ICS
ACT Inspector of Correctional Services

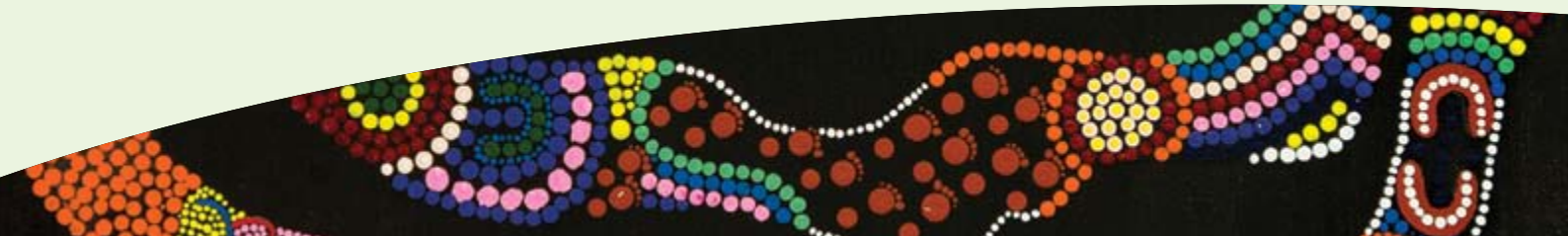
REPORT OF A REVIEW OF A CRITICAL INCIDENT

by the

ACT INSPECTOR OF CORRECTIONAL SERVICES

Assault of a detainee at the Alexander Maconochie Centre on 23 May 2018

ics.act.gov.au



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

ABOUT THIS REPORT

This report may be cited as:
ACT Inspector of Correctional Services (2018),
Report of a review of an assault of a detainee at the Alexander Maconochie Centre on 23 May 2018, OICS, Canberra

ACT Inspector of Correctional Services
GPO Box 158,
Canberra ACT 2601
T 1800 092 010
www.ics.act.gov.au

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

Design and artwork: 2B.com.au

ICS
ACT Inspector of Correctional Services

REPORT OF A REVIEW OF A CRITICAL INCIDENT

by the

ACT INSPECTOR OF CORRECTIONAL SERVICES

Assault of a detainee at the Alexander Maconochie Centre on 23 May 2018

Neil McAllister
ACT Inspector of Correctional Services
October 2018

ACT INSPECTOR OF CORRECTIONAL SERVICES
P 1800 932 010 | E ICS@act.gov.au | GPO Box 158, Canberra City ACT 2601

Letter of Transmittal

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

Dear Madam Speaker

I am pleased to provide you with a report entitled 'Report of a Review of a Critical Incident by the ACT Inspector of Correctional Services: Assault of a detainee at the Alexander Maconochie Centre on 23 May 2018' for tabling in the Legislative Assembly pursuant to Section 30 of the *Inspector of Correctional Services Act 2017* (ACT) (the Act).

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

As required under Section 29 of the Act a draft copy of the review has been provided to The Hon Shane Rattenbury MLA, Minister for Corrections and Ms Alison Playford, Director-General of the Justice and Community Safety Directorate. Comments were received and considered.

Yours sincerely

Neil McAllister
ACT Inspector of Correctional Services
22 October 2018

Contents

1. EXECUTIVE SUMMARY

1.1 On 23 May 2018 an Indigenous detainee (Detainee Z) was assaulted by a non-Indigenous detainee (Detainee X) at the Alexander Maconochie Centre (AMC). The victim had scalding water poured over his head and was then struck over his head by a can contained in a sock. He received burns and a laceration which resulted in him being taken to Canberra Hospital for treatment. The perpetrator had some hot water splash on him but did not require hospital treatment.

1.2 The incident occurred while staff were locking down the unit for the night. They responded immediately and resolved the incident quickly and without use of force.

1.3 The reason for the assault is unclear but there was no intelligence to suggest that there were "issues" between the two detainees prior to 23 May 2018.

