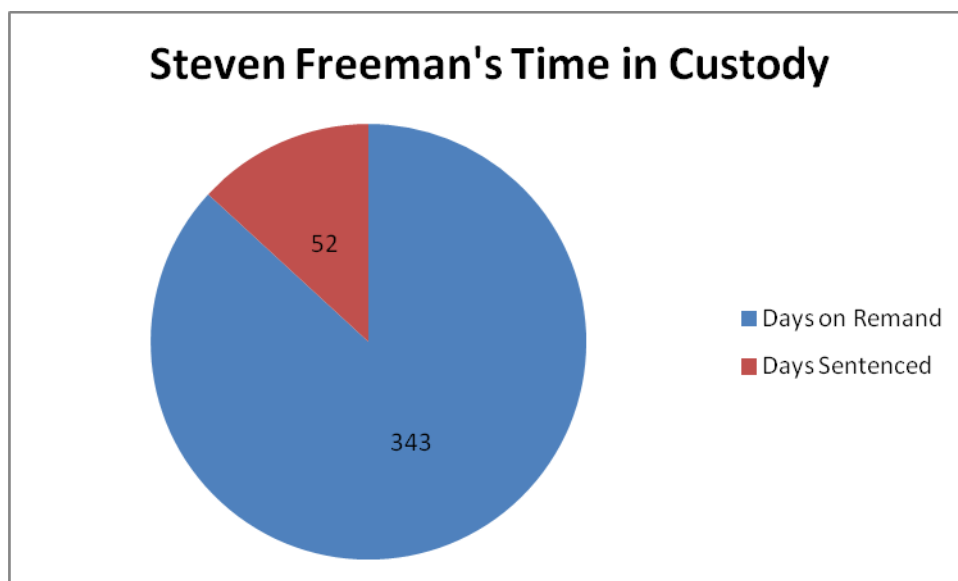


FIGURE 1: STEVEN FREEMAN'S TIME IN CUSTODY AS A DETAINEE ON REMAND AND AS A SENTENCED DETAINEE

Part 6. The Alexander Maconochie Centre

6.1 Establishment of the AMC

6.1.1 The AMC was officially opened in September 2008, with the first detainees arriving on 30 March 2009, coinciding with the closure of the Belconnen Remand Centre (BRC). It was intended to be a human rights compliant prison with a focus on rehabilitation.

6.1.2 The AMC was named after Alexander Maconochie, who was a prison reformist on Norfolk Island in the 1840s. In 2012, former Chief Minister, Jon Stanhope MLA wrote:

*'The prison was the first in Australia to be built and operated in accordance with human rights legislation and principles. The fact it is named in honour of Alexander Maconochie, superintendent of the Norfolk Island penal colony from 1840 to 1844, a prison reformer unmatched in Australia before or since, was to be a constant reminder of the prison's aims as a reforming institution, one which reflects a commitment to human rights and a belief in the possibility of rehabilitation and redemption.'*⁴

6.1.3 Reviews and reports of the AMC, particularly those conducted in the initial years noted the increasing pressure on accommodation. ACTCS told the Inquiry a number of custodial officers were relocated from the BRC to the AMC, including significantly the senior custodial management team. Their experience in the management of a correctional facility was limited and additional staff from other backgrounds and jurisdictions were recruited.

6.1.4 The AMC was constructed differently from most other correctional facilities. This design led to difficulties in detainee management.

6.1.5 The Knowledge Consulting Report (2011), found that the AMC was at a critical stage in its history and had not, to that point, achieved its vision of human rights compliance with a focus on rehabilitation.

6.1.6 In 2011, with a newly appointed General Manager of Custodial Operations, the AMC embarked on a program of change and stabilisation. In 2013, an experienced Deputy General Manager was appointed, bringing additional corrections experience.

6.1.7 As a result, over the last 5 years, ACTCS reports that there have been a number of significant changes to the management of the AMC.

6.1.8 ACTCS told the Inquiry that it has created a permanent Indigenous Liaison Officer position, developed new Indigenous-specific programs and engaged Ngunnawal elders to make regular visits. ACT Health also provides funding for Winnunga Nimmityjah Aboriginal Health Services' health and wellbeing program at the AMC.

⁴ Stanhope.J (2012) *'The Prisoners as a Human Being'*. Right Now: Human Rights in Australia.
<http://rightnow.org.au/opinion-3/the-prisoner-as-a-human-being/>.

- 6.1.9 In the Report into Rehabilitation Services for Male Detainees (2015), the ACT Auditor General noted that since the Knowledge Consulting Report (2011), management practice had led to a cultural change with a greater emphasis on relationships between staff and detainees. This environment was more conducive for rehabilitation. The Report estimated this change would still take some time.

*'External stakeholders advised that they had observed a changing culture in ACTCS. ACTCS officers acknowledged that this is the beginning of a long journey that may take ten years. The 'culture change' is likely to have contributed to the improved operating environment at the AMC achieved by a reduction of staff overtime, an improved ratio of planned leave to unplanned leave, reduced use of force to restrain detainees, fewer lockdown hours, and shorter lengths of stay by detainees in the Management Unit.'*⁵

- 6.1.10 Changes to ACTCS recruitment practices have resulted in an increasing number of Aboriginal and Torres Strait Islander custodial staff members.
- 6.1.11 The Inquiry notes that while the AMC has made notable progress, Steven Freeman's treatment in custody reveals that significant improvements are still needed.

6.2 Physical Layout of the AMC

- 6.2.1 The AMC comprises a collection of different buildings accommodating both male and female detainees across maximum, medium and minimum security classifications.
- 6.2.2 ACTCS told the Inquiry that since opening the AMC has increased its detainee capacity from approximately 270 to 539.
- 6.2.3 At the time of Steven Freeman's admission in April 2015, the AMC had a capacity of 370 detainees, comprising 341 male and 29 female (including classifications of maximum, medium and minimum security). The AMC campus had a range of accommodation options including cottages and cell blocks. The majority of detainees share double cells, with single cells available only in some cottages, the Management Unit and Crisis Support Unit.
- 6.2.4 During Steven Freeman's detention at the AMC, two new accommodation units were opened. These are two new multipurpose units known as 'Accommodation Unit', which opened in February 2016 and the 'Special Care Centre', which opened in September 2015.
- 6.2.5 In 2016, construction commenced on a new multipurpose facility, bakery and laundry upgrade to provide more opportunities for detainee employment. An extensive upgrade of prison security has also been completed.

⁵ Cooper. M (2015) *'The rehabilitation of male detainees at the Alexander Maconochie Centre'*. ACT Auditor General's Report No 2/2015, page 14.

Part 7. April 2015 Arrest

7.1 Contact with Law Enforcement

- 7.1.1 Steven Freeman came in contact with ACT Policing from an early age.
- 7.1.2 Steven Freeman's family told the Inquiry that he was repeatedly stopped by police while driving, restrained on several occasions and on one occasion was led handcuffed through a shopping mall. The Inquiry notes the family's perceptions that ACT Policing "harassed" Steven Freeman.

7.2 Police Custody

- 7.2.1 In March 2015, ACT Policing members visited Narelle King's home when searching for Steven Freeman. Narelle King told the Inquiry that one ACT Policing officer said, "if we don't get him, someone else will". Narelle King also told the Inquiry that there was a "hit out on [Steven Freeman]". The Inquiry understands from Narelle King that Steven Freeman may have been involved with a drug consignment that was only part-delivered.
- 7.2.2 ACT Policing was unable to confirm the basis of this comment, and in March 2015 had no intelligence holdings relating to a risk to Steven Freeman's safety.
- 7.2.3 Narelle King told the Inquiry that she subsequently informed the Aboriginal Legal Service (ALS) about the ACT Policing officer's comment regarding Steven Freeman's safety.
- 7.2.4 Steven Freeman was arrested by ACT Policing at 12.37 pm on 27 April 2015 and charged at the Belconnen Police Station. The charges preferred against him were: escape from custody; and possessing an offensive weapon with intent. Steven Freeman's offending behaviour had been preceded by a period of illicit drug use over some months, commencing in January 2015, including methamphetamine (ICE).
- 7.2.5 ACT Policing's screening of Steven Freeman, as documented in the Prisoner History form, provided to ACTCS, was consistent with the RCIADIC Report recommendations.⁶ These assessments indicated that Steven Freeman was not considered at risk of suicide or self-harm. The documentation recorded a burn injury to his forearm, that had been sustained prior to his arrest.
- 7.2.6 The Inquiry notes that the Prisoner History form did not identify Steven Freeman as an Aboriginal person. Alongside the question "Is the defendant an Aboriginal or Torres Strait Islander Person" is the word "NO". The Inquiry notes this error was inadvertent since all other procedures relevant to an Aboriginal offender were followed.

⁶ Royal Commission into Aboriginal Deaths in Custody (1991) '*National Report*'. http://www.austlii.edu.au/au/other/IndigLRes/rciadic/?utm_source=PoliticOz&utm_campaign=4ca357a674-PoliticOZ_26_September_2014&utm_medium=email&utm_term=0_673b6b002d-4ca357a674-302966797. Recommendations 125 and 126.

- 7.2.7 Steven Freeman was transferred from Belconnen Police Station to the City Watchhouse. There, Steven Freeman was seen by an ACT Policing nurse, who requested that the Forensic medical officer assess Steven Freeman's burn injury. Steven Freeman declined the medical treatment.
- 7.2.8 When ACT Policing interviewed Steven Freeman on 27 April 2015, he said that when low on money, he would search through vehicles, but was unable to recall events due to his use of illicit drugs and alcohol. ACT Policing recorded that at 3.46 pm Steven Freeman no longer wished to participate in the interview and declined to hear any further allegations. The Inquiry notes that Steven Freeman may have been exhausted. Narelle King told the Inquiry that Steven Freeman had not slept for some time prior to his arrest because of illicit drug and alcohol use (perhaps 12 days). Steven Freeman's family told the Inquiry he had lost weight and appeared "gaunt".
- 7.2.9 Consistent with relevant legislation and procedure, ACT Policing notified the ALS of Steven Freeman's arrest. ALS later spoke with Steven Freeman.
- 7.2.10 Steven Freeman spent the night of 27 April in custody at the City Watchhouse and appeared in the ACT Magistrates Court the following day, 28 April 2015. His application for bail was refused and he was remanded in detention.
- 7.2.11 The responsibility for Steven Freeman's custody transferred from ACT Policing to ACTCS at 8.06 am on 28 April 2015. In accordance with a memorandum of understanding (MOU) between the Australian Federal Police (ACT Policing) and the Justice and Community Safety Directorate⁷ on Working Relationships, finalised on 10 June 2010, ACT Policing provided the following documentation to ACTCS a:
- prisoner history report;
 - bail extension report; and
 - prisoner property report.
- 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.
- 7.2.13 The Inquiry notes that Steven Freeman would most likely have been under the influence of illicit drugs and alcohol at the time of the transfer of his custody from ACT Policing to ACTCS.
- 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

⁷ Justice and Community Safety Directorate is the ACT Directorate responsible for ACTCS and the AMC.

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.⁸ 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.
- 7.2.17 The Inquiry notes also that there was no requirement in procedure or practice at that time for a more comprehensive approach to information sharing between ACT Policing and ACTCS.
- 7.2.18 The Inquiry notes further since that time, ACT Policing now provides the following information to ACTCS, in relation to each detainee: the statement of facts for the current charges; a list of ACT Policing alerts; and relevant intelligence holdings. This enhanced information sharing arrangement is discussed further at paragraph 11.1.4.

⁸ Justice Health Services is that part of ACT Health that provides health services at AMC (and Bimberi Youth Justice Centre).

Part 8. ACTCS Custody

8.1 Initial Assessment

- 8.1.1 ACTCS's assessment by custodial officers of Steven Freeman began at 8.15 am on 28 April 2015 in the city. Steven Freeman was placed in the ACTCS cells at the court on his own and observed every 15 minutes, consistent with the RCIADIC Report recommendations.⁹ It was then that ACTCS staff members commenced assessing Steven Freeman for accommodation, and the supervisor of the Court Transport Unit reported his initial reaction as being that Steven Freeman "had no issues with anyone at the AMC".
- 8.1.2 The assessment process continued with another custodial officer. Staff members reported that Steven Freeman was again asked whether he had concerns about other detainees that may threaten or harm him while in custody. Again, the officer recorded that he answered "no" and indicated he wished to be classified as a "mainstream" detainee. He was transferred to another holding cell with other mainstream detainees, and staff members reported that he was "observed to have no apparent issues or concerns".
- 8.1.3 Steven Freeman then underwent a Transport Risk Assessment, and again no concerns were identified. The Court Transport Unit induction officer recorded that Steven Freeman "presented as calm and settled at the time of induction. Nil issues disclosed. Injury to right hand and arm". Steven Freeman was transported to the AMC with three other mainstream detainees, two of whom identified as Aboriginal and/or Torres Strait Islander.

8.2 Assessment at the AMC

- 8.2.1 Steven Freeman arrived at the AMC at approximately 1.50 pm according to ACTCS records. At 2.24 pm the induction process continued. ACTCS provided the Inquiry CCTV footage of the assessment, which the Inquiry reviewed.
- 8.2.2 Steven Freeman was assessed for just less than two hours in a separate admissions area.
- 8.2.3 ACTCS officers reported that during his admission process at the AMC, Steven Freeman indicated he identified as Aboriginal, that he had not been previously assaulted in custody, that he did not require any non-association considerations and he had a cousin in custody at the AMC.
- 8.2.4 The ACTCS internal review of its compliance with the RCIADIC Report suggests that the RCIADIC recommendations regarding separation and assessment for new arrivals has been implemented, as new detainees are placed in a separate cell for the duration of the assessment period.
- 8.2.5 After his assessment was complete, Steven Freeman was again asked about any association issues he may have had. He indicated to an admissions officer that he had

⁹ RCIADIC, above n 6, Recommendations 137 to 139.

concerns with detainees in Remand Unit 1.¹⁰ Steven Freeman did not disclose names or details regarding those concerns. As a result of this disclosure, a more senior officer, the Admissions Supervisor, took Steven Freeman into a private interview room to obtain further details.

- 8.2.6 Steven Freeman had a history in the youth justice system, about which ACTCS would not have known. Youth Justice is a separate Government agency to ACTCS within another ACT Government Directorate, named Community Services.
- 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.
- 8.2.8 As a result of the assessment, the decision was made to accommodate Steven Freeman in Sentenced Unit 1. ACTCS records indicate that Steven Freeman agreed.
- 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 Justice Health Services Assessment

- 8.3.1 Steven Freeman was assessed on admission at the AMC by a Justice Health Services nurse and, consistent with standard procedure, documented not to be at risk of self harm or suicide. Justice Health Services confirmed that it did not receive any information from ACT Policing about Steven Freeman's pre-arrest behaviour and disclosures in police custody.
- 8.3.2 Subsequently, Steven Freeman was seen by a Justice Health Services nurse and medical officer, who treated his injured forearm.
- 8.3.3 In the induction assessment, the Justice Health Services nurse recorded that all Steven Freeman's vital signs were normal and that he was able to respond to the questions in the induction assessment.
- 8.3.4 Steven Freeman told the Justice Health Services nurse that he had been using methamphetamine (ICE). This information was recorded, as the Justice Health Services nurse made a reference to a "significant daily ICE habit" at a cost of \$300 per day. The Inquiry found no other response to this significant disclosure. No methamphetamine (ICE) withdrawal assessment was made (or if it were, it was not documented), no care plan was developed for the possibility Steven Freeman might experience withdrawal and no referral was made for drug counselling. ACT Health told the Inquiry that Justice Health Services did not observe any signs of withdrawal.

