GOVERNMENT OF WESTERN AUSTRALIA

JULY 2013

Directed Review into an Incident at Banksia Hill Detention Centre on 20 January 2013

85

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Office of The Inspector of Custodial Services

Directed Review into an Incident at
Banksia Hill Detention Centre on 20 January 2013

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MOVING FROM RIOT AND DISARRAY TO A BETTER FUTURE

INTRODUCTION

On the evening of Sunday 20 January 2013, an extremely serious incident of mass disorder erupted at Banksia Hill Juvenile Detention Centre ('Banksia Hill'). It was by far the most serious incident of this type in Western Australia since the Casuarina Prison riot of Christmas Day 1998 and can fairly be described as a 'riot'.

On 21 January 2013, the then Minister for Corrective Services Hon Murray Cowper MLA directed me to undertake a review of the incident. The terms of reference included the context of the incident and its contributing or causal factors; security infrastructure and practices; the adequacy of emergency management planning and responses; and the subsequent housing of detainees at Hakea Prison. He also asked me to review staffing levels at Banksia Hill and the impact of the incident on staff.[i]

This report makes some strong criticisms and wide-reaching recommendations. However, it is important to emphasise that many staff in the Department of Corrective Services ('the Department') demonstrated courage, strength of character and good judgement at the time of the riot and have continued to do so. They deserve the community's respect, admiration and gratitude.

It is also important to emphasise that this is not a report about the individual responsibility of detainees on the night. That is a matter for the Western Australia Police (WAPOL) and the Department. WAPOL has carried out investigations and a number of charges have been laid as a result. I have found that Banksia Hill's problems have many dimensions and had been escalating over the 18 months preceding the riot, but this does not justify destructive behaviour.

REPORT AND ACKNOWLEDGMENTS

This report contains 35 recommendations. Some involve matters that lie within the control of the Department but many involve broader questions for government. The recommendations are essentially directed at outcomes rather than processes. They aim not only to enhance safety and security for staff and detainees at Banksia Hill but also to improve community protection, the treatment of detainees, efficiency and accountability.

This report is accompanied by a number of Review Papers. These papers examine issues such as security, infrastructure, governance, emergency management and staffing in more detail than this report and each one is a significant resource in its own right. In order to provide additional expertise and 'fresh eyes', a number of consultants assisted in the review. Their knowledge, experience and insights have been invaluable.

Contemporaneously with this review the Auditor General conducted a performance audit of the project to redevelop Banksia Hill in the period from 2009 to 2012. His audit was fully independent of my Inquiry but the findings of the two reports are consistent in every respect.[ii]

i The Inspector of Custodial Services is accountable to Parliament, not to the government, and can therefore decline to undertake a direction. However, I readily agreed to undertake this Inquiry.

ii See www.audit.wa.gov.au

I would like to acknowledge the active and positive engagement in this review by a large number of people in the Department of Corrective Services, especially during a tumultuous time for the Department. I have shared the key findings of this Inquiry with the Department throughout, and it has had opportunity to comment on the draft report. Those inputs and engagement are greatly appreciated. I have also held meetings with representatives from a number of other government departments.

In the course of this review we received a number of submissions from professional bodies, advocates and other interested parties.[iii] In addition, we consulted with families and key service providers. Again, I am most appreciative of these valuable contributions.

A PLEA FOR RATIONAL DEBATE

There has been a good deal of media and political interest in the events of 20 January and their aftermath. In addition, over the past month, the Department has been the subject of unprecedented media criticism. This report contains many negative findings and it is likely in the current climate, that these will gain the most attention. However, I urge commentators, politicians and readers to approach the report with a sharp and objective focus on its recommendations about future improvements. It is important to understand and reflect on past failings but sensationalism and point-scoring will do nothing to improve community safety, the circumstances of young people in detention, or the morale and safety of youth justice staff and management. Nor will they contribute to future improvement.

WHAT HAPPENED AND WHAT DIDN'T HAPPEN ON 20 JANUARY?

In understanding events on the night, and in developing a balanced response, it is important to bear some fundamental points in mind. The damage caused by the detainees, especially to their cells and living areas, was unacceptable, affronting and costly, and many people were traumatised, including detainees as well as staff. However, the detainees did not target staff with violence and essentially avoided any such contact. They did not attempt to escape and did not light fires, and there is no evidence of detainee on detainee violence or of gang related violence.