1.4 Although one of the detainees was a remandee (perpetrator), and the other a sentenced offender, both had extensive criminal histories, prior episodes of imprisonment and had been involved in assaults on other detainees at AMC.

1.5 I find that both detainees were properly classified as Medium Security and that their placement in the same unit was reasonable.

1.6 Overall, I find that the incident was not reasonably foreseeable by ACT Corrective Services (ACTCS).

1.7 As required under s 29 of the *Inspector of Correctional Services Act 2017* (ACT) (the Act) a draft copy of this report was provided to Shane Rattenbury MLA, Minister for Corrections and Ms Alison Playford, director-general of the Justice and Community Safety Directorate. Comments were received from the Director-General on behalf of herself and the Minister. I gave consideration to their comments in the preparation of the final report.

2. FINDINGS & RECOMMENDATIONS

2.1 There is one recommendation and ten findings arising from this review. I will follow-up on Findings 1 and 2. In addition to the recommendation, I draw ACTCS' attention to Findings 8 and 10.

Finding 1:	That Section 27 of the *Inspector of Correctional Services Act 2017* (ACT) needs to be reviewed to clarify its relevance to the review of a critical incident.
Finding 2:	That Section 17(2)(g) of the *Inspector of Correctional Services Act 2017* (ACT) needs to be reviewed to clarify the meaning of 'admitted to a hospital'.
Finding 3:	That AMC custodial and medical staff responded in a timely and effective manner to the assault on Detainee Z.
Finding 4:	That both detainees involved in the incident on 23 May 2018 were appropriately classified as Medium Security.
Finding 5:	That there was no intelligence information available to suggest that Detainee Z was at risk of assault by Detainee X.
Finding 6:	That there were no failings of security procedures or practices that contributed to the assault on Detainee Z.

Finding 7:	That desirably, Detainee Z's mother should have been informed of his injuries by a person of Aboriginal or Torres Strait Islander background.
Recommendation 1:	ACTCS policies and procedures should be reviewed so that in the event of injury or illness affecting an Indigenous detainee, where possible and appropriate, a person of Aboriginal or Torres Strait Islander background notify the next of kin of the detainee.
Finding 8:	That "Strict Protection" is not adequately defined in ACTCS policies or procedures.
Finding 9:	That in terms of the detainees' correctional histories and prison experience, it was reasonable that they be accommodated in the same unit.
Finding 10:	That the Aboriginal and Torres Strait Islander Detainee and Offender Policy was updated in 2018 but does not refer to including the Indigenous Liaison Officer or Indigenous Case Manager in debriefings.

3. INTRODUCTION

3.1 Authority to conduct a review of a critical incident

Section 18(1)(c) of the Act provides that the Inspector *'may review a critical incident on the inspector's own initiative or as requested by a relevant minister or relevant director-general.'*

This review was conducted at my own initiative.

3.2 What is a 'critical incident'?

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

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

This review concerns an event relevant to s 17(2)(g).

3.3 What must the Inspector report on?

Section 27 of the Act requires that the Inspector must include certain things in a report of a review.

However, I am of the opinion that while the requirements of s 27 have relevance to the conduct of a review of a *correctional centre* or a *correctional service* some have little or no relevance to the review of a *critical incident*. In that regard this report has been structured to capture the intent and spirit of s 27 but without specific reference to some of the topics.

I have "flagged" the ambiguity in s 27 relating to critical incidents as a matter that should be addressed in a future review of the Act (Finding 1 below).

3.4 Public interest considerations relating to this report

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

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

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

In accordance with s 28(2)(d), certain information that might reveal the identities of detainees and staff involved in the incident has been withheld in this report.

4. FORM OF THE REVIEW

4.1 Form and methodology

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

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

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

4.1.4 Prior to this incident, the Inspectorate and ACTCS had commenced the development of a Memorandum of Understanding (MOU) concerning the respective roles and responsibilities of the agencies with regard to the review of critical incidents. I have attached a slightly redacted version[1] of the MOU as **Appendix 1** to this report so that Members of the Legislative Assembly and the general public can have a clearer understanding of the critical incident review process.