¹⁰ These names reflect the original design intent of the AMC. As is noted in the Report, both remanded and sentenced detainees are accommodated together in both.

- 8.3.5 Justice Health Services did not provide the information about Steven Freeman’s “significant daily ICE habit” to ACTCS. The Inquiry notes that Justice Health did not provide this information to TCH either on Steven Freeman’s emergency presentation there later on 28 April following his assault. ACT Health acknowledged that a formal, written process for clinical handover should have occurred on Steven Freeman’s emergency transfer to TCH.
- 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.
- 8.3.7 According to ACT Health, signs of methamphetamine (ICE) withdrawal are symptomatic and include agitation and aggression. The Inquiry notes Steven Freeman exhibited such behaviour on 6 May 2015 at the TCH, when staff called a “Code Black”. This incident is discussed at paragraph 9.2.7.
- 8.3.8 The Inquiry **concludes** also that this situation reveals an instance of inadequate information sharing in relation to Steven Freeman. 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 Admission to the AMC Sentenced Unit 1

Accommodation Shortage

- 8.4.1 Custodial officers reported at the time of Steven Freeman’s admission that the AMC was “very short on bed vacancies”. ACTCS told the Inquiry that around that time the AMC was running at 125 per cent bed occupancy.
- 8.4.2 The ACTCS General Manager during Steven Freeman’s bail hearing (in June 2015) agreed with the proposition put by the ALS that, when Steven Freeman was assigned to Sentenced Unit 1, there were few if any other options.¹¹

¹¹ Transcript of Proceedings, *Christine Elizabeth Walters v Steven Claude Freeman* (ACT Magistrates Court), CC4358/15, Magistrate Dingwall, 10 June 2015, page 7.

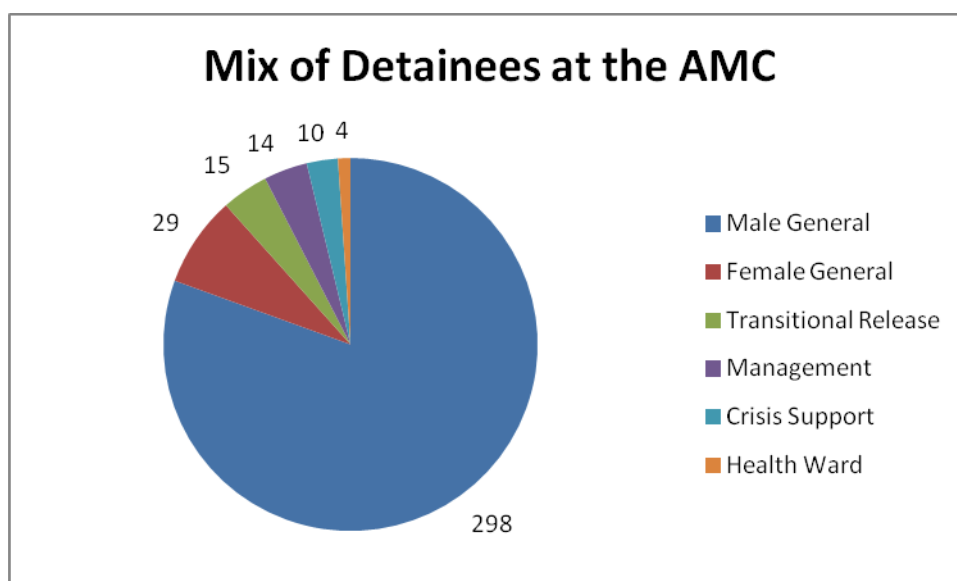


FIGURE 2: MIX OF DETAINEES AT THE AMC IN APRIL 2015

8.4.3 The AMC presents particular management challenges because detainees from a relatively small ACT jurisdiction and community are held in a single prison.

8.4.4 As the Knowledge Consulting Report (2011) stated:

“That ACT Corrective Services in commissioning the AMC faced a considerable and unique challenge when compared to most jurisdictions in that the ACT is a “one correctional centre jurisdiction”. This means that the AMC houses all categories of detainees from those on remand (unconvicted and or awaiting sentencing), through all sentenced security classifications and both genders.”¹²

8.4.5 ACTCS informed the Inquiry that the AMC has to manage up to 16 classifications and categories of detainee. The Inquiry notes that the AMC’s physical layout and design is not well suited for the contemporary requirement to manage such diversity.

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.

Allocation of Accommodation for Steven Freeman

8.4.7 The Inquiry notes Steven Freeman would have been unwell and vulnerable, although perhaps this was not apparent, when he was assigned to Sentenced Unit 1 at the AMC,

¹² Knowledge Consulting (2011) ‘Independent review of Operations at the Alexander Maconochie Centre, ACT Corrective Services’. http://www.justice.act.gov.au/resources/attachments/Report_of_Independent_Review_of_AMC_12_March_2011.pdf. Page 31.

due to his recent prolonged use of illicit drugs and alcohol. Steven Freeman's methamphetamine (ICE) use in particular meant he had not slept for almost two weeks.

- 8.4.8 The Inquiry notes also that assessment of suitable accommodation for Steven Freeman included a number of conversations with him, when he would have been affected by illicit drugs and alcohol.
- 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.
- 8.4.10 The Inquiry notes that the AMC could not realistically make the best decision concerning Steven Freeman's placement in a matter of hours.
- 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.
- 8.4.12 When Steven Freeman was placed in Sentenced Unit 1, it had 36 detainees of whom 20 were sentenced detainees and 16 were on remand. There were two beds vacant. The two single cells equipped with CCTV were both occupied by detainees who had particular risk factors.

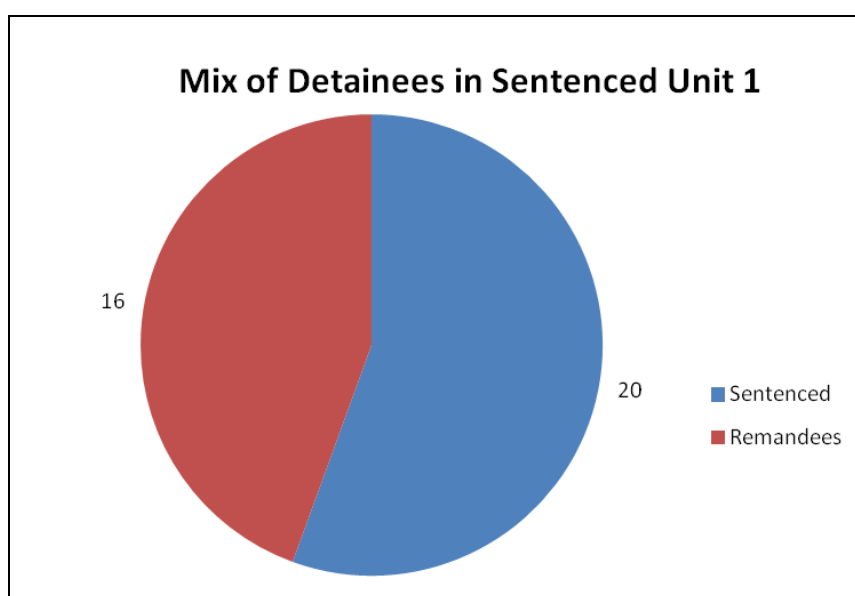


FIGURE 3: MIX OF DETAINEES IN SENTENCED UNIT 1

- 8.4.13 Sentenced Unit 1 accommodates a mixture of mainstream detainees, that is those not under some form of protection, primarily classified as medium level security. There were ten other detainees who identified as Aboriginal in the Unit, and one who identified as Torres Strait Islander. Steven Freeman was placed in cell 2 with another Aboriginal detainee.

- 8.4.14 The Inquiry notes that Steven Freeman's cell was on the ground floor and almost the furthest away from the custodial officers station located within Sentenced Unit 1. For a detainee on observation, which is the case for all newly arrived detainees, the Inquiry notes also that a cell closer to the custodial officers station would have been more observable.
- 8.4.15 The Inquiry understands that news travels quickly through the AMC about new detainees arriving from the court. Accordingly, Steven Freeman's pending arrival at the AMC would have been known before he appeared in Sentenced Unit 1.
- 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.
- 8.4.17 The Inquiry notes that, since Steven Freeman's assault, the AMC places all new arrivals initially in Remand Unit 2 in a "new receptions" unit, generally for a period of five days. This facility and longer period of assessment enables the AMC to observe and collect information in order to make a more informed and considered assessment of a detainee's placement.
- 8.4.18 Changes have been made since Steven Freeman's assault. In particular, three new cameras have been installed in Sentenced Unit 1 facing towards the cell doors. Had these cameras been in place at the time of Steven Freeman's assault, there would have been additional evidence available to ACT Policing and ACTCS about which detainees entered Steven Freeman's cell.
- 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.

8.5 Steven Freeman's Assault

- 8.5.1 According to ACTCS records, Steven Freeman was taken to Sentenced Unit 1 at approximately 4.30 pm. Observations every thirty minutes commenced and the custodial officer responsible reported to his supervisor that he felt suspicious after noticing detainees near Steven Freeman's cell from 5.30 pm. However, ACTCS told the Inquiry that it is not unusual for detainees to greet a newly arrived detainee.
- 8.5.2 CCTV footage shows Steven Freeman entering the communal cooking area of the cell block on a couple of occasions. Subsequently, he returned to his cell to lie down. The protocol at the AMC is that detainees may shut their cell door, which will automatically lock, particularly if they wish to have privacy.
- 8.5.3 At 6.00 pm, a custodial officer spoke to Steven Freeman and his cell mate. He reported being concerned that Steven Freeman was trying to sleep while other detainees were entering his cell. He instructed Steven Freeman's cell mate to close the door and ensure no other detainees entered. His cell mate stated:

"No, I will be in the cell and there will be people coming in and out."

- 8.5.4 This custodial officer returned at 6:15 pm, at which time he observed Steven Freeman alone in the cell. The custodial officer recalls the cell was closed and locked, and through the cell door observation window he observed Steven Freeman sleeping on the top bunk. The Inquiry confirmed via ACTCS records that the cell was opened by swipe card at several times between 6.15 and 6.33 pm.
- 8.5.5 The inquiry notes that this log was not requested by ACT Policing or provided to ACT Policing by ACTCS. The Inquiry considers that this evidence is relevant to the investigation of Steven Freeman's assault and notes this deficiency.
- 8.5.6 The Inquiry provided this information to ACT Policing. ACT Policing told the Inquiry that it is re-evaluating the evidence it holds about Steven Freeman's assault.

8.6 ACTCS Response to Assault

- 8.6.1 At 6.30 pm, eight minutes after his last check, a custodial officer returned to Steven Freeman's cell and found him alone, lying on the floor severely injured. A "Code Pink", which is used for medical emergencies, was called. The ACTCS incident log suggests that one of the custodial officers commenced first aid. The Inquiry understands that the actions of this custodial officer probably saved Steven Freeman's life.
- 8.6.2 The ACTCS Code Pink Medical Emergency Procedure 2014 complies with the recommendations of the RCIADIC.¹³ The policy was followed, and advice which medical professionals provided the Inquiry confirms the first response to Steven Freeman's injuries was appropriate.

Notification to the Family

- 8.6.3 On the evening of Steven Freeman's assault, the ACTCS acting Executive Director, informed Narelle King of the assault on her son, Steven Freeman. Before that, the acting Executive Director was unsuccessful in attempting to contact both the ACTCS Aboriginal Case Worker and ACTCS Indigenous Liaison Officer to inform them of the incident and involve them in notifying Steven Freeman's family.
- 8.6.4 On the morning of 29 April, the Aboriginal Case Worker contacted Steven Freeman's family to provide support.
- 8.6.5 The Inquiry notes that the acting Executive Director made every effort to comply with the ACTCS policy but was unable to do so.
- 8.6.6 The Inquiry **concludes** the ACTCS response following Steven Freeman's assault was appropriate.

¹³ RCIADIC, above n 6, Recommendations 158, 159 and 160.

8.7 Justice Health Services Response to the Assault

- 8.7.1 At 6.36 pm, Justice Health Services nurses attended Steven Freeman in his cell and an ambulance was called shortly afterwards. Justice Health Services staff members provided initial treatment to Steven Freeman until paramedics arrived at 6.50 pm. A second ambulance arrived at 6.58 pm.
- 8.7.2 The Inquiry **concludes** the Justice Health Services immediate response to Steven Freeman's assault was appropriate.

Part 9. Admission to The Canberra Hospital

9.1 Intensive Care Unit

- 9.1.1 Steven Freeman arrived at The Canberra Hospital (TCH) at 7.51 pm.
- 9.1.2 Steven Freeman spent nine days in TCH from 28 April 2016 to 7 May 2016. During that time, he remained in the custody of ACTCS.
- 9.1.3 At 8.40 pm, the AMC acting General Manager arrived at the hospital, spoke to Steven Freeman's family and offered support.
- 9.1.4 Steven Freeman's condition was serious. He was in the Intensive Care Unit (ICU) from 28 April to 2 May 2015.
- 9.1.5 Steven Freeman's mother, Narelle King, felt disrespected by health staff members during her visits to TCH. In particular when she sought information about Steven Freeman's injuries, she was told to ask the AMC. Narelle King was not notified of his transfer from the ICU to the Neurosurgical Ward. Narelle King told the Inquiry she suffered distress when she went to the ICU and discovered Steven Freeman was not there. Her reported reaction was that he had died.
- 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 Neurosurgical Ward

- 9.2.1 As already noted, information known by Justice Health Services about Steven Freeman's use of illicit drugs, including methamphetamine (ICE), and alcohol was not passed on to TCH. On 29 May 2015, a TCH social worker made a notation that Steve Freeman's mother, Narelle King, told her that Steven Freeman had been using methamphetamine (ICE) in the preceding months.
- 9.2.2 ACT Health informed the Inquiry that it can take several weeks for a person to withdraw from methamphetamine (ICE). Generally, the physical withdrawal occurs in one or two weeks.
- 9.2.3 ACT Health advised that the time frame for withdrawal can differ.
- 9.2.4 In the view of the Inquiry, this information should have resulted in a care plan for Steven Freeman's multi-substance withdrawal being developed and this information being considered in his care more broadly.
- 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.