A FRAGILE FACILITY WHERE A MAJOR SECURITY INCIDENT WAS ENTIRELY FORESEEABLE[iv]

Western Australia previously had two juvenile detention centres, Banksia Hill and Rangeview Remand Centre. In early 2009, the government announced that Rangeview would be converted to a minimum-security prison for young adult men and that Banksia Hill would become the sole detention centre. The last of the Rangeview detainees moved to Banksia Hill on 5 October 2012 and the privately operated Wandoo Reintegration Facility opened at the old Rangeview site in November 2012.

iii These are not separately published but are available at www.oics.wa.gov.au
iv See Chapters 2 and 3.

Unfortunately, the project to amalgamate Rangeview with Banksia Hill was fraught with difficulty. There were promising signs in the early stage, though progress in developing key documentation was too slow. In mid-2011 the Centre appeared reasonably well-placed but there were significant fragilities including staff shortages, excessive lockdowns of detainees in their cells, poor responses to detainee misbehaviour and an increasing disconnect between management and staff regarding amalgamation.[v] Had these issues been addressed at the time, the risks would have been reduced.

During the remainder of 2011 and through to amalgamation in October 2012, the risks increased markedly. Further building delays and the difficulty of managing a detainee population alongside a construction site compounded the problems but did not cause them. This period saw an escalation in serious incidents, including assaults on staff, numerous roof ascents, and a violent high-risk escape involving the stealing of a contractor's vehicle in August 2012.

Over the same time period, the Department made too many changes to the management of youth custodial services, both onsite and at head office level. This led to a lack of clear leadership, a lack of continuity and increasing instability. Ultimately, the amalgamation project became a case study in how not to manage change.[vi]

By October 2012 the Department was in a difficult position. It needed to balance the risks and costs associated with deferring the handover of Rangeview against the risks at Banksia Hill. I have concluded that it placed insufficient weight on the risks at Banksia Hill and did too little to address those risks as they became increasingly evident.[vii] It is of particular concern that the Department failed to follow through on some specific 'risk mitigation strategies' to which it committed in formal advice to the then Minister for Corrective Services in April 2012. I am also unable to find any rational explanation for how the Department could have allowed amalgamation to proceed in early October when, on 26 October 2012, its security directorate considered that Banksia Hill was 'at crisis point and the risk of a major incident is very real'. The fundamental risk factors were essentially no different on 26 October than they had been for the preceding nine to twelve months.

A new management team which started in November 2012 made immediate efforts to address the problems and had begun to make some progress. However, the issues and risks were so fundamental that they could not be addressed by January 2013.

In summary, the precise events of 20 January were not predictable. However, given the risks at Banksia Hill itself and the lessons to be learned from earlier reports into prison riots in Western Australia, a major security incident was entirely predictable.

v OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 76 (Mar 2012).

vi See Chapter 6.

vii In August 2012 I had advised that because of the risks, amalgamation should be deferred by an absolute minimum of one month, with the injection of resources to allow Banksia Hill and the staff at both Rangeview and Banksia Hill to be better prepared. This would not necessarily have prevented the riot but it would have reduced the risks: see Chapter 2.

STABILITY, SAFETY AND SECURITY[viii]

In the aftermath of the riot, there has been a strong focus on 'hardening' the facility by installing bars, and grilles and fences. However, as evidenced in the state's adult prison system, stability reflects a balanced approach between physical security, procedural security (systems and procedures) and dynamic security (a busy regime and positive professional engagement between staff and detainees).

This report has identified numerous weaknesses in terms of the security culture at Banksia Hill. Fortunately some things are not rocket science and should be capable of resolution with good will and good management. First, idle, bored children will invariably become frustrated and are very likely to act out their frustrations. Bars and grilles will not stop this and it is essential that Banksia Hill returns to providing a full and active regime including rehabilitative programs and recreation.[ix]

Secondly, there is a lax security culture. For example, we found that some staff have been taking items such as phones, wallets, lighters, keys, tinned food and medications into the centre's operational areas. This is simply not acceptable. Thirdly, the detainees had easy access to rubble, debris and building materials during the riot and had also used it in previous incidents. Some of this was the result of recent construction activity but the rest had been there for some time. Again this is basic and not acceptable.

EMERGENCY MANAGEMENT PLANNING AND RESPONSES[x]

We have concluded that the response to the unfolding emergency on the night was generally good and in many respects exemplary. Incident management was marked by intelligent and pragmatic decision making, with a strong focus on staff safety, and collaboration between the Department and WAPOL was good. It is a credit to all that nobody was seriously injured in such a volatile situation. However, there are some areas of concern and opportunities for improvement in terms of incident management. In particular, there were insufficient welfare checks of those detainees who remained in their cells, some of whom were vulnerable. In addition, key decisions were not properly recorded and some aspects of incident control require consideration.