4.1.5 In the case of the incident that is the subject of this report, I decided to conduct a desk-top review partly because there was uncertainty as to whether the assault victim was 'admitted to hospital' and thus met the definitional requirements of a critical incident under s 17(2)(g) of the Act (refer to section 5.1.7 of this report). I was also of the opinion that unlike some other critical incidents that I have reviewed in other jurisdictions, the facts of this incident were evident from the beginning due to staff being on-hand and the entire event being recorded on CCTV.

1 Telephone numbers of officials deleted for privacy reasons

5. THE REVIEW

5.1 How, when and where the incident occurred

5.1.1 The incident occurred at approximately 6:20pm in a two-story male unit at the AMC when staff were commencing the evening lock-in of detainees. Corrections Officer (CO) H who was on the ground floor with COs B and M, heard a commotion coming from the upper landing and observed two detainees involved in a physical altercation. Corrections Officer H called for assistance on the radio and directed the detainees to stop fighting. Corrections Officers H and M then made their way up the stairs where they found Detainee X near the top of the stairs and Detainee Z further down the landing. Detainee X complied with the direction to go to his cell and was locked-in by CO M.

5.1.2 Detainee Z had blood over his face and was shouting at staff that he was burning and to not come near him. He was offered a container of water which he poured over his head. Some of the bloody water entered his mouth which caused him to spit it out. Unfortunately, some of this fluid struck CO H on the face and eye. This was not seen as an intentional act on the part of Detainee Z. Corrections Officer H received treatment and blood testing on the night of the incident and is subject to further blood test monitoring.

5.1.3 Detainee Z was given first aid treatment before being taken to Canberra Hospital by ambulance at 7:40pm. Detainee X was treated on-site for hot water contact to his arm but was assessed as not requiring hospital treatment.

5.1.4 CCTV footage of the incident showed Detainee X apparently waiting for Detainee Z at the top of the stairs before entering his cell and returning to the landing with a kettle and a sock containing an object (later identified as a metal can). Detainee X then poured the kettle over Detainee Z's head before striking him with the can. The detainees then engaged in a short scuffle before staff intervened.

5.1.5 Detainee X reportedly told staff[2] that the assault came about because Detainee Z had 'been standing-over[3] the unit detainees for too long and they were sick of it'. Detainee Z reportedly told police that he and Detainee X had argued a couple of days before the incident.[4]

5.1.6 On arrival at Canberra Hospital at 7:56pm, Detainee Z was treated in the Emergency Department (ED) for 'Partial thickness (blisters, epidermal loss) burn of head and neck' and '4cm abrasion on scalp'.[5] The Discharge Letter does not record the time of his discharge but Detainee Z returned to AMC at 2:15am on 24 May 2018, some six hours later.

5.1.7 This is where the uncertainty about whether Detainee Z was 'admitted to a hospital' arises in the context of the definition of critical assault incident. While at Canberra Hospital Detainee Z was treated in the ED but was not admitted to a ward. When I sought clarification from ACT Health[6] I was advised that a person presenting to the ED might not be taken to a ward if it was assessed that the treatment they required could be provided in a timely manner in the ED. ACT Health also advised that another reason for providing treatment to Detainee Z in the ED may have been because there were no available ward beds at the time he was received.

---

2 ACTCS Incident Synopsis Report, 24 May 2018
3 Prison jargon for bullying, threatening behaviour
4 ACTCS Incident Synopsis Report, 24 May 2018
5 Canberra Hospital Emergency Discharge Letter dated 24 May 2018
6 Telephone conversation

5.1.8 I decided that it would not be productive to pursue the issue as to whether Detainee Z was officially 'admitted to a hospital' (i.e. a critical incident) on this occasion but this definitional uncertainty will need to clarified with ACT Health, and perhaps with the ACT Government Solicitor, in the event of a similar incident occurring in the future.