- 9.2.6 According to ACTCS records, at approximately 6.15 am on 4 May 2015 Steven Freeman was verbally abusive towards TCH staff members.
- 9.2.7 On 6 May 2015, TCH staff members called a Code Black in relation to Steven Freeman's behaviour in the neurosurgical ward. A Code Black is one of a series of emergency response codes used in Australian hospitals to deal with incidences of violence or aggression.
- 9.2.8 The Inquiry has confirmed with several witnesses that Steven Freeman behaved in an uncharacteristically aggressive fashion on this occasion.
- 9.2.9 The Inquiry notes that TCH clinical records do not indicate any clinical assessment into what caused Steven Freeman to act in this way. It does not appear that the decision to discharge Steven Freeman was revisited following the Code Black.

9.3 Restraint at TCH

- 9.3.1 Case notes indicate that on 5 May 2015, Steven Freeman was handcuffed while going outside to smoke.
- 9.3.2 ACTCS case notes also record that Steven Freeman was handcuffed during the Code Black incident on 6 May 2015. Following that episode of behaviour, the decision was made that Steven Freeman should be handcuffed for all movements within the hospital and only be unrestrained while in his ward bed.
- 9.3.3 Steven Freeman's family told the Inquiry that Steven Freeman was restrained for periods of time on 6 and 7 May 2016.
- 9.3.4 In 2014, the then Health Services Commissioner conducted a review of the restraint of a detainee who was receiving mental health treatment at the Adult Mental Health Unit (AMHU) at TCH. In response, ACTCS changed its Escort Policy, which now requires that the General Manager authorise restraint in excess of two hours in escort situations.¹⁴

9.4 Discharge from TCH

- 9.4.1 Steven Freeman was discharged from TCH on 7 May 2015.

¹⁴ The Inquiry notes the 2007 Human Rights Audit of ACT Correctional Facilities recommendations about the use of restraint, and notification to the Health Services Commissioner.

Part 10. Bail Hearings

- 10.1.1 On being discharged from TCH on 7 May 2015, Steven Freeman went straight to the ACT Magistrates Court, where he sought bail. Steven Freeman was represented by the Aboriginal Legal Service (ALS).
- 10.1.2 Steven Freeman's mother, Narelle King, gave evidence before the court that she was concerned about her son's safety if he returned to the AMC. Narelle King told the court she had received a phone call that her son would die if he went back to the AMC. Narelle King also told the court she thought Steven Freeman would be safer in the community and made a commitment to look after him if he were released on bail.
- 10.1.3 ACT Policing gave evidence on 7 May 2015 that it had concerns about Steven Freeman's safety in the community
- 'I believe the defendant's safest place at the moment would be within AMC. The 19 stolen motor vehicles I'm talking about were involved in several police pursuits around the ACT. These pursuits were often called off due to the reckless driving behaviour which involved crossing to the other side of the road and driving up on footpaths. One of those stolen motor vehicles was involved in a serious motor vehicle collision where that 16-year-old female sustained those back injuries. I believe the defendant is still in an able position and capable of driving a motor vehicle. With his current drug use, whether he would be feeling pain or effected, I think if he were to take drugs and conduct in that sort of behaviour that he would re-engage in the criminal activity that he was already involved in.'*¹⁵
- 10.1.4 Chief Magistrate Walker summarised the prosecution's argument against bail before her on 7 May 2015 as being:
- '...effectively on four grounds; failure to answer bail, further offending, the protection of the public and the protection of the defendant himself. The prosecution places its greatest emphasis on the question of further offending.'*¹⁶
- 10.1.5 On 7 May 2015, Chief Magistrate Walker refused Steven Freeman bail.
- 10.1.6 The Inquiry notes that at this bail hearing the prosecution recommended that Steven Freeman be marked as a "detainee at risk".¹⁷ This did not occur.
- 10.1.7 On Tuesday 12 May 2015, Steven Freeman sought a review of this decision before Magistrate Peter Dingwall. The ALS appeared for Steven Freeman and argued there was a change of circumstances since the Chief Magistrate's refusal of bail, in that his mother, Narelle King, was prepared to provide surety of \$90,000.

¹⁵ Transcript of Proceedings, *The Queen v Steven Claude Freeman* (ACT Magistrates Court), CC12126/14, Chief Magistrate Walker, 7 May 2015, page 8.

¹⁶ Ibid, page 25.

¹⁷ Ibid, page 16.

- 10.1.8 ACTCS staff members gave evidence before Magistrate Dingwall that Steven Freeman would be safe if he was remanded in custody. The AMC Deputy General Manager gave evidence that AMC had placed Steven Freeman in the safest possible place for his own protection.
- 'I believe we've done absolutely everything in our power to stop that. As I said there's no guarantees going forward. Mr Freeman himself may fall out with another detainee and there may be an altercation...I know where he is now he is extremely safe.'*¹⁸
- 10.1.9 The ALS, who appeared for Steven Freeman, also argued that he could not be provided adequate health care at the AMC. Magistrate Dingwall dismissed this argument on 10 June 2015 after assessing clinical records from ACT Health.
- 10.1.10 Magistrate Dingwall's consideration of Steven Freeman's application for bail lasted several weeks until 10 June 2015. It is unusual for a bail hearing to last this long, with the key points of discussion being whether the interaction of *Human Rights Act 2004* and the *Bail Act 1992* should result in the mixing of Steven Freeman with sentenced prisoners. The Inquiry notes that Magistrate Dingwall sought to hear all relevant information to ensure he made the right decision regarding Steven Freeman's bail consideration.
- 10.1.11 Ultimately, Magistrate Dingwall refused Steven Freeman's bail application, largely because of concerns that he was a flight risk.
- 10.1.12 At the bail hearing on 12 May 2015 Magistrate Dingwall noted "...it hasn't been done up until now but I'll mark his paper 'detainee at risk'"¹⁹.
- 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.

Aboriginal and Torres Strait Islander considerations in bail and sentencing

- 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.
- 10.1.15 On 1 September 2016, the Inquiry attended a forum hosted by the ACT Justice and Community Safety Directorate (JACS) on the use of *Gladue* reports in Canada, that seek to provide a court with information prior to sentencing, and sometimes bail, when considering criminal charges against an Aboriginal person. These reports are provided by

¹⁸ Transcript of Proceedings, *Director General v Steven Claude Freeman* (ACT Magistrates Court), CC4358/15, Magistrate Dingwall, 28 May 2015, page 21.

¹⁹ Transcript of Proceedings, *Christine Elizabeth Walters v Steven Claude Freeman* (ACT Magistrates Court), CC4358/15, Magistrate Dingwall, 12 May 2015, page 20.

an independent, Aboriginal-led service, that seeks to provide the courts details of the inter-generational trauma and disadvantage suffered by Aboriginal people in Canada.

- 10.1.16 Recommendation 92 of the RCIADIC established the principle that imprisonment ought to be a last resort as a sanction for Aboriginal and Torres Strait Islander people.
- 10.1.17 The relevant Canadian legislation does not compel a court to automatically change a person's sentence in light of this information and in particular, the court cannot impose a sentence outside the range of legally available penalties. Nonetheless these reports serve a educative role in ensuring all participants in the criminal proceedings are aware of the defendant's background and were introduced in light of the overrepresentation of Aboriginal people in the Canadian justice system.
- 10.1.18 The Inquiry understands that the ACT Government is in the process of developing a bail support service. In formulating this model, the Government should consider what role a Aboriginal-led organisation could have in providing bail support. Such a role could for example include:
- Making legislative provision for the presentation of *Gladue* style reports for sentencing in the ACT, and funding a service to provide this information based on the Canadian model;
 - Participating as a friend of the court in bail hearings, including providing options and information to the court about the background of an accused person, and alternatives to remanding them in custody.
 - Adopting the requirement in the NSW *Bail Act 2013* that Aboriginal and Torres Strait Islander status is explicitly considered;
 - Considering whether the onuses in the Bail Act for an accused person to overcome are consistent with the *Human Rights Act 2004*, including what effect the routine mixing of remand and sentenced detainees should have on a court assessing an application for bail.
- 10.1.19 Further, the Inquiry notes the ACT is establishing a Ngunnawal Bush Healing Farm. The Farm will provide a culturally appropriate alcohol and other drug residential rehabilitation service. Construction was delayed in the face of opposition from neighboring landholders. The Farm is expected to open in early 2017.
- 10.1.20 This facility could have been a suitable placement for Steven Freeman following his assault at the AMC. The Inquiry heard from the Aboriginal community that the initial eight beds at the new facility may not be sufficient, particularly if it is an option for those on bail.

Part 11. Investigation of the Assault

11.1 ACTCS Internal Management Review

- 11.1.1 On 13 May 2015, ACTCS completed an Internal Management Review (IMR) into the assault on Steven Freeman.²⁰ The Inquiry notes that ACTCS is now establishing a multidisciplinary team at the AMC to review all assaults.
- 11.1.2 The IMR made three recommendations for the ACTCS to:
- a) consult with AFP (ACT Policing) to determine how transfer of intelligence from police to ACTCS may be enhanced.
 - b) develop an after-hour's emergency phone contact list, debrief checklist, incident instruction flip charts and scene log template.
 - c) when considering appropriate accommodation and placement options relating to AMC additional facilities, consider the feasibility of new arrival induction unit.
- 11.1.3 As discussed at paragraph 7.2.11, an MOU was established between the AFP and the Justice and Community Safety Directorate on 10 March 2010. The MOU was being reviewed at the time of Steven Freeman's assault, and an updated version was signed on 9 June 2015.
- 11.1.4 After the assault on Steven Freeman, and consistent with the recommendations of the 2015 IMR, ACT Policing agreed to increase the amount of information provided to ACTCS. From August 2015, ACT Policing began providing ACTCS with:
- the statement of facts for current charges;
 - a list of all victims;
 - a list of known associates; and
 - a list of alerts on ACT Policing records those are relevant to the safety of the detainee or other detainees at the AMC, any victims, the AMC or the community.
- 11.1.5 Subject to privacy provisions (and conventions), the ACT Policing Corrections Liaison Officer also forwards all intelligence holdings to the AMC intelligence unit that:
- are relevant to the safety of detainees and the operations of the AMC; and
 - considered reasonably necessary to assist ACT Corrective Services in preventing the commission of criminal offences within the AMC.

²⁰ An IMR is an internal review by ACTCS to significant incidents.

- 11.1.6 These changes reflect a deficiency in policy and procedure at the time of Steven Freeman's admission. The Inquiry notes that the RCIADIC recommended that MOUs of these kinds be subject to ministerial approval.
- 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.

CCTV and Staff Observations

- 11.1.8 The ACTCS internal review found that at the time Steven Freeman was assaulted in cell 2 of Sentenced Unit 1, both CCTV cameras and the custodial officers station did not have direct line of sight to cell 2.
- 11.1.9 According to ACTCS' internal review, on the day of Steven Freeman's assault there were two cameras mounted to the ceiling of the Unit. They were preset to view the common area and are located at either end of the unit to maximise the area of coverage.
- 11.1.10 Sentenced Unit One has two floors of cells, and these cameras can be manually controlled from the Main Control Room or Operations Control Room to view both the upper and lower cell doors. There were no cameras in individual cells, with the exception of two cells on the ground floor, adjacent to the custodial officer's station. These cells are used for "various detainee management purposes".
- 11.1.11 Both cameras were set to a particular position at 7.00 am on the morning of 28 April 2015. As such, neither camera was positioned to view the assault, although one camera was repositioned immediately after the assault to face the door of cell 2 when the code pink was called at 18.32.
- 11.1.12 On viewing the CCTV footage, the Inquiry noted that one camera was repositioned upwards at 5.25 pm. ACTCS reported to the Inquiry that this was due to a large group of detainees congregating on the upper level of Sentenced Unit 1, and the repositioning was intended to provide a better view of their activities. Neither in its original location, nor the slightly repositioned state, did the camera provide any coverage of Steven Freeman's cell.
- 11.1.13 Custodial officers reported that the door to cell 3 was open at the time of the assault, obscuring the view of cell 2 from the custodial officers station.
- 11.1.14 The location and repositioning of the CCTV cameras at the time of Steven Freeman's assault meant that there is no direct recording of what occurred. Both the 2015 IMR and, in evidence given during Steven Freeman's bail hearings, ACTCS staff members found the current CCTV camera system to be inadequate.
- 11.1.15 The Knowledge Consulting Inquiry (2011) had recommended that ACTCS investigate change to the CCTV arrangements. This recommendation related to issues with the recording system, the length of time video was retained and the definition of critical incident. It also recommended that ACTCS investigate changes to the CCTV in the Crisis

Support Unit. None of these issues was apparently present in relation to Steven Freeman.²¹

11.1.16 Following the assault of Steven Freeman, three additional fixed cameras were fitted in the two sentenced units and two remand units which provide extensive coverage of all cell doors. In the last 6 months, ACTCS has installed the following additional cameras:

- 12 in accommodation blocks;
- 2 in walkway to visits;
- 2 in visits yard;
- 10 in education; and
- 2 in the kitchen.

11.1.17 Nonetheless, neither ACT Policing, ACTCS, nor this Inquiry, was able to determine which detainees were present in Steven Freeman's cell at the time of his assault. Even with this increased CCTV coverage, a risk remains that such an assault could occur again.

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.

11.1.19 The Inquiry notes that ACTCS was not able to provide detailed information about why one of the cameras was repositioned at 5.25 pm. The Australian Standard on the Management and Operation of CCTV states:

*"That a complete and thorough operator's log should be kept for each work station."*²²

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

11.1.21 The Inquiry notes the Australian Standard on the Management and Operation of CCTV says:

*"Good training is essential for achieving effective and proper use of CCTV. When a potential incident occurs, the operator needs to be able to react to monitor the event accurately and not lose information that could be pertinent to any future investigation."*²³

²¹ Knowledge Consulting, see above n 12, page 41 and 75.

²² Australian Standard (2006) 'Closed circuit television (CCTV) Part 1: Management and operation,' AS 4806.1 – 2006. page 24.

²³ Ibid, page 15

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

Recommendation 1: That ACT Corrective Services conduct a survey of electronic surveillance at the AMC to ensure best practice protection for, and the security of, detainees including:

- training for AMC custodial officers operating CCTV cameras; and
- developing protocols relating to camera settings, movement and recording.

11.1.23 Due to a time error on the CCTV footage, it was difficult for the Inquiry to confirm the observation times recorded. Due to this error, the Inquiry had to rely on the assistance of ACTCS officers to confirm that an officer undertook four observations between 5.30 and 6.30 pm, two more than necessary, due to concerns about Steven Freeman.

11.1.24 The Australian Standard on the Management and Operation of CCTV states

“When recording material from a CCTV system the operator should ensure the time/date generator is correctly displayed and synchronized to the exact time/date on all the systems equipment.”²⁴

11.1.25 Further the Standard provides that recorded information should be of the high quality required by the courts if it is to be admitted in evidence. It is essential, therefore, that recorded information intended to be used as evidence maintains total integrity and continuity at all times.²⁵

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.