Whilst the response on the night was generally good, Banksia Hill was very poorly placed in terms of its emergency preparedness. The emergency management plan was out of date, there was no viable contingency plan for evacuation, and staff training was seriously deficient. The report makes a number of recommendations to address these matters.

viii See Chapter 4.
ix This is not only good sense, it is in line with the principles of the *Young Offenders Act 1994*.
x See Chapter 5.

STAFFING AND MANAGEMENT[xi]

It has become public knowledge since the riot that Youth Custodial Services is facing major staff shortages through high levels of workers compensation claims and unscheduled absenteeism through sick leave. This cultural malaise must be addressed for welfare and financial reasons as well as operational reasons. I make a number of recommendations in this regard.

JUVENILES AT HAKEA PRISON[xii]

Given the extent of the damage to Banksia Hill and the lack of any alternative juvenile facility, the Department transferred the majority of the detainees to Hakea Prison during the two weeks following the riot. They are still there six months later and at this stage it is not clear when they will start to return to Banksia Hill.

I have reached two primary conclusions. First, after taking full account of the difficult circumstances faced by the Department in the aftermath of the riot, I have concluded that the initial three week period of almost total lockdown of detainees was not reasonable and was not necessary by way of risk management.[xiii] Secondly, I have concluded that the regime in place subsequently at the Hakea Juvenile Facility has fallen sort of a suitable level of service to young people in detention because of shortfalls in education, programs and recreation, and because of continuing lockdowns. Importantly, as the Chair of the Supervised Release Review Board has told the Inquiry, the lack of programs has also escalated community risk.

In addition, I have recommended that the Department alters its current practices with respect to the use of restraints and strip-searching. Use of both practices has become in many instances routine when it should be based on an individual risk assessment.

THE FUTURE

The immediate challenge facing the Department is the safe and prudent return of detainees to Banksia Hill. It is currently targeting the return to begin in late August 2013 but there is no certainty. The capital works program at Banksia Hill is not yet complete and Youth Custodial Services is still afflicted by serious staff shortages. Realistically, unless there is a sudden and unforeseeable change, it is likely to be several months before all detainees are back at Banksia Hill. It is therefore essential that, despite the physical deficiencies at Hakea, the Department provides a better regime.

Chapter 8 contains a series of recommendations relating to the future. Some of these are matters that the Department must address, including improved record keeping and improvements to the services offered to young people aged 18 to 25 in the adult prison system. Other recommendations will require broader government consideration and direction.

xi See Chapter 6.

xii See Chapter 7.

xiii In a Supreme Court challenge to the legality of the initial transfer of the detainees and the subsequent decisions to declare parts of Hakea Prison to be a juvenile facility, Chief Justice Martin upheld those decisions given the emergency circumstances in which they were made (*Wilson v Joseph Michael Francis, Minister for Corrective Services for the State of Western Australia* [2013] WASC 157). My findings are not inconsistent with His Honour's views.

As the Inquiry proceeded I formed the view that a fresh approach is required and that responsibility for youth justice services should lie with an agency whose primary responsibility is youth justice, not adult imprisonment. Currently, youth justice services accounts for $100 million of the Department's total budget but reliable estimates suggest that another $200 million or more is spent across government on services for youth at-risk. There are strong arguments in favour of a establishing either a new government department or a Youth Justice Commission (along the lines of the Mental Health Commission) to oversee this expenditure and to drive youth justice into the future. Key outcomes should be a sharper focus on regional youth, Aboriginal youth and mental health.

It is clear that more diverse options are required for managing young people in custody, including regional placements. It is striking that Banksia Hill is the largest juvenile detention centre in Australia and that other jurisdictions generally have a range of options. It is also important not to forget the pressing needs of women prisoners. I have therefore recommended that a master plan for the use of all existing custodial facilities, adult and juvenile, should be developed to better inform future investment decisions.

Neil Morgan
Inspector of Custodial Services
26 July 2013

Recommendation Summary

Recommendation 1

The regime at Banksia Hill should be re-engineered so as to reflect a clear and consistent philosophy that accords with legislative requirements relating to juvenile detention. This philosophy should emphasise that the ultimate purpose is, as far as possible, to rehabilitate the young people and prepare them for release back into the community.

To that end, and in order to improve safety and security, there must be a stronger emphasis on the provision of a full and active regime and positive rehabilitative programs, including:

- education;
- skills training;
- recreation and sport; and
- counselling and offender programs.

Recommendation 2

The conditions of detention at Banksia Hill should be enhanced so as to meet improved standards of decency and dignity, including:

- minimisation of lockdown arrangements;
- cessation as far as possible of double-bunking (other than necessary buddy-cell arrangements);
- effective climate control measures, particularly in summer;
- improved dietary standards; and
- attention to standards of bedding and clothing.