Finding 2:

That Section 17(2)(g) of the *Inspector of Correctional Services Act 2017* needs to be reviewed to clarify the meaning of 'admitted to a hospital'.

5.2 The timeliness and effectiveness of centre staff and centre management in responding to the incident

5.2.1 Three COs were close-by in the unit when the incident occurred and responded immediately by locking down the perpetrator and attending to the victim's injuries. Both detainees were assessed and treated at the scene by AMC nursing staff before ambulance officers arrived at 7:00pm, only some 40 minutes after the incident occurred.

Finding 3:

That AMC custodial and medical staff responded in a timely and effective manner to the assault on Detainee Z.

5.3 Whether there were policies, procedures and practices in place for the proper assessment and classification of the detainees

5.3.1 The *Detainee Classification Policy*[7] sets out the factors that must be considered in determining a detainee's security classification and the effects of security classification on decisions such as accommodation placements. Underpinning the policy is the *AMC Prisoner Classification Procedure*.

5.3.2 At the time of the incident both detainees were classified as Medium Security:

(Medium) security mandates a physical environment similar to that of maximum security; that is a secure cell within a secure accommodation building and confinement within a secure perimeter. However, a medium security detainee will not usually require an individual special management plan, as is the case for a maximum security detainee. Medium security will be the normal classification determined for new receptions to custody, in the absence of especially high levels of risk being identified, and will also be available as progression for maximum security detainees demonstrating a reduced level of risk.[8]

5.3.3 Having reviewed the criminal histories and related materials I am satisfied that both detainees were appropriately classified as Medium Security.

Finding 4:

That both detainees involved in the incident on 23 May 2018 were appropriately classified as Medium Security.

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

5.4.1 I examined the intelligence notes made on both detainees prior to the incident. There were no notes that "linked" the detainees. Detainee Z (the victim) had one minor note made in 2017 (tattoos) which is of

7 *Corrections Management (AMC Detainee Classification) Policy 2012*, NI2012-299

8 *Corrections Management (AMC Detainee Classification) Policy 2012*, NI2012-299

no relevance to the incident. Detainee X had two notes made (March & April 2018) that suggest he was asserting himself as the "leader" of the unit and attempting to bolster support from other detainees. However, the intelligence information did not suggest that Detainee X was at risk of assaulting other detainees.

Finding 5:

That there was no intelligence information available to suggest that Detainee Z was at risk of assault by Detainee X.

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

5.5.1 The unit was adequately staffed (three COs to 48 detainees) at the time the incident occurred. The unit staff responded quickly and maintained control of the unit until other officers came to their assistance.

Finding 6:

That there were no failings of security procedures or practices that contributed to the assault on Detainee Z.

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

5.6.1 The Incident Reporting Policy[9] that was in force at the time of the incident and has since been repealed sets out a process for internal notification of incidents to specified ACTCS staff (e.g. Executive Director, ACTCS). However, it is silent regarding timeframes for notifications and makes no mention of external notifications to, for example, the Minister for Corrections. I note that new policies and procedures do include timeframes and refer to notification of external entities. While I am satisfied that telephone notifications were made in a timely manner to myself and ACT Policing, ACTCS should consider having an "Incident Checklist" as an aide-memoire for staff to ensure that all notifications and other actions that may be required (e.g. establishment of a crime scene) are not overlooked. Such checklists are in common use in other jurisdictions.