11.1.27 The ACT Government previously trialled the use of Radio Frequency Identification (RFID) bracelets and anklets to track the movements of detainees.²⁶ Such a device indicates a detainee’s whereabouts every two seconds. The data can be stored and logged.

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 ACT Policing Investigation

11.2.1 At 10.30 pm, ACT Policing detectives and forensics officers arrived at the AMC and entered Sentenced Unit 1. They treated cell 2 as a crime scene. Shortly after arriving, ACT Policing detectives commenced questioning detainees.

²⁴ Ibid, page 23.

²⁵ Ibid, page 21.

²⁶ Deare.S (2006) ‘RFID to track ACT Prisoners’. ZDNET. <http://www.zdnet.com/article/rfid-to-track-act-prisoners/>.

- 11.2.2 The Inquiry acknowledges the efforts of ACT Policing detectives and forensic officers who investigated Steven Freeman's assault.
- 11.2.3 The Inquiry notes that Steven Freeman declined to identify his assailants and that ACT Policing gave evidence during his bail application that he had reported he would seek revenge when released.
- "The defendant refused to go on tape and on record and provide any evidence as to who those persons were, however, did state to police that his intention was to receive bail today and seek revenge on those persons by putting them in a coma."*²⁷
- 11.2.4 The Inquiry understands that ACT Policing did not interview all custodial officers on duty on the night of 28 April 2015.
- 11.2.5 When the Inquiry spoke to the custodial officer who found Steven Freeman injured in his cell, he provided information about Freeman's assault, which the Inquiry passed to ACT Policing.
- 11.2.6 An ACT Policing officer told the Inquiry that police distinguished between the criminal charges Steven Freeman was facing, and the investigation of his assault in which he was a victim.
- 11.2.7 Narelle King was notified on Christmas Day 2015 that ACT Policing was closing its investigation into Steven Freeman's assault, and that no charges would be preferred. Narelle King told the Inquiry it is a cause of frustration and grief that her son's assailants and their motives remain unidentified.
- 11.2.8 Subsequent to the closing of the police investigation, this Inquiry was provided information about the identity of those involved in Steven Freeman's assault. The Inquiry provided this material to ACT Policing. Nonetheless, the Inquiry is unable to determine who assaulted Steven Freeman in April 2015.
- 11.2.9 An impediment to ACT Policing, ACTCS and this Inquiry is the unwillingness of detainees to discuss what occurs in a prison environment. This situation is due to several factors including concerns about the safety of those who provide information and an inherent distrust of authority.
- 11.2.10 The Inquiry notes that the threat of violence at the AMC is real. The Inquiry notes also and accepts that detainees see the need to protect themselves by maintaining silence.
- 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

²⁷ Transcript of Proceedings, *The Queen v Steven Claude Freeman* (ACT Magistrates Court), CC12126/14, Chief Magistrate Walker, 7 May 2015, page 7.

Freeman's bail hearings, ACT Policing gave evidence that they were not treating his assault as an attempted murder investigation.²⁸

Recommendation 2: That ACT Policing accord a higher priority to the investigation of any assault at the AMC.

11.2.13 A view expressed to the Inquiry was that ACT Policing could not proceed to charge a person with an offence unless the victim was willing to act as complainant. The Inquiry can find no legislative barrier to ACT Policing charging without a complainant.

Recommendation 3: That ACT Policing, ACTCS and ACT Director of Public Prosecutions develop and adopt pro-charge and pro-prosecution policies in relation to assaults at the AMC.

11.3 Disciplinary Charges

- 11.3.1 ACT Policing notified ACTCS in December 2015 that no criminal charges would result from its investigation of Steven Freeman's assault. The response to such an incident can be a criminal investigation or an ACTCS disciplinary investigation, but not both concurrently.
- 11.3.2 Once ACT Policing decided not to proceed, ACTCS determined it had insufficient evidence to lay disciplinary charges despite suspicions about the detainees involved.
- 11.3.3 Nonetheless, in assessing this aspect of Steven Freeman's treatment in custody, the Inquiry notes the lack of disciplinary or criminal charges arising from Steven Freeman's assault.
- 11.3.4 The Inquiry notes also that the sense of grievance extends beyond the AMC to family members in the community, as is the case with Steven Freeman's family.
- 11.3.5 At the Inquiry's request, ACTCS provided the following summary of serious assaults on detainees. A serious assault is defined as an act of physical violence resulting in injuries that require treatment involving hospitalisation overnight in a medical facility or ongoing medical treatment, as well as all sexual assaults.²⁹

²⁸ Ibid, page 13.

²⁹ As defined in the Productivity Commissioner's annual Report on Government Services.

	Number of Serious Assaults Detainee on Detainee Total	Number of Serious Assaults Detainee on Detainee: Victim was Aboriginal and/or Torres Strait Islander	Number of Assaults Referred to ACT Policing	Number of Assaults that proceeded to charge	Number of Assaults that proceeded to Prosecution	Number of Assaults that resulted in formal disciplinary action	Time between notification to police and notification whether charges would be laid
2015-16	0	0	0	0	0	0	0
2014-15	2	1	1	0	0	1	12 months + 16 days
2013-14	5	2	5	1	1	1	<12hrs
2012-13	2	1	1	1	1	1	<12hrs

- *The difference between number of assaults referred to ACT Policing and number of assaults that proceeded to charge is due to the victim providing a statement of no complaint.*

- 11.3.6 Concerns were also expressed in terms of management and control of the AMC. That detainees were not being held to account for their actions was thought to undermine control of AMC management.
- 11.3.7 The Inquiry notes that in all Australian jurisdictions, work safety authorities and the police often investigate work sites in partnership.³⁰
- 11.3.8 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. 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.

11.4 The Reason for the Assault

- 11.4.1 One of the questions asked by the family and community of this Inquiry was why Steven Freeman was assaulted two hours after being placed in Sentenced Unit 1.
- 11.4.2 The Inquiry notes that not knowing who assaulted Steven Freeman has left his mother, Narelle King, and other family members, in a state of anxiety for their personal safety.

³⁰ As discussed for example in Queensland WorkSafe, *A Death in the Workplace: A Guide for Family and Friends*, 2013, https://www.worksafe.qld.gov.au/_data/assets/pdf_file/0006/82716/a-death-in-the-workplace.pdf (accessed 5 November 2016)

- 11.4.3 The Inquiry became aware of the rumours circulating in the community about why Steven Freeman was assaulted.
- 11.4.4 A rumour was that Steven Freeman had caused offence when he left injured passengers behind at the scene of a car accident. Reference was also made to personal relationships outside the AMC. Steven Freeman himself, based on phone conversations, seemed to be under the impression that the assault was motivated by incidents involving a “female”.
- 11.4.5 It seems clear to the Inquiry that Steven Freeman was not anticipating the assault, at least not from the detainees in Sentenced Unit 1.
- 11.4.6 The CCTV footage shows some detainees taking clothing to laundry shortly afterwards and it appears some detainees may have changed their shoes.
- 11.4.7 It was reported to the Inquiry that after engaging in acts of violence in the AMC, detainees change their clothing, wear bigger (or different) shoes and use punching bags at the gym to disguise hand injuries. The Inquiry was also told that there is bleach available for detainees that they can use to clean clothes and other items.
- 11.4.8 Steven Freeman’s experience is an example of the unique challenges of running a single correctional institution in the ACT, where the detainees have known each other for many years and mix in the same circles. Retribution is always a risk.
- 11.4.9 The Inquiry understands that the assault was more severe than intended and became frenzied. The Inquiry understands also that those involved felt the assault “went too far” and there was immediate anxiety that they could be subject to manslaughter or even murder charges.

Part 12. Return to the AMC from TCH

12.1 Treatment at the AMC by ACTCS

- 12.1.1 Steven Freeman returned to the AMC on 7 May 2015. His mother, Narelle King, visited him the same day. The meeting took place in a private room in the AMC visiting area although other detainees and their families were nearby. Narelle King told the Inquiry that Steven Freeman was the subject of curiosity because of his bandaged head and bruised face. According to Narelle King, this situation caused her and Steven Freeman embarrassment and discomfort.
- 12.1.2 AMC management considered there was a risk of Steven Freeman being assaulted again. Accordingly, on 11 May 2015, AMC management arranged for a number of Aboriginal and Torres Strait Islander detainees to meet with Steven Freeman. The AMC Indigenous Liaison Officer and Aboriginal Case Manager attended, as did the acting AMC General Manager. Discussion at this meeting indicated that Steven Freeman would not be safe in the Remand Block, Sentenced Block or Sentenced Cottage. In the AMC management's view, protection accommodation was the safest option for Steven Freeman.
- 12.1.3 Accordingly, in the days following, Steven Freeman was placed in the Management Unit in a cell by himself with no association with other detainees. Initially, Steven Freeman was on a regime of 60 minute observations.
- 12.1.4 The acting AMC General Manager said (during Steven Freeman's bail application):
- "The original decision was to put him in a management unit which is certainly a more isolated area, just until we could confirm where else in the main centre we felt would be appropriate and also to speak to Steven Freeman, himself, about the consideration of safety going forward into his placement in the Centre."*³¹
- 12.1.5 The Inquiry notes that measures were put in place to monitor Steven Freeman during this period. These measures included regular visits by Corrections Psychological and Support Services (CPSS) staff, the Indigenous Liaison Officer, Aboriginal Case Manager, acting General Manager and regular interactions with custodial officers.
- 12.1.6 On 20 May 2015, 13 days later, Steven Freeman was transferred to the Remand Cottage, where he was able to mix with other detainees, in accordance with his wishes.
- 12.1.7 On 15 February 2016 Steven Freeman was relocated to the recently completed Accommodation Unit North wing on seven days separate confinement for a breach of discipline. On the 24 February 2016, Steven Freeman was relocated to AU South wing where he remained until his death.

³¹ Transcript of Proceedings, *Christine Elizabeth Walters v Steven Claude Freeman* (ACT Magistrates Court), CC4358/15, Magistrate Dingwall, 10 June 2015, page 3.

12.2 Health Care on Return to the AMC from TCH

- 12.2.1 Steven Freeman was reviewed by the Justice Health Services Primary Care nurse “in clinic” on 7 May at 5.00 pm. On 8 May 2015, the TCH discharge summary was reviewed and noted by Justice Health Services medical officer and follow-up appointments made with TCH.
- 12.2.2 On 8 May 2015, the TCH discharge summary was reviewed and noted by a Justice Health Services medical officer and follow-up appointments made with TCH. On that day, Steven Freeman was also seen by the ACTCS Senior Psychologist and the ACTCS Indigenous Liaison Officer.
- 12.2.3 On 11 May, Justice Health Services Forensic Mental Health Service conducted a full mental health assessment to assess Steven Freeman’s risk of self harm and need for ongoing mental health care.
- 12.2.4 Each weekday at the AMC, ACTCS chairs a High Risk Assessment Team (“HRAT”) meeting. In attendance are representatives from ACTCS (custodial officers, offender services and CPSS) and ACT Health (Forensic Mental Health Services and the Primary Care Team of Justice Health Services).
- 12.2.5 The HRAT considered Steven Freeman’s case on 12 May 2015, and in doing so, it discussed the wellbeing assessments. It noted the outcome of the meeting, which had taken place the previous day, that AMC management had arranged between Steven Freeman and some Aboriginal and Torres Strait Islander detainees.
- 12.2.6 The HRAT assessed Steven Freeman in the following terms,
“AMC MHS [Mental Health Services] reports that the detainee is denying suicidal ideation but remains at risk due the adverse outcomes of a meeting with a group of other Indigenous detainees, his recent severe head injury, his drug use, his questionable supports and recent family breakdown. HRAT notes that the meeting with other Indigenous detainees highlighted the detainee’s lack of support in AMC, and his limited support in the community.”
- 12.2.7 The HRAT decided that Steven Freeman be placed on an increased observation regime from every 60 minutes to every 30 minutes.
- 12.2.8 Steven Freeman’s reaction to the meeting with other Indigenous detainees was to tell his mother, Narelle King, that:
“...no one in here likes me. They all want to kill me. Everyone wants to kill me...Had a meeting today and half the [detainees] want to kill me.”
- 12.2.9 On 12 May 2015, Steven Freeman was seen by the Forensic Mental Health staff member, who noted that he was “not experiencing any issues with sleep, appetite, memory or concentration”.

- 12.2.10 On 13 May 2015, Steven Freeman was seen by the ACT Health Aboriginal Liaison Officer, who encouraged him to continue engaging with Forensic Mental Health.
- 12.2.11 On 15 May 2015, Justice Health Service undertook a multidisciplinary review, which included a number of psychologists, mental health nurses and a psychiatric registrar, who planned to keep Steven Freeman under review due to his recent head injury.
- 12.2.12 Forensic Mental Health staff attempted to see Steven Freeman on 18 May 2015, but were unable due to AMC operational issues. This assessment took place instead on 19 May 2015, and Steven Freeman was noted to be not at risk of self harm and “sleeping and eating well”.
- 12.2.13 On 20 May 2015, Steven Freeman was seen by the Justice Health Services medical officer. As a consequence, Justice Health Services advised ACTCS that the observation regime could cease. ACTCS acted on this advice and Steven Freeman was moved to the Remand Cottage.
- 12.2.14 On 29 May 2015, Justice Health Services undertook another multidisciplinary review. The Review noted no mental health issues, advised the ACT Health Aboriginal Liaison Officer to maintain contact with Steven Freeman and refer him back to Forensic Mental Health if his mood or mental state deteriorates. No such referral was made.
- 12.2.15 On 25 June 2015, Steven Freeman returned to TCH for a brain scan.
- 12.2.16 On 22 July 2015, an ACTCS custodial officer recorded that Steven Freeman “refused health appointment this day”. The Inquiry could not determine the purpose of the appointment.
- 12.2.17 On 6 August 2015, Steven Freeman went to TCH for another brain scan. When he became impatient at having to wait, the custodial officers returned Steven Freeman to the AMC without the scan taking place. The Inquiry understands Steven Freeman wanted to return to the AMC for a family visit.
- 12.2.18 On 9 September 2015, Steven Freeman attended a rescheduled appointment for a scan. The results of this scan were subsequently considered by a Justice Health Services medical officer. Steven Freeman was not present. The Inquiry notes the month delay in rescheduling this appointment.

Treatment of Steven Freeman’s Head Injury

- 12.2.19 According to clinical records, Steven Freeman was not seen personally after 20 May 2015 by a Justice Health Services medical officer, and after 9 September 2015, no further consideration was given to him by Justice Health Services in relation to his head injury.
- 12.2.20 TCH neurosurgeon, who treated Steven Freeman, told the Inquiry that following a head injury like Steven Freeman’s, the patient needs to be monitored, in particular for headaches and disrupted sleep.
- 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.