Recommendation 3

The balance between physical, procedural and dynamic security should be re-calibrated in ways that are consistent with the above objectives and the Department should develop and promulgate a statement as to how these matters should be balanced.

Recommendation 4

The Department should review its criteria and processes for making security ratings, ensure that these processes are consistently applied, and spell out in Youth Custodial Rules or elsewhere the operational and regime implications for each level of security.

Recommendation 5

The Department must ensure that the Youth Custodial Rules and Standing Orders relating to Banksia Hill are brought fully up to date. It should also institute processes for ensuring that they are regularly reviewed, remain relevant to changing circumstances and effectively communicated with staff with the provision of appropriate training.

Recommendation 6

The staff culture in relation to dynamic and procedural security should be addressed as a matter of urgency, with a particular emphasis on training needs and ongoing reinforcement. Where appropriate, the Department should be prepared to invoke disciplinary provisions if individual staff members fail to comply with requirements.

Recommendation 7

Physical security assessments should be regularly undertaken at Banksia Hill by the Department's Emergency Support Group or other independent experts. The testing should reflect practical risk not just the physical strength of a structure. Where weaknesses are identified, appropriate remedial measures should be taken in a timely way and in a manner consistent with detention centre philosophies. All decisions and actions should be clearly recorded.

Recommendation 8

It is recommended that the Department undertakes a comprehensive assessment of how dynamic, procedural and physical security weaknesses are contributing to the high number of roof ascents by detainees and implements appropriate remedial measures.

Recommendation 9

The Department should ensure that it engages proactively with the Department of Fire and Emergency Services with respect to fire fighting capability at every site where new units or fences have been built or where other major construction activity has occurred.

Recommendation 10

The Department should examine ways to enhance its intelligence capacity through improvements to proactive as well as reactive information gathering/analysis.

Recommendation 11

The Department should resource and develop the on-site Security Team at Banksia Hill. Subject to ensuring that juvenile detention facilities are not equated with adult prisons, enhanced central security expertise should also be provided.

Recommendation 12

In order to improve emergency management preparedness the Department should:

(a) ensure that emergency management plans at all adult and juvenile facilities are regularly reviewed, fully up to date, and include viable emergency evacuation plans; and

(b) Improve staff training in emergency management and keep clear records of the findings and recommendations arising from scenario training and reviews of critical incidents.

Recommendation 13

The Department should examine and implement improvements to its systems and processes for conducting safety and welfare checks of detainees and prisoners in the event of incidents of mass disorder such as that which occurred at Banksia Hill on 20 January 2013.

Recommendation 14

In order to improve its emergency management responses the Department should:

(a) Further develop its protocols regarding the roles of the on-site Superintendent and the Emergency Support Group (ESG) Superintendent, especially in situations involving a whole-of-site incident;

(b) Evaluate the resources needed by the ESG to improve response times at weekends and evenings; and

(a) In consultation with WA Police, evaluate the opportunities for improved site navigation capacity during emergency situations.

Recommendation 15

Staff generally, and the Primary Response Team (PRT) in particular, should be provided with better training for responding to unfolding incidents and de-escalation techniques. This should occur in the context of more general training in dynamic and procedural security (see Recommendation 6). The PRT should not be equipped with weapons such as batons, pepper spray and Tasers.

Recommendation 16

The Department should examine the lessons to be learned from events in the youth custodial system since 20 January 2013 with respect to recovery from emergencies. In particular, it should ensure that debriefs are organised for all staff and that longer term strategies are implemented to rebuild staff confidence and resilience.

Recommendation 17

The senior management structure of the Department should be reviewed with a focus on improving correctional outcomes, efficiencies and service delivery. This process will require external direction and needs to be commenced urgently. Depending on the results of this review, a revised structure can then be implemented soon after the appointment of a new Commissioner and in consultation with that person.

Recommendation 18

(a) Appointments to all management positions at Banksia Hill should be finalised; and

(b) Adequate head office support must be provided in areas such as finance and human resources.

Recommendation 19

There should be an independent review of FTE staffing levels in Youth Custodial Services, taking into account comparative data about the numbers and deployment of staffing in other Australian juvenile detention facilities and prevailing standards. This needs to be undertaken as a matter of urgency.

Recommendation 20

The above review should examine the drawbacks and benefits of the 12-hour shift system currently pursued in the juvenile detention system and alternative models.

Recommendation 21

The above review should investigate the present arrangements for and use of personal leave and the causes for and impact of workers' compensation claims in the Youth Custodial area.