5.6.2 I note that ACTCS contacted the victim's mother promptly on the night of the incident, informed her of her son's injuries and that he was being treated in Canberra Hospital. She was provided with a "24/7" phone number to call if she wanted updates on his condition.[10] On 24 May 2018 (after Detainee Z had been returned to AMC) she was contacted again and offered a special visit.[11] However, it is of concern that neither of the AMC staff who spoke to her were Aboriginal people, particularly given that there were AMC Aboriginal staff, including Indigenous Liaison Officers, who could have made contact with her in a culturally appropriate manner. This is particularly important given the fact that conveying information to a next of kin about a serious injury to a detainee could be a highly stressful situation, where cultural sensitivity is expected. In relation to deaths in custody, this issue was reflected in Recommendation 19 of the Royal Commission into Aboriginal Deaths in Custody.

9 *Corrections Management (Incident Reporting) Policy 2014 (No 1)* NI2017-538 (repealed on 28 June 2018). The new policy and procedure relevant includes the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2018 (No 2)* NI2018-458 and *Corrections Management (Incident Reporting) Operating Procedure 2018 (No 2)* NI 2018-456 effective from 17 August 2018

10 Case Note made at 11:29pm on 23 May 2018

11 Case Note made at 9:51am on 25 May 2018

5.6.3 In relation to culturally appropriate practices for notifying next of kin of Aboriginal and Torres Strait Islander detainees in cases of medical emergency, I note that the relevant ACTCS policies and procedures do not include any reference to the desirability of having an Aboriginal or Torres Strait Islander staff member contact next of kin where possible.[12] I note also that a previous version of the Aboriginal and Torres Strait Islander detainee policy did consider cultural aspects of notification of next of kin when transferring detainees to hospital.[13]

Finding 7:

That desirably, Detainee Z's mother should have been informed of his injuries by a person of Aboriginal or Torres Strait Islander background.

Recommendation 1:

ACTCS policies and procedures should be reviewed so that in the event of injury or illness affecting an Indigenous detainee, where possible and appropriate, a person of Aboriginal or Torres Strait Islander background notify the next of kin of the detainee.

5.7 The history of the institutional conduct of the detainees

5.7.1 Detainees X and Z were admitted to AMC in January 2018 and June 2015, respectively. Prior to the incident on 23 May 2018 both had been involved in custodial incidents.

5.7.2 Detainee X had been cited in 7 incidents (in 4 months), including one involving a physical altercation with another detainee and one instance where he spat on another detainee.

5.7.3 Detainee Z had been cited in 15 incidents (in 3 years), including five physical altercations and one instance where he threatened a CO.

5.8 Particulars of the detention status of the detainees at the time of the incident

5.8.1 Detainee Z was serving a lengthy prison sentence for serious offences. Detainee X was a remandee facing a number of charges involving alleged driving and theft offences. At the time of the incident both detainees had a 'Strict Protection' status[14] and were classified as Medium Security. However, I could not find a clear definition of 'Strict Protection' in ACTCS policies or procedures i.e. what differentiates Strict Protection from Protection and what is different about the management regimes? This question is relevant as to whether Detainees X and Z were appropriately accommodated in the same unit.

Finding 8:

That 'Strict Protection' is not adequately defined in ACTCS policies or procedures.

12 *Corrections Management (Aboriginal and Torres Strait Islander Detainee and Offender) Policy 2018*, NI 2018-49; *Corrections Management (Next of Kin) Policy 2012*, NI 2012-206 (Repealed on 28 June 2018 but in force at the time of the incident); and the policies and procedures enacted subsequent to the incident namely the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2018 (No 2)*, NI 2018-458 and the *Corrections Management (Incident Reporting) Operating Procedure 2018 (No 2)*, NI 2018-456

13 *Corrections Management (Aboriginal and Torres Strait Islander Detainees) Policy 2011* NI2011-705 (Repealed)

14 Protection refers to the restriction or denial of the prisoner's (sic) opportunity to go into, or remain in, a particular part of a correctional centre; and/or the restriction or denial of the prisoner's opportunity to associate with other prisoners (sic); when either or both of these directions are taken for the purposes of protecting the prisoner. *Corrections Management (Protection) Policy 2011* (Restricted), NI2011-50

5.9 Whether, on balance, it was reasonable to allow the detainees involved in the incident to associate with each other prior to the incident

5.9.1 Detainee Z is an Indigenous man aged in his late 30s. Detainee X is a non-Indigenous man aged in his mid-30s.

5.9.2 Some comment on the detainees' respective criminal histories is necessary in the context as to whether there may have been a "mismatch" in accommodating them in the same unit e.g. a vulnerable, inexperienced prisoner with a predatory, experienced prisoner. In this case both detainees had extensive criminal histories, beginning as juveniles.