12.2.22 TCH neurosurgeon told the Inquiry that while some of these symptoms would be expected in a normal recovery, carers would generally be encouraged to present the patient to a doctor or hospital if these symptoms worsened.

12.2.23 Justice Health Services told the Inquiry that it advised ACTCS as follows:

"On 7 May 2015, following Mr Freeman's return to the AMC, the document titled AMC Medical Rating Plan – Primary Health Detainee Summary form was completed by Justice Health Services and provided to ACTCS staff. This form documented the medical observations for Mr Freeman and that ACTCS should observe Mr Freeman for symptoms or behaviours re 'post serious head injury'."

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.

12.2.25 The Inquiry notes that the Justice Health Services AMC Medical Rating Plan template was filled out with scant detail in relation to Steven Freeman. The template provides space for comment in relation to:

- Potential issues;
- Management strategies;
- Placement;
- AODS (alcohol and other drugs) issues;
- Risk factors;
- Medical symptoms; or
- Behaviours to be observed.

12.2.26 None of these topics was addressed in the advice provided on 7 May and 20 May 2015. There was no reference to the need to monitor Steven Freeman for headaches and/or sleep disruption. Also, the advice did not refer to the possibility that, for Steven Freeman, symptoms could persist for many months.

- 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.

Steven Freeman's Demeanour after his Head Injury

- 12.2.29 Steven Freeman's mother reported to the Inquiry that her son was not the same person after his 2015 assault at the AMC.

"My son wasn't the same after he come out of that coma." and

"Steven was never the same after that bashing."

- 12.2.30 Steven Freeman's mother, Narelle King, and his partner told the Inquiry that Steven Freeman complained of headaches on his return to the AMC. A detainee, who was accommodated with Steven Freeman between 20 May 2015 and August 2015, said:

"Not headaches or migraines, these things were ... bringing him to tears. They were hurting him, and all they offered was Panadol."

- 12.2.31 On 25 May 2016, Steven Freeman emailed a friend:

"...since i first came in i really haven't been able to sleep right i don't know why but it's...annoying. [sic]"

- 12.2.32 Justice Health Services clinical records indicate no contact with Steven Freeman about these symptoms. Also, the clinical records do not indicate that Steven Freeman was given paracetamol.

- 12.2.33 Justice Health Services told the Inquiry that if a detainee is given paracetamol or other non-prescription medication, Justice Health Services nurse will document it. If a detainee receives non-prescription medication for several days, the Justice Health Services nurse will seek clarification and, if appropriate, referred to the Justice Health Services medical officer.

- 12.2.34 The Inquiry asks, but is unable to answer, whether this instance was an example of inadequate record keeping, or whether Steven Freeman was not being monitored following his head injury.

- 12.2.35 The Inquiry notes that there is information that Steven Freeman was suffering symptoms which may have been related to his head injury, namely headaches and disrupted sleep.

- 12.2.36 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.³² 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.

- 12.2.37 The Inquiry notes that the Justice Health Services Primary Care Team is in the process of implementing a more assertive follow-up system for people discharged from TCH to the AMC.

Steven Freeman's Dental Care at the AMC

- 12.2.38 On 1 January 2016, Steven Freeman requested a dental appointment indicating that he was in pain and that he was unable to eat or sleep due to the pain.
- 12.2.39 According to ACT Health, appointment requests are prioritised according to need. The appointment was scheduled for 8 April 2016, but was cancelled due to the dentist being on leave. The appointment was re-scheduled for 30 May 2016, and therefore Steven Freeman was not seen prior to his death.
- 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.

Mental Health and Counselling Services at the AMC

- 12.2.41 The AMC Aboriginal Case Manager told the Inquiry that Steven Freeman was on his return from TCH to the AMC withdrawn and possibly fearful. The same Aboriginal Case Manager noted that Steven Freeman reported "that he keeps to himself and does not engage with many others in the pod". Two separate case notes made by a custodial officer record that Steven Freeman was "cantankerous and obtuse".
- 12.2.42 As noted at paragraph 12.2.3, on his return to the AMC in May 2015, Steven Freeman was assessed by mental health services provided by Justice Health Services and the AMC Corrections Psychological and Support Services (CPSS). The Inquiry notes that Steven Freeman did not have subsequent contact with these services. The Inquiry notes also that the Aboriginal Case Manager and Indigenous Liaison Officer were in at least monthly contact with Steven Freeman from his return from TCH. But for this contact, the state of Steven Freeman's mental health and need for counselling were not addressed.
- 12.2.43 Several previous reviews of the AMC have been critical of mental health services, and the lack of broader counselling services.³³
- 12.2.44 In response to these Reports, the AMC established specialist expertise in the CPSS with a view to improving psychosocial, therapeutic and psychological (including counselling)

³² ACTCS notes there are two types of observations at AMC: custodial and medical.

³³ See for example the 2011 Knowledge Consulting Report and 2013 Review of the Crisis Support Unit.

services. ACT Health has also increased staffing numbers, with two additional staff in Justice Health Services and three additional in the Forensic Mental Health team.

- 12.2.45 The tensions between ACT Health and ACTCS in relation to the mental health services were identified in these reports. The Inquiry notes that these tensions have been reported in the media.³⁴
- 12.2.46 The Inquiry notes that this tension persists and is also present in the wider AMC - Justice Health Services relationship. The Inquiry notes also that ACT Health and the ACT Justice and Community Safety Directorate have instituted several measures to attempt to address this issue.
- 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).

Health Care for Aboriginal and Torres Strait Islander Detainees

- 12.2.48 The Royal Commission into Aboriginal Deaths in Custody recommended that "Corrective Services in conjunction with Aboriginal Health Services should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon [a range of issues]". These issues include the involvement of Aboriginal health services in the provision of general and mental health care to Aboriginal prisoners.³⁵
- 12.2.49 In its submission to this Inquiry, the Winnunga Nimmityjah Aboriginal Health Service noted that it is universally accepted in Australia that health care delivered by Aboriginal managed, led and staffed health organisations produces the best health outcomes for Aboriginal and Torres Strait Islander peoples. Winnunga Nimmityjah has produced two reports about providing holistic health services to Aboriginal and Torres Strait Islander detainees, one in 2007 and the other in 2011. These reports are listed at Appendix 3.
- 12.2.50 Winnunga Nimmityjah Aboriginal Health Service gave the Inquiry an updated version of its proposed "Winnunga-AMC Collaboration – health care model", which proposes a holistic model of care for detainees at the AMC. This model of care seeks to integrate the social and emotional wellbeing of detainees with clinical services. The model has a focus on psychosocial rehabilitation and includes Winnunga Nimmityjah providing the substantive core service delivery and programs to Aboriginal clients business hours, Monday to Friday. Winnunga Nimmityjah proposes that Justice Health Services provide after-hours and weekend on-call cover for Winnunga-AMC clients. Winnunga Nimmityjah notes that information sharing protocols with Justice Health Services would have to be discussed to ensure accurate detainee records.

³⁴ Knaus. C (31 August 2016) 'Prisons psychiatric experts undermined on suicidal inmates'. *The Canberra Times*, <http://www.canberratimes.com.au/act-news/prisons-psychiatric-experts-undermined-ignored-on-suicidal-inmates-20160808-gqneci.html>.

³⁵ RDIADIC, above n 6, Recommendation 152.

- 12.2.51 Steven Freeman's family members told the Inquiry that although Steven Freeman used a number of general practitioners in Canberra, Winnunga Nimmityjah Aboriginal Health Service was his primary health care provider.
- 12.2.52 The Inquiry notes that Winnunga Nimmityjah Aboriginal Health Service held information in its clinical records regarding Steven Freeman's health. The Inquiry notes that during Steven Freeman's time at the AMC, and his admission at TCH, there could have been liaison between Justice Health Services and Winnunga Nimmityjah. This potential exchange did not occur, although Justice Health Services did seek information about Steven Freeman's immunisation records from Winnunga Nimmityjah.
- 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.

The Way Forward

- 12.2.54 The report has noted previously some of the complexities which AMC management has to deal with. As a prison, the AMC presents unique management challenges.
- 12.2.55 The Inquiry notes that one of those challenges is the present state of the relationship between the AMC and Justice Health Services. The Inquiry notes that the relationship is unsatisfactory from both parties' perspectives. Commitment to the need to work cooperatively is lacking.
- 12.2.56 One consequence of the present arrangement is that AMC management is denied sufficient access to information about detainees - held by Justice Health Services - relevant to its responsibilities. In making this observation, the Inquiry recognises the inherent tension between the AMC responsibility to manage a prison and the Justice Health Services requirement for professional autonomy and its responsibility to preserve patient/detainee confidentiality and trust in the course of providing health services.
- 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.
- 12.2.58 The Inquiry notes that the relationship between the AMC and Justice Health Services needs to change. That change needs to be more than just an undertaking by them to do better in the future. Indeed the relationship needs to be reformed and health services at the AMC provided under contract or MOU. On this basis, health services would be

provided to detainees in a framework that recognises AMC management's overall responsibility for the AMC and Justice Health Services requirements and responsibilities.³⁶

- 12.2.59 At the same time, the reformed relationship between the AMC and Justice Health Services needs to make provision for Winnunga Nimmityjah Aboriginal Health Service to provide health services to those indigenous detainees at the AMC who chose to use it. Accordingly, health services at the AMC would involve an additional service provider.
- 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.
- 12.2.63 The Inquiry appreciates that, in establishing a three-way relationship between the AMC, Justice Health Services and Winnunga Nimmityjah Aboriginal Health Service, some important principles need to be recognised. One such principal is that health professionals cannot be subject to supervision by non-health professionals in their professional role. Another principle is that the regime of confidentiality established by the *Health Records (Privacy and Access) Act 1997* and the obligation of health professionals to maintain patient confidentiality must be maintained. Under the contract or MOU efforts to uphold these two principals will be one of the focuses of the coordinating committee as issues arise.
- 12.2.64 Under this new framework, the Inquiry envisages that information will be shared between all three entities to the extent possible, yet consistent with the principals identified above.
- 12.2.65 The inquiry suggests that the task of establishing the contract or MOU be finalised within six months of the completion of this review and that thereafter the relationship between the AMC, Justice Health Service and Winnunga Nimmityjah Aboriginal Health Service be reviewed annually.

³⁶ The Inquiry records that ACT Health provided the Inquiry with the AMA Position Statement "Health and the Criminal Justice System – 2012", which states: "Health service policy and provision in prisons and juvenile detention facilities must be provided independent of corrections authorities."

- 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.
- 12.2.67 The Inquiry notes that other states and territories have banned smoking in prisons. The Inquiry does not make this suggestion. However, the addition of Winnunga Nimmityjah Aboriginal Health Service as a partner in the delivery of health services at the AMC would provide an opportunity for it to provide the “No Boondah” smoking cessation program.
- 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.
- 12.2.69 ACT Health told the Inquiry that it supports the idea of Winnunga Nimmityjah being part of an integrated health service within the AMC, noting that indigenous detainees should have the choice to attend either the Aboriginal Health Service or Justice Health Services. ACT Health reported that how information is shared between two treating teams (and additionally with ACTCS CPSS) will need to be clarified.
- 12.2.70 The Inquiry notes its conclusions and recommendations may require legislative changes.

Recommendation 4: That the arrangements for the provision of health care at the AMC be established, under contract or memorandum of understanding, to reflect the respective responsibilities of AMC (ACTCS) and Justice Health Services (ACT Health).

Recommendation 5: That Winnunga Nimmityjah Aboriginal Health Service be integrated into the provision of health care at the AMC, in order to introduce its holistic model of care to Indigenous detainees.

12.3 Rehabilitation

- 12.3.1 In a written submission to the Inquiry, former Chief Minister Jon Stanhope AO referred to the original vision of the AMC “as being the most human rights-compliant, rehabilitative-focussed prison in the world.” In September 2008, the then Attorney-General Simon Corbell MLA, said:

“The AMC will ensure better rehabilitation prospects for ACT prisoners, operating under the “healthy prison concept”, which emphasises the importance of providing an environment...where prisoners ...are encouraged to improve and be rehabilitated.”³⁷

- 12.3.2 The AMC develops an Individual Learning Plan (ILP) to determine a detainee’s educational needs. On 8 October 2015, the AMC developed an ILP for Steven Freeman. Completing an ILP helps a detainee to think about “who he/she is, what his/her skills and knowledge are, and how he/she can be assisted to get where he/she wants to go (your goals)”.
- 12.3.3 Steven Freeman’s ILP identified his interests in hairdressing, performing and song writing. He enrolled in first aid, blood borne virus awareness and construction industry induction courses, which he completed. Steven Freeman’s application to participate in the Culture and Land Management program, known as CALM, was not approved because of the risk posed to his safety by mixing with other Indigenous detainees.
- 12.3.4 The AMC also develops a case plan to address a detainee’s criminogenic needs.³⁸ Section 78(2) of the Corrections Management Act states that this should include:
- outline work and activities for the detainee;
 - be based on an assessment of the needs, capacities and disposition of the detainee;
 - be consistent with the resources available to the director general to manage the detainee; and
 - if the detainee is an offender—outline how the detainee is to be prepared for lawful release and reintegration into society at the earliest possible time.
- 12.3.5 The AMC develops a case plan for a detainee on remand for more than six months (250 days). Every sentenced detainee receives a case plan. Section 73 of the Corrections Management Act provides as follows.
- “The director-general must arrange for a case management plan to be prepared for a detainee as soon as practicable after the detainee’s admission to a correctional centre.”*
- 12.3.6 However section 78 states that the Director-General must make an individual case management plan for sentenced detainees only, although he or she may make a plan for remanded detainees also.

³⁷ Stanhope, J (11 September 2008) ‘New Alexander Maconochie Centre officially opened’. <http://info.cmcd.act.gov.au/archived-media-releases/mediac26c.html?v=7402&s=177>.

³⁸ That is factors causing or likely to cause criminal behaviour.

- 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.
- 12.3.8 No case plan was developed for Steven Freeman, yet he spent 343 days on remand, and a further 52 days as a sentenced detainee at the AMC. The Inquiry notes this deficiency in terms of Steven Freeman’s rehabilitation.
- 12.3.9 The AMC also did not assess Steven Freeman for any affect to his cognitive functions following his head injury. It is unknown if Steven Freeman suffered any cognitive impairment after his head injury. Assessing whether Steven Freeman suffered any long term impact from his head injury and trauma did not feature in management of him at the AMC, including his rehabilitation. The Inquiry notes also this deficiency.
- 12.3.10 Steven Freeman expressed interest in a number of employment opportunities. For example in February 2016, Steven Freeman applied to work “in the kitchen or any available job”. Steven Freeman worked for a period as a cleaner in the Remand Cottage. This employment ceased when he was moved to different accommodation (see paragraph 12.5.3).
- 12.3.11 In about April 2016, Steven Freeman began to focus on improving his fitness and engaged in early morning exercise with other detainees. This interest in exercise appears to have been initiated by Steven Freeman himself.
- 12.3.12 The Inquiry notes that the RCIADIC recommended that Aboriginal detainees have the opportunity to perform meaningful work and undertake education courses in self-development, skills acquisition, vocational education and training including education in Aboriginal history and culture.³⁹ This recommendation is reflected in the Standard Guidelines for Corrections in Australia.⁴⁰
- 12.3.13 Both the Auditor-General and the ACT Legislative Assembly Standing Committee on Justice and Community Safety recommended a greater focus on the strategic planning of rehabilitation services. The Standing Committee also recommended an increase in resources to ACTCS for this purpose.

Rehabilitation for Remanded Detainees

- 12.3.14 In evidence before the Legislative Standing Committee on Justice and Community Safety, the then Executive Director of ACTCS suggested that an interpretation of human rights may be a reason to limit case management of remanded detainees.

“...with remand detainees, as part of human rights, you cannot compel someone to work...When you are combining in a jail a remand population and a sentenced population,

³⁹ RCIADIC, above n 6, Recommendation 184

⁴⁰ Government of Western Australia Dept. of Justice, [et al.] (2012) ‘Standard Guidelines for Corrections’. http://aic.gov.au/media_library/aic/research/corrections/standards/aust-stand_2012.pdf. Guidelines 3.6, 3.7 and 3.8

you are always going to have a residual number, even when we have got industries going really well—and we are heading towards that—who will never work.”⁴¹

- 12.3.15 The Inquiry notes that there are complexities in providing rehabilitative programs to remanded detainees including the unknown period of remand and that some programs require admission of guilt.
- 12.3.16 The Human Rights Commission President (and Human Rights Commissioner), in her evidence before the Standing Committee, said that while presumption of innocence was a consideration for the rehabilitation of remanded detainees, being on remand should not be a barrier to people accessing programs.⁴²
- 12.3.17 The ACT Auditor-General in her Report on rehabilitation of male detainees said:
- “It is probable that remanded detainees have fewer opportunities available to them than sentenced detainees for being purposefully occupied in therapeutic and employment programs.”⁴³*
- 12.3.18 The ACT Auditor-General commented that for those remanded and later sentenced, their prior time in remand was a substantial proportion of their eventual sentence length.⁴⁴

Structured Day

- 12.3.19 The Inquiry notes the link between limited access to rehabilitation programs and the lack of a structured day at the AMC. On 15 March 2016, in an email to a friend, Steven Freeman said:
- “...it does get boring [sic] in here”*
- 12.3.20 The lack of meaningful activity, apparent in Steven Freeman’s experience, remains an issue. Appearing before the Legislative Assembly Standing Committee on Justice and Community Safety, the then ACTCS Executive Director, said:
- “...We are getting them out of bed to do what? While we do have people that participate well in programs and education, when you consider that our client group are not great in terms of concentration, they could probably cope with only a couple of sessions of*

⁴¹ Transcript of Proceedings, *Inquiry into the Auditor-General’s report on the rehabilitation of male detainees at the Alexander Maconochie Centre* (ACT Legislative Assembly), Standing Committee of Justice and Community Safety, 13 April 2016, page 37.

⁴² Transcript of Proceedings, *Inquiry into the Auditor-General’s report on the rehabilitation of male detainees at the Alexander Maconochie Centre* (ACT Legislative Assembly), Standing Committee of Justice and Community Safety, 16 May 2016, page 61.

⁴³ Cooper. M (2015) ‘The rehabilitation of male detainees at the Alexander Maconochie Centre’. ACT Auditor General’s Report No 2/2015. Page 17.

⁴⁴ Ibid, page 191.

programs a week, for example, our cognitive self-skills, which is two sessions a week, two hours each session. I do not think they could cope with much more than that.”⁴⁵

- 12.3.21 The Inquiry notes that the lack of rehabilitative opportunities and a structured day for detainees has been identified by several reports concerning the AMC.
- 12.3.22 Detainees told the Inquiry that they would have up to 1 to 2 hours of programs, education or employment a week.
- 12.3.23 The ACT Auditor-General reviewed rehabilitation services for male detainees in 2015. In her Report, the ACT Auditor General recommended that in developing a structured day, ACTCS take into account the specific requirements of remanded detainees.⁴⁶ In her evidence to the Standing Committee on Justice and Community Safety’s Inquiry into that Report, the ACT Auditor-General said:

“Rehabilitation plans prior to the opening of the AMC in 2008, with detainees coming in 2009, refer to six hours a day, 30 hours a week. In reality, activity levels were around five hours a week...The achievement of a structured day with purposeful activity was not evident in the first five years of the AMC.”⁴⁷

- 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.

Reasons for Limited Rehabilitation

- 12.3.25 The Inquiry notes the factors which militate against rehabilitation opportunities and limited structured day are:

- prolonged periods on remand;
- accommodation pressures, which limit the use of limited space for programs and education.

- 12.3.26 Criminologist David Biles, has urged the ACT Government to adopt key performance measures aimed at reducing the period a person spends on remand.

“The problem is not that too many accused offenders are remanded in custody but that they are held there for disgracefully long periods...Our aim should be do everything

⁴⁵ Transcript of Proceedings, *Inquiry into the Auditor-General’s report on the rehabilitation of male detainees at the Alexander Maconochie Centre* (ACT Legislative Assembly), Standing Committee of Justice and Community Safety, 13 April 2016, page 37.

⁴⁶ Cooper, above n 5, Recommendation 10, page 19.

⁴⁷ Transcript of Proceedings, *Inquiry into the Auditor-General’s report on the rehabilitation of male detainees at the Alexander Maconochie Centre* (ACT Legislative Assembly), Standing Committee of Justice and Community Safety, 13 April 2016, page 2.

possible to ensure the overwhelming majority of people remanded in custody should be held for a maximum of three months,”⁴⁸

- 12.3.27 The Inquiry notes that a bakery, expanded laundry facilities and multi-purpose facility at the AMC is nearing completion.
- 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.

Recommendation 6: That ACTCS establish a separate remand prison within the AMC to ensure remanded detainees are segregated from sentenced detainees.

12.4 Drug Testing at the AMC

Induction Drug Testing

- 12.4.1 At the AMC, all detainees are required to undergo drug testing on induction. The ACTCS Corrections Management (Drug Testing) Policy 2011, which was in place at the time of Steven Freeman’s admission, stated that all new detainees would be drug tested within 72 hours of induction.
- 12.4.2 The Inquiry notes that Steven Freeman was not drug tested on admission because he was assaulted within hours of induction and taken to TCH. The Inquiry notes also that on his return to the AMC from TCH, Steven Freeman was not drug tested either.
- 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.
- 12.4.4 Steven Freeman would probably have experienced withdrawal from his multi-substance use while in TCH and on immediate return to the AMC. The Inquiry notes that he did so without support (that is detoxification, medical or therapeutic program).
- 12.4.5 ACT Health told the Inquiry that on 13 November 2015, Steven Freeman was assessed by the Alcohol and Drug Service by phone. On 9 November 2015, he was unwell when the Alcohol and Drug Service Court Diversion Service (CADAS) visited the AMC in person to undertake the assessment.
- 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.⁴⁹

Random and Targeted Drug Testing

- 12.4.7 At the AMC, all detainees may be directed to undertake random or targeted drug testing.

⁴⁸ Canberra Times, 23 June 2014, <http://www.canberratimes.com.au/comment/remand-numbers-in-act-prison-remain-a-problem-20140620-zsg6n.html> (accessed 19/09/16)

⁴⁹ This programs aims to affect personal change linked to substance dependence and criminal behaviour.

- 12.4.8 In accordance with the ACTCS Drug Testing Policy, Steven Freeman was tested on four occasions. In October and November 2015, and again in May 2016, he recorded negative results. In January 2016, after having achieved a form of self-rehabilitation by not using drugs for seven months in custody, Steven Freeman recorded a positive result. The Inquiry notes that the positive result was for buprenorphine. This drug is legal when prescribed, but it was not prescribed to Steven Freeman at the AMC. Accordingly, Steven Freeman's use of this drug at the AMC was a disciplinary breach.
- 12.4.9 Steven Freeman was punished for this breach. For a month, he was restricted to non-contact visits, which are meetings with family and friends through a glass partition. The Inquiry notes that this restriction punishes not only the detainee, but the detainee's family and other visitors.
- 12.4.10 In 2015, the ACTCS Drug Testing Policy was changed. Under the revised policy, the AMC can punish a detainee for a positive random drug test result. The Inquiry notes that a possible consequence of a positive drug test is preclusion from a rehabilitation program.
- 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.

12.5 Illicit Drugs at the AMC

- 12.5.1 Several detainees told the Inquiry that illicit drugs can be obtained at the AMC. On 14 February 2016, a custodial officer reported:
- "At the time and date specified above I did clearly see detainee Freeman crawl under the outside fence of Remand Cottage and, retrieve an item [sic]. He then crawled back under the fence. Upon arrival of the area I could see the detainee, namely Freeman running back towards the Cottage...Upon inspection of the fenced area, it had been tampered with and a 1 foot hole had been made in it. Detainee Freeman admitted crawling through the fence and stated that he was getting the football that had been kicked over!"*
- 12.5.2 Narelle King told the Inquiry that when she discussed this incident with Steven Freeman, he told her he was threatened with assault if he didn't collect the item. Narelle King also told the Inquiry that when she encouraged Steven Freeman to tell someone, he said it was his life on the line if he did so.
- 12.5.3 Although nothing was found, on 15 February 2016, Steven Freeman was disciplined. Steven Freeman was placed in the recently constructed Accommodation Unit (AU) North Wing, where he was segregated from other detainees for seven days.
- 12.5.4 The Inquiry notes the AMC detainees' comments about the availability of illicit drugs at the AMC.

12.6 Methadone at the AMC

- 12.6.1 Steven Freeman's family expressed the strong view to the Inquiry that it was unlikely that Steven Freeman would ever have used heroin prior to his time in custody, because of his sister's death from a heroin overdose.
- 12.6.2 In April 2016, Steven Freeman was prescribed methadone. The reasons for prescribing methadone are documented in a half-page note on Steven Freeman's Justice Health Services clinical records.
- 12.6.3 ACT Health told the Inquiry that while the documentation for this prescription was limited, Justice Health Services medical officers are very experienced methadone prescribers and routinely gather available information and undertake a comprehensive assessment in order to make a clinical decision. Steven Freeman signed the Opioid Guidelines Rights and Responsibilities Form acknowledging among other things: information sharing, treatment, policies and procedures, side effects and risks of other drugs. The Inquiry notes that the form requires the medical officer to co-sign, yet no medical officer's signature is recorded on Steven Freeman's form.
- 12.6.4 ACT Health told the Inquiry that Justice Health Services is currently developing more comprehensive proforma documentation of the detailed medical consultations that occur within Justice Health Services prior to a detainee being prescribed Methadone.
- 12.6.5 Several Indigenous detainees spoke to the Inquiry about their perception that methadone is easily obtained through prescription at the AMC. For example, one detainee said:
- "You only have to say you got a drug problem ... and you want to get on that [methadone] and they'll chuck you on it."*
- 12.6.6 ACT Health told the Inquiry methadone is not only prescribed as an opiate substitution for heroin use, it is also prescribed for chronic pain management.
- 12.6.7 Winnunga Nimmityjah Aboriginal Health Service told the Inquiry that, based on its experience, it exercises caution about prescribing opioid replacements and other drugs on request. Since many of its clients are suffering intergenerational and personal trauma, and sometimes request methadone, Winnunga Nimmityjah told the Inquiry it also seeks to address the underlying cause.
- 12.6.8 Previous reviews of the AMC have considered the provision of methadone at the AMC. The Burnet Institute Report (2011) suggested that a number of participants to that Review were "concerned that detainees experienced undue influence from health staff members to commence methadone".⁵⁰ The ACT Human Rights Commissioner's Audit of the Women's Area of the AMC noted "mixed views" with some detainees feeling its availability was appropriate, while others reporting it was easy to be placed on the drug.

⁵⁰ Burnet Institute (2011) Final report: External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre.
<http://www.health.act.gov.au/sites/default/files/Burnet%20Institute%20Report.pdf>. Page 107.

- 12.6.9 In her report on rehabilitation of male detainees at the AMC, the ACT Auditor General noted:

“A number of stakeholders reported concerns about the provision of methadone to detainees: that methadone was provided to detainees who did not require it; and that methadone doses were increased with little consideration. Due to the seriousness of these concerns, and the frequency with which they were raised, discussions were held with the ACT Health Services Commissioner and Justice Health.”⁵¹

- 12.6.10 The Auditor General analysed Justice Health Services data and found the percentage of the AMC detainees on methadone, as part of an opioid substitution program, had been broadly consistent from January 2011 until September 2014.
- 12.6.11 ACT Health told the Inquiry that Justice Health Services reviewed its Methadone Program, most comprehensively in 2012-13, and again in response to the Auditor General’s concerns in 2015. Currently, internal benchmarking with the ACT Health Alcohol and Drug Service, and external benchmarking with NSW Justice Health is underway to further improve the Methadone Program at the AMC.
- 12.6.12 The Inquiry notes that the Health Services Commissioner (of the ACT Human Rights Commission) is able to respond to individual health complaints, and has maintained a watching brief in relation to trends in prescribing methadone at the AMC.⁵² The Inquiry also notes that there is uncertainty about the use of methadone at the AMC. Steven Freeman’s experience has again brought this uncertainty to attention.

Recommendation 7: That the Health Services Commissioner (of the ACT Human Rights Commission) conduct an own-initiative investigation into the prescription of methadone to detainees at the AMC.

12.7 Culture

- 12.7.1 Because Steven Freeman was an Aboriginal detainee, the Inquiry notes that there is a cultural aspect to every facet of his experiences at the AMC.⁵³ Many of these aspects are dealt with at various parts of this Report. The following topics are dealt with here: cultural awareness training; recognition of Aboriginal culture including through NAIDOC (National Aborigines and Islanders Day Observance Committee); Smoking Ceremony; and recruitment of Aboriginal staff.
- 12.7.2 ACT Government data on daily average detainee population showed in the March 2016 quarter, at the AMC 102 detainees identified Aboriginal and Torres Strait Islander out of a total population of 420 detainees. Aboriginal and Torres Strait Islander detainees therefore represented nearly a quarter (24.4%) of the detainee population.

⁵¹ Cooper, above n 5, page 128.

⁵² Ibid, page 129.

⁵³ The Inquiry notes that under the Human Rights Act, ACT Government agencies must act and make decisions consistently with human rights, including section 27(2) dealing with Aboriginal and Torres Strait Islander peoples’ cultural rights.