5.9.3 Detainee X's criminal history was predominantly associated with theft and related offences, and a few instances of assault offences. He had received prison sentences on a number of occasions.

5.9.4 Detainee Z's criminal history was characterised by a number of serious violent offences, numerous theft and burglary related offences, numerous driving related offences and a number of assault offences. He had served several terms of imprisonment in another jurisdiction for these offences.

5.9.5 On balance, the detainees were not a "mismatch" in terms of their prison experience.

Finding 9:

That in terms of the detainees' correctional histories and prison experience, it was reasonable that they be accommodated in the same unit.

5.10 The action taken by the centre/ agency to respond to issues identified in any internal review/debrief

5.10.1 An incident debrief was conducted on 31 May 2018. The only matter of concern raised was the difficulty experienced by staff trying to move Detainee Z down the stairs which were wet. However, it does not appear that an Aboriginal person attended the debrief, which is contrary to an opportunity for improvement identified by ACTCS in its 'Final Report on ACT Corrective Services 2014-15 Internal Review of Relevant Recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC)' (RCIADIC Review), viz:

Certain policies and procedures could be made more consistent, for example, the Corrections Management (Critical Incident Stress Debrief) Policy and the Corrections Management (Aboriginal and Torres Strait Islander Detainees) Policy whereby critical incident de-briefing involving an Indigenous detainee include the ILO or Indigenous Case Manager.

5.10.2 I note that the Critical Incident Stress Debrief Policy has not been reviewed since the RCIADIC Review.

Finding 10:

That the Aboriginal and Torres Strait Islander Detainee and Offender Policy was updated in 2018 but does not refer to including the Indigenous Liaison Officer or Indigenous Case Manager in debriefings.

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

5.11.1 I note that this incident involving detainee on detainee violence potentially engages a number of rights in *the Human Rights Act 2004* (ACT) (HR Act).

5.11.2 Of most relevance is the right to protection from cruel, inhuman or degrading treatment in s 10(1)(b), and the right to humane treatment when deprived of liberty in s 19 which includes the obligation to segregate accused persons from convicted persons except in exceptional circumstances.

5.11.3 The scope of these obligations are such that ACTCS is required to take positive steps to protect detainees from violence and ill-treatment by other detainees,[15] including by implementing measures such as conducting screening assessments of detainees, confiscation of weapons, segregating detainees, regular supervision of detainees, and ensuring acceptable space for each detainee, with priority for preventive measures over repressive ones.[16]

5.11.4 On the basis of materials reviewed, I am satisfied that ACTCS had in place appropriate protective measures through their segregation policy and intelligence gathering.

5.11.5 I note in passing that this incident involved a remandee and a convicted detainee who were accommodated in the same unit, which is, on the face of it, contrary to s 19 of the HR Act and s 44 of the *Corrections Management Act 2007* (ACT).

5.11.6 As the victim of the assault, Detainee Z is an Aboriginal man, this incident may also engage the right to recognition and equality before the law (HR Act, s 8) and cultural and other rights of Aboriginal persons (HR Act, s 27).

5.11.7 Notwithstanding that Detainee Z is an Aboriginal man, there is no evidence that the assault on him was racially motivated. As to the treatment of the detainees by staff, both were provided with medical care to the standard required and the incident was managed without the use of force. I have noted findings elsewhere in relation to culturally appropriate notification of next of kin.

---

15 See, for example, the United Nations Human Rights Committee concluded that Article 10(1) of the ICCPR had been breached where Jamaica had neglected to take measures to protect the complainant from being assaulted regularly by other inmates. *Daley v Jamaica* Human Rights Committee, View of 31 July 1997 Comm. 750/1997, para 7.6

16 See van Kempen, P 'Positive Obligations to Ensure the Human Rights of Prisoners' in Tak, P and Jendly, M (eds) 2008, *Prison policy and prisoners' rights - the protection of prisoners' fundamental rights in international and domestic law,* Nijmegen: Wolf Legal Publishers

6. OTHER MATTERS ARISING FROM THE REVIEW

6.1 There were no other matters arising from the review.

APPENDIX 1

MEMORANDUM OF UNDERSTANDING

between

ACT INSPECTOR OF CORRECTIONAL SERVICES

and

ACT CORRECTIVE SERVICES

concerning

CRITICAL INCIDENTS

August 2018

Application

1. This is a Memorandum of Understanding (MOU) between the ACT Inspector of Correctional Services and the Executive Director of ACT Corrective Services ('the parties').

2. The objective of this MOU is to establish and maintain a constructive and cooperative working relationship between the parties regarding their respective responsibilities in the event of a critical incident.

Authority

3. The parties derive authority to consult and exchange information from the *Corrections Management Act 2007* (ACT) and *Inspector of Correctional Services Act 2017* (ACT) and the arrangements set out in this MOU.

Examples: Section 7 of *Corrections Management Act 2007* (ACT) and Section 17 of the *Inspector of Correctional Services Act 2017* (ACT)

Terms used in this MOU

4. The following terms and abbreviations are used in this MOU:

Act:	*Inspector of Correctional Services Act 2017* (ACT)
ACTCS:	ACT Corrective Services
Contractor:	A person engaged by the OICS under s14 of the Act
DI:	Deputy Inspector of Correctional Services (when appointed)
ED:	Executive Director, ACTCS
GMCO	General Manager Custodial Operations, ACTCS
Inspector:	Inspector of Correctional Services
OICS:	Office of the Inspector of Correctional Services

What is a critical incident?

5. Section 17(2) of the Act states:

critical incident means any event in a correctional centre or in the provision of correctional services that involves any of the following:
(a) the death of a person;
(b) a person's life being endangered;
(c) an escape from custody;
(d) a person being taken hostage;
(e) a riot that results in significant disruption to a centre or service;
(f) a fire that results in significant property damage;
(g) an assault or use of force that results in a person being admitted to a hospital;
(h) any other incident identified as a critical incident by a relevant Minister or relevant director-general.

Interpretation of section 17(2) of the Act

6. The Act does not define the meaning of:

- 'significant' in (e) and (f)
- 'disruption' in (e)

For the purposes of this MOU, Oxford English Dictionary meanings are taken as a guide:

Disruption:	Disturbance or problems which interrupt an event, activity, or process.
Significant:	Sufficiently great or important to be worthy of attention; noteworthy.

Uncertainty as to whether an incident is a 'critical incident'

7. Given that there is some ambiguity about s17(2) of the Act, if a situation were to arise where the parties disagreed, or were unsure, as to whether an incident was a critical incident they will seek a decision from the Minister for Corrections or the Director-General, Justice and Community Safety Directorate, pursuant to s17(2)(h) of the Act.

Initial Notification of a critical incident

8. In the event of an incident that could reasonably be considered to be a critical incident, the ED, or in their absence the GMCO, will notify the Inspector by telephone within 4 hours of confirmation that the incident was critical in nature or where an incident is ongoing, within 4 hours of an incident commencing.

9. If for some reason the Inspector is not contactable by phone the leaving of a voice mail message(s) will constitute initial notification.

10. Current (as at 25/06/18) contact numbers for ACTCS and OICS relevant officers are provided at Appendix 1 to this MOU.