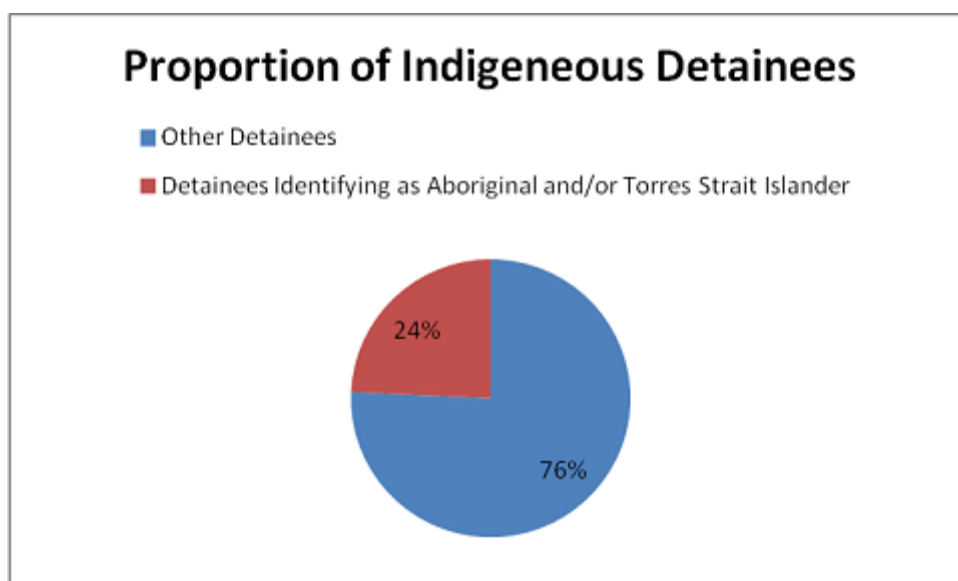


FIGURE 4 PROPORTION OF INDIGENOUS DETAINEES AT AMC, MARCH 2016

Cultural Awareness Training

- 12.7.3 The RCIADIC Report recommended that everyone who works with Indigenous people be encouraged to participate in cultural awareness training to explain contemporary Indigenous communities, customs and traditions.⁵⁴
- 12.7.4 ACTCS' internal review of relevant recommendations of the RCIADIC Report noted that from 2008-2014, 125 ACTCS staff members attended Aboriginal and Torres Strait Islander cultural awareness training. This training is part of the entry level training program for new recruits and mandatory for new probation and parole community corrections officers. The training is provided by the AMC Official Visitor, Tracey Whetnall, who is Indigenous and qualified to provide this training.
- 12.7.5 The Inquiry notes that in relation to Justice Health Services staff members, seven had completed cultural awareness training - four through an e-learning package and three attended face-to-face. The Inquiry understands that a new e-learning package, which is expected to be ready the end of 2016, is being developed. A face-to-face training package was sought without success.
- 12.7.6 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. 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

⁵⁴ RCIADIC, above n 6, Recommendation 96

significant number and proportion of Aboriginal and Torres Strait Islander persons in custody.

Recognition of Aboriginal Culture

- 12.7.7 The Inquiry notes that Steven Freeman did not attend the AMC NAIDOC event in July 2015 because AMC management decided that the risk to his safety was too great if he mixed with other Indigenous detainees.
- 12.7.8 At the AMC, an effort is made to recognise significant cultural events and dates for Aboriginal and Torres Strait Islander peoples. NAIDOC week, held each July, is one such event. Other events include National Sorry Day in May and National Reconciliation Week in June. These events provide an opportunity for detainees, their families and community elders to come together.

Smoking Ceremony

- 12.7.9 On 2 June 2016, a Ngunnawal elder undertook a smoking ceremony of the cell where Steven Freeman died. The Inquiry notes that ACTCS made an effort to arrange this ceremony and have it conducted with due cultural sensitivity. Local Ngunnawal elders were consulted and attempts made to contact the family. Despite these efforts, Narelle King told the Inquiry she was not contacted or consulted about the ceremony.
- 12.7.10 The outcome was unsatisfactory for Narelle King, who is a Bundjalung woman. Narelle King told the Inquiry that it is now too late to address the issue. Narelle King continues to experience distress and anxiety that her own cultural practices, being those of the Bundjalung people, were not enacted and further, that her family did not participate in a significant cultural ceremony in the place where Steven Freeman died. Narelle King impressed upon the Inquiry that ACTCS failed to understand that Aboriginal people are made up of separate and distinct nations with their own cultural protocols and the failure to appreciate that fact has caused hurt and offence for her and her family.
- 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.

Recruitment of Aboriginal Staff

- 12.7.12 ACTCS currently has several identified Aboriginal and Torre Strait Islander positions:
- An Aboriginal and Torres Strait Islander Senior Policy Officer;
 - Two AMC Aboriginal Case Mangers;
 - An AMC Indigenous Liaison Officer;
 - Two Indigenous Probation and Parole Officers; and
 - An Aboriginal Client Support Officer.

- 12.7.13 In mid-2016, there were 13 ACTCS employees who identify as being from an Aboriginal and/or Torres Strait Islander background which represents 3.39% of ACTCS employees. This number is above the Council of Australian Government's target of 2.6% Indigenous public sector employment by 2015. In a recent recruitment round for custodial officers, six recruits identified as Indigenous.

12.8 The AMC: Human Rights Compliant?

- 12.8.1 The ACT was the first Australian jurisdiction to incorporate international civil and political rights in domestic legislation.
- 12.8.2 The *Human Rights Act 2004* refers to the human rights of detainees, as does the Corrections Management Act.⁵⁵
- 12.8.3 When the AMC opened in 2008, former Chief Minister Jon Stanhope said:

"For the first time in Australia, we have a prison that is fully human rights compliant. The AMC has been designed, built and will be operated under human rights legislation, based on the ACT Human Rights Act 2004 and human rights principles".⁵⁶

Segregation of Remanded and Sentenced Detainees

- 12.8.4 As noted at paragraph 8.4.12, when Steven Freeman arrived at the AMC, he was allocated to Sentenced Unit 1, which had a mixture of remanded and sentenced detainees.
- 12.8.5 Section 19 of the Human Rights Act provides that an accused person must be segregated from convicted people, except in exceptional circumstances.⁵⁷ At the AMC, there is no separate remand accommodation. Since 2009, remanded and sentenced detainees have been accommodated together. The Inquiry notes the AMC's original design included separate accommodation for remanded and sentenced detainees.
- 12.8.6 In June 2015, when reviewing Steven Freeman's bail, Magistrate Dingwall commented on the human rights requirement to segregate remanded and sentenced detainees.⁵⁸

"On the face of it, that would be a breach of his human rights under section 19 of the Human Rights Act. But the human right provided by section 19 is not breached if there are

⁵⁵ See section 9 of the Corrections Management Act 2007

⁵⁶ Stanhope. J (11 September 2008) 'New Alexander Maconochie Centre officially opened'. <http://info.cmcd.act.gov.au/archived-media-releases/mediac26c.html?v=7402&s=177>.

⁵⁷ The Inquiry notes that s 28 of the Human Rights Act provides also for all rights to be reasonably and proportionality limited. Applying this further qualification to the existing "exceptional circumstances" caveat in s 19 leads to a lack of clarity and confusion about how this section is to be interpreted.

⁵⁸ The Inquiry notes that the ACT Human Rights Commissioner was not notified of these proceedings, even though they canvassed important human rights issues, including the correct interpretation of "exceptional circumstances" for the purposes of the Human Rights Act.

exceptional circumstances. In this particular case, in my view, there are clearly exceptional circumstances pertaining to the defendant's safety."⁵⁹

12.8.7 Magistrate Dingwall commented also.

*"That seems to be what the evidence is suggesting, that the physical capability of the AMC doesn't enable remandees to be segregated from each other effectively. That's simply a matter of fact. There is no other facility....it's certainly something the executive needs to give consideration to."*⁶⁰

12.8.8 During the hearing, as reflected in the court transcript, Magistrate Dingwall confirmed the Executive's responsibility to keep Steven Freeman (and other detainees) safe while in custody.⁶¹

12.8.9 The Inquiry notes that Steven Freeman had a human right, as a remanded detainee, to be segregated from sentenced detainees, but for the exceptional circumstance that arose because of the pressure of accommodation at the AMC, as identified by Magistrate Dingwall.

12.8.10 The Inquiry understands that the reason why the remanded detainees are not segregated from sentenced detainees is that AMC management has both a shortage of accommodation options and 16 categories of detainee to accommodate. With detainee safety as the priority, AMC management accommodates remanded and sentenced detainees together to maximise the physical facilities available. In so doing, the human right for remanded detainees to be segregated from sentenced detainees is subordinated to other considerations.

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.

12.8.13 In passing, the Inquiry notes that female detainees are located at the AMC. Although female detainees have separate accommodation, they share with male detainees such facilities as the Hume Health Centre, the Crisis Support Unit, and other common facilities including programs, visits and education.

⁵⁹ Transcript of Proceedings, *Christine Elizabeth Walters v Steven Claude Freeman* (ACT Magistrates Court), CC4358/15, Magistrate Dingwall, 10 June 2015, page 28.

⁶⁰ Transcript of Proceedings, *Christine Elizabeth Walters v Steven Claude Freeman* (ACT Magistrates Court), CC4358/15, Magistrate Dingwall, 10 June 2015, page 19.

⁶¹ Transcript of Proceedings, *Christine Elizabeth Walters v Steven Claude Freeman* (ACT Magistrates Court), CC4358/15, Magistrate Dingwall, 12 May 2015, page 16-17.

- 12.8.14 Although every measure is taken to segregate male and female detainees at the AMC, the Inquiry received an unconfirmed report from a reliable source about the possible recent exploitation of a female detainee.
- 12.8.15 If female detainees were in a facility totally separate, AMC management would have more options to accommodate male detainees, and as noted by ACTCS, would help to improve and manage the incidence of violence at the AMC. The Inquiry notes also that human rights standards state that it is preferable for female detainees to be located in a totally separate facility from male detainees.⁶² If male and female detainees were located in separate facilities, the AMC would achieve increased human rights compliance.⁶³
- 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.
- 12.8.17 The Inquiry notes that, from 4 June 2015 until 22 February 2016, the ACT Government temporarily used additional accommodation space at the Symonston Correctional Facility, which is located 6 kilometres from the AMC. In February 2016, two new multipurpose units, the Special Care Unit and the Accommodation Unit, opened at the AMC.
- 12.8.18 The Inquiry notes also that in these two new units, AMC management continue to accommodate remanded and sentenced detainees together.
- 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.

12.9 Personal Safety

- 12.9.1 As noted at paragraph 10.1.2, when Steven Freeman returned in May 2015 to the AMC from TCH there were concerns for his personal safety. Steven Freeman and others were not willing to provide information about who assaulted him in May 2015.

⁶² Section 31 of the Human Rights Act provides that international law may be used to interpret the content of human rights. Rule 8 of the United Nations Standard Minimum Rules for the Treatment of Prisoners states men and women should generally be held in separate institutions, and where if an institution receives both men and women, the State must ensure that the whole of premises allocated to women shall be entirely separate.

⁶³ The Inquiry notes the ACT Human Rights Commission told the Inquiry that it is critical that female detainees are not further disadvantaged by the small scale of another facility, and they continue to have access to an equivalent range of programs, employment options and other facilities as male detainees.

- 12.9.2 In May 2016, Steven Freeman spoke on the phone to a friend about an altercation with another detainee. Steven Freeman said that the other detainee attempted to “stab” him with a pen. Steven Freeman reported getting the better of the situation and coming to no harm.
- 12.9.3 The Inquiry notes all phone calls to and from the AMC are recorded, and randomly monitored. AMC staff members identified this confrontation. The Inquiry cannot assess the AMC’s response because Steven Freeman died the day after this phone call. The incident does however reveal the risk of violence that Steven Freeman (and other detainees) faced.
- 12.9.4 One Indigenous detainee, who was able “to look after himself”, told the Inquiry that while at the AMC he was torn between serving his sentence free of conflict and disciplinary charges on the one hand, and on the other hand lending support and protection to vulnerable detainees, some of them Aboriginal, from the standover tactics and violence of other detainees.
- 12.9.5 The Inquiry heard about a detainee who was subjected to a random act of violence while playing cards. He was approached from behind by another detainee, who began sawing at his ear with a serrated plastic knife.
- 12.9.6 From these accounts, the Inquiry came to appreciate that detainees at the AMC exist in apprehension of attacks and reprisals. Some detainees reported that their response to this remain was to remain in their cells most of the time. Some detainees suggested to the Inquiry that their experience at the AMC was worse in this regard than at NSW prisons.
- 12.9.7 Some Indigenous sources told the Inquiry that the AMC is not run by custodial officers, but by a handful of detainees. The Inquiry notes that AMC management reported that it actively breaks up such influence and employs dynamic management responses to minimise risk.
- 12.9.8 The Inquiry was told that detainees are not willing to speak to ACT Policing, AMC staff or oversight agencies about acts of violence. The fear of reprisal is real and those who report to authority are labelled “dogs”.
- 12.9.9 The Inquiry notes that the apprehension of attacks and reprisals persists at the AMC and that only some assaults lead to prosecution or disciplinary charges. This situation is exacerbated by a “code of silence” among detainees.

12.10 The AMC: Independent Accountability

- 12.10.1 Three agencies provide independent oversight and conduct investigations in relation to the AMC.

ACT Human Rights Commission

- 12.10.2 In relation to the AMC, except for health services and unlawful discrimination,⁶⁴ the Human Rights Commission has no power or jurisdiction to investigate individual complaints. The Human Rights Commissioner can undertake systemic reviews into the impact on human rights of ACT Government laws, and has the power to enter and inspect the AMC.⁶⁵ The Commissioner can inspect the register of detainees, strip and body search register, use of force register and record of disciplinary action.

ACT Ombudsman

- 12.10.3 The ACT Ombudsman can receive and investigate a complaint that raises a matter of administration in relation to an ACT Government agency, including the AMC. As noted above, the ACT Ombudsman's jurisdiction does not include complaints about health services or unlawful discrimination, which are dealt with by the ACT Human Rights Commission. The ACT Ombudsman also monitors any trends of concern that may develop or systemic issues that may arise concerning ACT Government administration, including at the AMC.

Official Visitors

- 12.10.4 The Attorney-General appoints two Official Visitors, one Indigenous and non-Indigenous, under section 10 of the *Official Visitor Act 2012*. The Official Visitor role is to receive and investigate prisoner complaints and grievances, and conduct inspections at the AMC in response. The Official Visitors report to the Minister for Corrections.

An Independent Inspectorate

- 12.10.5 The Inquiry notes that, in 2016, the Legislative Assembly Standing Committee on Justice and Community Safety considered the Auditor-General's Report on rehabilitation at the AMC. The Standing Committee's Report recommended that the ACT Government advise on progress regarding the appointment of an ACT Inspector of Prisons, or an equivalent office, as soon as possible.⁶⁶

An effective oversight regime

- 12.10.6 In April 2016, Steven Freeman and his cell mate sought to contact the ACT Ombudsman about an incident when they were strip searched in a public area. The reason was a paint brush had gone missing during an art class. Due to technical difficulties with the phone, they were unsuccessful. The Inquiry understands this phone issue has been resolved, but it did pose an impediment to detainees contacting the relevant oversight agency.