12. Within 24 hours of the telephone notification, the ED will provide the Inspector by email (cc. Deputy Inspector) with brief details of the incident, including but not limited to:

- nature of incident
- where it happened
- when it happened
- injuries to staff or detainees
- status of security and good order of the location
- media interest

13. Where the Inspector or DI learns of what may be a potential critical incident by another means than from the ED, they will call the ED, or in their absence the GMCO in as soon as is practicable to clarify the situation.

Provision of relevant information

14. Where the Inspector determines to undertake a full review of a critical incident, ACTCS will provide a copy of the following paperwork within 7 working days, or if required earlier, as reports are available.

- Officer reports
- Incident Synopsis
- Detainee Injury Form if appropriate
- Hot and Cold debrief minutes if available
- Any other identified documentation

15. Where the Inspector determines to undertake a 'desk top review' of a critical incident, ACTCS will provide a full pack consisting of the above and any further associated documentation within 4 weeks of the incident.

Inspector may refer a matter to another investigative entity

16. Section 32 of the Act provides that:

> *(2) The inspector may decide not to review or examine the matter and to refer the matter together with any relevant documents or information in the inspector's possession or control, to an investigative entity.*
>
> ...
>
> *investigative entity means an entity with power to require the production of documents or the answering of questions including, for example, the chief police officer, the human rights commission and the ombudsman.'*

Note, by definition, ACT Corrective Services is not an *investigative entity*.

Timing of Inspector's referral to another investigative entity

17. Timing of a referral could occur at the outset of an incident (e.g. to ACT Policing in the event of suspected arson) or it could occur later as information/evidence came to light.

18. In either case, Inspector will notify the ED by telephone and email as soon as practicable if a referral is to be made. However, it is noted that s32(4) of the Act provides that *'Nothing in this section requires the investigative entity to deal with he referred matter.'* This means that the Inspector may decide to proceed/continue with a review until such time that a referral has been accepted.

ACTCS may commence an internal review of a critical incident

19. The Inspector recognises that, in the event of a critical incident, ACTCS will inevitably need to conduct an initial review of the incident to, among other things:

- Provide timely and accurate information to the Minister and/or Director-General
- Ensure that both safety and security are addressed immediately to prevent any further incident
- Ensure that witnesses are identified
- Identify and secure evidence
- Take written reports from staff involved in the incident

20. Nothing in this section precludes ACTCS from launching a staff misconduct investigation[1] arising from an incident.

OICS may bring equipment into a corrective services location

21. As provided for under s19(5) of the Act, the OICS (including its contractors) may take equipment into a corrective services location for the purposes of a review. Such equipment may include:

- Computers
- Cameras
- Voice recording devices

22. Any such equipment remains subject to gate entry procedures and must be signed in and out of any correctional centre.

23. By oral agreement between the parties, equipment does not include mobile phones.

OICS will comply with reasonable safety or security instructions

24. The OICS (including its contractors) will comply with reasonable safety or security instructions while on-site. For example:

- Presentation of identification
- Searching of bags and equipment
- Searching of the person, other than strip-searching
- Adherence to any emergency measures such as a "no movement" order
- Carry a personal duress device or radio
- In the event of an emergency situation arising, follow the directions of custodial officers to ensure safety and security

[1] The ICS has no power under the Act to conduct staff misconduct investigations

25. A 'reasonable safety or security instruction' does not include a requirement for OICS staff to be escorted unless there are sound safety and/or security reasons for doing so (e.g. incident in progress).

26. In general, such instructions must not unnecessarily impede the carrying out of the functions of the Inspector under the Act.

Date of effect

27. This MOU comes into effect on the date on which it is signed by both of the parties.

Amendment and termination

28. This MOU can be amended or varied following the written agreement of both parties or can be terminated at any time by written notification by either party.

Neil McAllister
ACT Inspector of Correctional Services

Date: 23 August 2018

Jon Peach
Executive Director
ACT Corrective Services

Date: 4 September 2018

www.ics.act.gov.au