⁶⁴ The position of Health Services Commissioner/Discrimination Commissioner has responsibility for these functions.

⁶⁵ Section 41. In 2014, the Human Rights Commissioner, undertook a 'Human Rights Audit' into the treatment of female detainees at the AMC.

⁶⁶ Standing Committee on Justice and Community Safety (2016) *Inquiry into Auditor-General's Report on the Rehabilitation of Male Detainees at the AMC*.

http://www.parliament.act.gov.au/__data/assets/pdf_file/0017/910331/Report-on-A-G-s-report-on-rehabilitation-at-the-AMC-Final.pdf . Recommendation 5, page 59.

- 12.10.7 The Inquiry notes the ACT Human Rights Commission initiative to convene regular meetings of oversight agencies. This forum enables otherwise disparate efforts to be coordinated. The Inquiry notes also that Prisoners Aid has recently joined this group.
- 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.
- 12.10.10 The Inquiry notes that on 3 November 2016, Winnunga Nimmityjah Aboriginal Health Service published a public notice indicating it has commenced the process to change its name to Winnunga Nimmityjah Aboriginal Health and Community Services. The Inquiry understands this name change reflects the organisations commitment to provide a broader range of services to the Indigenous community.

A Need for a Procedure for Critical Incidents at the AMC

- 12.10.11 Following Steven Freeman's assault in 2015, various calls were made publicly for an independent review of the circumstances of his assault.
- 12.10.12 In other jurisdictions, there are arrangements for near death and other serious incidents in custody to be the subject of independent review.
- 12.10.13 In his written submission to the Inquiry, Jon Stanhope referred to the United Kingdom (England and Wales) procedure whereby police make a self-referral to the Independent Police Complaints Commissioner in relation to a decision that may result in a problematic or controversial outcome. In the case of Steven Freeman, such a referral would have related to the decision of ACT Policing not to prefer any charges in relation to his assault in 2015.
- 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.
- 12.10.15 The Inquiry suggests some of the features of the United Kingdom Prisons and Probation Ombudsman model be considered for such reviews including reporting publicly, liaising

closely with family members, speaking to detainees and staff directly, receiving submissions, and identifying systemic issues raised by the individual circumstances.⁶⁷

- 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.

Recommendation 8: That the ACT Ombudsman have the role of reviewing the response to all critical incidents at the AMC, including serious assaults.

12.11 Contact with Family and Friends

- 12.11.1 Steven Freeman was in contact with his family and friends by telephone and email. This contact occurred every day. The Inquiry notes that Steven Freeman enjoyed the support of his family and that the AMC's arrangements facilitated such contact.

- 12.11.2 The Inquiry notes also that this support appeared to result in Steven Freeman's demeanour improving at the AMC. Notes made by case managers at this time refer to Steven Freeman exhibiting positive behaviour. On 25 February 2016, a custodial officer noted that:

"Freeman mixed well with the other detainees today. He seemed happy and was joking and laughing with the other detainees. He was compliant respectful and polite."

- 12.11.3 On 27 February 2016, another custodial officer recorded:

"Detainee is in good spirits. Mixes well within the yard. Participated in a game of yard cricket. Had a visit this afternoon. Nil issues."

- 12.11.4 And on 28 February 2016 another custodial officer records:

"Detainee Freeman has been actively social this morning with other detainees playing cards and talking [sic]... Polite, compliant and respectful behaviour."

- 12.11.5 The Inquiry notes that these case notes also occur after 24 February 2016, when Steven Freeman was relocated to AU South wing and accommodated with a 22 year old Aboriginal man. Phone recordings and email messages from Steven Freeman indicate their relationship to be a positive one.

- 12.11.6 The Inquiry was told the arrangements for face to face visits did not always run smoothly. The Inquiry heard from Steven Freeman's family and friends about frustration in the visiting arrangements, including that detainees are routinely brought late to the visits area. As a consequence, an hour long visit could be curtailed to forty-five minutes. Steven Freeman's family also reported difficulties in making bookings for visits.

⁶⁷ The UK Prisons and Probation Ombudsman independently investigates serious assaults and deaths, in parallel to the police and the coroner.

- 12.11.7 The Inquiry notes that visiting days were recently reduced from six days per week to five (Wednesday to Sunday).
- 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 Steven Freeman's Death in Custody

- 12.12.1 The manner and cause of Steven Freeman's death at the AMC is excluded from the Inquiry's terms of reference and are a matter for the Coroner. The Inquiry is nonetheless concerned about some related circumstances, including the notification of his death to his mother, Narelle King, and the ACTCS response.

Notification

- 12.12.2 Narelle King was told of her son's death when five ACT Policing officers attended her residence on the day of his death. None was Indigenous. ACT Policing told the Inquiry that experienced male and female Detective Sergeants were assigned to pass the message to Narelle King.
- 12.12.3 ACTCS confirmed that it is standard policy and procedure that deaths in custody be communicated to next of kin by ACT Policing. The Aboriginal community reported its concerns to the Inquiry about this process, and expressed dismay that ACT Policing officers in such number had attended Narelle King's home without an Aboriginal person known to her being present.
- 12.12.4 Narelle King told the Inquiry she felt threatened by such a large contingent of police arriving at her home, particularly given her son's history with ACT Policing.
- 12.12.5 The Inquiry notes the contrast between the ACTCS procedures for notifications of transfers to hospital and notifications of deaths in custody. ACTCS notifies relatives of detainees about transfers to hospital with an Indigenous staff member being involved.
- 12.12.6 Recommendation 19 of the RCIADIC Report requires that notification of deaths in custody be made in person where possible, by the custodial institution, preferably by an Indigenous person known to those being notified. The recommendation required that such notification should be given in a sensitive manner respecting the culture and interests of the persons being notified.
- 12.12.7 Change the Record in assessing ACT compliance with the recommendations of the RCIADIC Report, noted the lack of a clear policy in the ACT correctional system, and in particular the lack of a specific requirement that notifications of deaths in custody involve an Indigenous person.⁶⁸

⁶⁸ Change the Record, 'Review of the Implementation of the Recommendations of the RCIADIC - May 2015', <https://changetherecord.org.au/RCIADIC>

- 12.12.8 Recommendation 20 states that the ALS also be notified immediately of an Aboriginal death in custody. The ACTCS procedure includes that ACTCS notify ALS of such a death in custody.⁶⁹ ALS told the Inquiry that they were not informed directly of Steven Freeman's death, and learnt of his death from his mother the day after.
- 12.12.9 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. 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.
- 12.12.10 ACTCS should also ensure that the ALS is notified regarding deaths in custody.
- 12.12.11 Steven Freeman's family members reported that news of the death of an Aboriginal man was placed on Facebook by ACT Policing prior to Narelle King being notified of his death. While the information did not name the person, the family felt Steven Freeman could be identified from the information disclosed.
- 12.12.12 ACT Policing told the Inquiry that it did not place a Facebook post regarding Steven Freeman's death.
- 12.12.13 ACTCS told the Inquiry that no public statement was made regarding his death until Narelle King was notified. The Inquiry confirmed that the Minister for Corrections did not announce Steven Freeman's death until after Narelle King was notified.

Removal of Steven Freeman (when deceased)

- 12.12.14 Narelle King told the Inquiry that upon hearing of Steven Freeman's death, she sought to be with her son at the AMC but this request was refused. The Inquiry notes that this refusal remains a cause of sorrow for Narelle King.
- 12.12.15 Steven Freeman was pronounced dead at 11.11 am. Narelle King asked the Inquiry when Steven Freeman's body was removed from his cell on the day of his death. The Inquiry notes that it was at 4.43 pm. Narelle King told the Inquiry she remains distressed that her son lay alone for this period in his cell.

⁶⁹ Death in Custody checklist

Glossary

ACT – Australian Capital Territory

ACTCS – ACT Corrective Services

AFP - Australian Federal Police

ALS – Aboriginal Legal Service

AMC - Alexander Maconochie Centre

AMHU - Adult Mental Health Unit

AU – Accommodation Unit (at the AMC)

BRC – Belconnen Remand Centre

CALM – Culture and Land Management Program

Corrections Management Act – *Corrections Management Act 2007*

CPSS - Corrections Psychological and Support Services

FMH – Forensic Mental Health

ICU – Intensive Care Unit

ILP – Individual Learning Plan

JACS – Justice and Community Safety Directorate

IMR – Internal Management Review

MOU – Memorandum of Understanding

RCIADIC – Royal Commission into Aboriginal Deaths in Custody

RFID - Radio Frequency Identification

TCH – The Canberra Hospital

Appendix 1: Minister's Media Release

Released 02/06/2016

Independent Inquiry into Death in Custody

Following the death of Mr Steven Freeman at the Alexander Maconochie Centre (AMC) on 27 May 2016, I announced my intention to hold an independent inquiry into his treatment while in custody.

This inquiry will examine Mr Freeman's care and supervision during his period of incarceration, including whether ACT Corrective Services' systems operated effectively and in compliance with human rights obligations.

This inquiry cannot examine the manner and cause of death of the detainee as that will be addressed by the police investigation and the Coroner.

The Terms of Reference have now been finalised and are publicly available on the Justice and Community Safety Directorate website – www.justice.act.gov.au.

I am pleased to announce that Mr Philip Moss AM has been engaged to undertake this inquiry.

Until his retirement in July 2014, Mr Moss was employed as the Integrity Commissioner within the Australian Commission for Law Enforcement Integrity and has a wealth of experience in law enforcement and Government investigations and reviews.

Mr Moss most recently completed an independent review into allegations of abuse of immigration detainees in Nauru.

I anticipate Mr Moss will complete his review by 31 August 2016.

I would like to take this opportunity to reiterate my deepest sympathies to the family and friends of Steven Freeman and again ask that their privacy be respected.

I am mindful of the effect this death in custody may have on other detainees in the AMC, particularly those that identify as Aboriginal or Torres Strait Islander. ACT Corrective Services has put in place a number of measures to assist detainees in this difficult time, including:

- Support from Corrections Psychological Support Services Unit;
- Engagement with Relationships Australia to provide counselling services;
- Support from the Indigenous Chaplaincy Service;
- Visits by members of the Elders and Community Leaders Visitation Program and the Indigenous Official Visitor;
- Ongoing support by the AMC's Aboriginal Case Managers and Indigenous Liaison Officer; and

- Ongoing support for all detainees through their interaction with corrections officers.

ACT Corrective Services will continue to work proactively over the next few weeks to ensure detainees are culturally and sensitively supported in the wake of this death.

ACT Corrective Services is also working with the Indigenous Chaplaincy Service to arrange a culturally appropriate service within the AMC to commemorate Mr Freeman's life.

Appendix 2: Justice and Community Safety Directorate Media Release

Released 28/10/2016

Timeframe extended for independent inquiry into treatment of detainee

The independent inquiry into the treatment in custody of Mr Steven Freeman at the Alexander Maconochie Centre has been extended following a request from the Independent Reviewer, Mr Philip Moss AM.

Mr Moss has advised the report will be provided to the ACT Government by 7 November 2016.

Mr Moss is finalising the report and seeking feedback from stakeholders over the proposed content to ensure it is accurate and complete. The additional time will enable Mr Moss and the inquiry team to give full consideration to the views expressed as part of this process.

A timeline for the public release of the report will be established once a Minister for Corrections has been appointed by the incoming Government.

The terms of reference for the Inquiry into the Treatment in Custody of Detainee Steven Freeman and publicly available submissions can be found on the Justice and Community Safety Directorate's website at the following address: <http://www.justice.act.gov.au/news/view/1709/title/inquiry-into-the-treatment-in>

Appendix 3: Previous Reviews of the AMC

ACT Legislative Assembly Standing Committee on Justice and Community Safety Inquiry into the ACT Auditor General's Report: The Rehabilitation of Male Detainees at the Alexander Maconochie Centre, 2016.

ACT Auditor General's Report: The Rehabilitation of Male Detainees at the Alexander Maconochie Centre, 2015

Human Rights Audit on the Conditions of Detention of Women at the Alexander Maconochie Centre, April 2014. (ACT Human Rights Commission)

AMC Crisis Support Unit Report in Response to Knowledge Consulting, June 2013. (Dr Astrid Birgden)

Independent Inquiry of Operations at the Alexander Maconochie Centre, 2011 (Knowledge Consulting).

Burnet Institute Report, 2011.

Human Rights Audit of ACT Correctional Facilities, 2007. (ACT Human Rights Commission)

Appendix 4: Questions from Steven Freeman's Family

1. Was their DNA testing into any items found in Steven's cell after his assault in 2015?
2. Could Steven have closed his door and locked it from the inside when he was lying down prior to his assault in 2015?
3. Have there been changes to the CCTV cameras since Steven's assault?
4. Why was Steven handcuffed for almost entire time in hospital, even with two guards present?
5. Why were only two people allowed to be present in Mr Freeman's room while he was in hospital?
6. Why did hospital staff direct family to ACTCS to discuss Steven's health status and records while he was in hospital?
7. Why did Steven appear in court with no shoes and a gown after being transferred from hospital in May 2015?
8. How was Steven assessed to leave hospital and return to AMC?
9. What assessment of the impact of Steven injuries were made on his return to AMC?
10. What follow up health assessments and appointments did Steven have after his assault, and were these adequate?
11. Why was Steven moved into different accommodation at AMC in January 2016, after which time he lost weight and his demeanour changed?
12. Why was Steven always late for family visits at AMC?
13. Why was Steven not allowed to have a barbeque with his family for his birthday?
14. Why was Steven not allowed to go to NAIDOC celebrations or participate in the Shine for Kids program?
15. Why wasn't Steven electrocuted if he attempted to collect drugs from near the fence at AMC, for which he was subsequently disciplined?
16. Who was informed, and in what order, of Mr Freeman's 2015 assault and his passing in 2016?
17. Why was news of the investigation into Steven's assault concluding conveyed to the family by ACT Policing on Christmas Day 2015?
18. What role did the Human Rights Commission have after Steven's assault in 2015?
19. Should there be better diversion options or risk assessment so people like Steven aren't remanded in future?
20. What measures have been put in place to deal with the 'sophisticated supply racket' of drugs and mobile phones reported in the media in 2014?
21. How many detainees, particularly Aboriginal and Torres Strait Islander detainees have been seriously assaulted at the AMC since it opened?
22. Why has the payment system for families to deposit money for detainees changed this year?
23. Why were the CCTV cameras pointing away from Steven's cell door on the day of his assault?
24. Steven complained of headaches at AMC but didn't receive treatment?
25. Why was Steven assaulted in 2015 at AMC?
26. Was Steven harassed at AMC by other detainees and officers at AMC? If so, what response was provided to threats against Steven by another detainees?
27. How do drugs get into AMC?