Recommendation 22

The Department should ensure that structured formal performance reviews are regularly conducted with staff in order to identify areas for improvement and areas of achievement.

Recommendation 23

It is recommended that the Department review the adequacy of its policies, procedures and resources in the following areas: (i) case planning; (ii) occupational health and safety; (iii) the roles and training of unit managers; and (iv) the employment of more Aboriginal people, including as mentors for young people.

Recommendation 24

The Department should ensure that

(a) The number of scheduled and unscheduled lockdowns of detainees is substantially reduced and that accurate records are kept of the reasons for any lockdowns and their duration;

(b) Detainee participation in education, rehabilitative and recreational programs is substantially increased in keeping with the Department's standards for the management of youth custodial facilities; and

(c) Accurate records are kept with respect to each and every detainee of all of these matters.

Recommendation 25

Mechanical restraints must not be used as a routine measure to control the movement of detainees within detention centres. They should only be used following a proper assessment of the risk posed for and by the particular individual to be restrained in accordance with section 11D of the *Young Offenders Act 1994*.

Recommendation 26

The Department should review and alter its practices relating to the strip-searching of detainees:

(a) To cease the practice of routinely strip-searching detainees on every entry and exit to detention centres, particularly when they have been transported in a secure vehicle; and

(b) To ensure that strip-searches in relation to social visits are not routine but are undertaken only on reasonable suspicion of contraband, assessed on a case by case basis.

Recommendation 27

The Department must improve the scope, detail, accuracy and availability of records across all aspects of Youth Custodial Services.

Recommendation 28

It is recommended that the government conduct a high level review of expenditure on youth justice services across all agencies with a view to (i) gaining a more complete understanding of the full range and cost of services; (ii) appraising the balance between the budgets for custodial services, prevention and diversion schemes, and community-based supervision; and (iii) assessing future options.

Recommendation 29

It is recommended that the government:

(a) Develop plans and processes to transition youth justice services out of the Department of Corrective Services to an agency whose sole focus is youth justice; and

(b) To that end, establish either a Youth Justice Commission (modelled on the Youth Justice Board of England and Wales and the WA Mental Health Commission) or a stand-alone Youth Justice Department.

Recommendation 30

It is recommended that the government sets clear service and performance requirements for Youth Custodial Services and ensures that these requirements are subject to external monitoring, assessment and reporting. These service and performance requirements should cover all relevant areas, including security and safety, detainees' access to employment, education programs and recreation, lockdowns, and staffing levels, absenteeism and management.

Recommendation 31

It is recommended that government consider whether there are benefits in outsourcing some aspects of youth custodial operations, such as gatehouse security, allowing existing staff to be deployed to other areas.

Recommendation 32

Subject to its evaluation of performance by the Department of Corrective Services and to decisions regarding investment in new detention facilities, it is recommended that government consider whether a contestability model for Youth Custodial Services delivery will lead to improved outcomes.

Recommendation 33

It is recommended that government develop a master plan regarding the best use of existing adult and juvenile custodial facilities. The key outcomes of this should include:

(a) Provision of a wider range of options for youth, in order to allow for the better separation of different cohorts of detainees and to provide improved services to target issues of age, gender, legal status, the needs of Aboriginal youth and youth from regional areas, and specific problems such as mental health;

(b) Improvements to the conditions and services provided to adult female prisoners; and

(c) Better targeting of the needs of adult prisoners in areas such as mental health/ mental impairment.

Recommendation 34

It is recommended that the Department, drawing on experience with the Wandoo Reintegration Facility, develops new initiatives and injects the necessary resources into developing a sharper focus on the needs of young adult men and women held at prisons other than Wandoo.

Recommendation 35

Reforms and initiatives undertaken with respect to youth justice services should be underpinned by a focus on the needs of Aboriginal youth across the state, including innovative forms of engagement with Aboriginal organisations and service providers.

Chapter 1

SCOPE, PURPOSE AND METHODOLOGY

INTRODUCTION

1.1 On the evening of Sunday 20 January 2013, an extremely serious incident of mass disorder erupted at Banksia Hill Juvenile Detention Centre ('Banksia Hill'). It was by far the most serious incident of this type in Western Australia since what is generally known as the 'Casuarina Prison riot' of Christmas Day 1998.[1]

1.2 Banksia Hill is operated by the Department of Corrective Services ('the Department'). At the time of the incident it housed 185 males and 21 females.[2] The incident started when three detainees climbed onto a roof, not an infrequent event at Banksia Hill. In total, 61 detainees escaped from their cells and had 'run amok'.[3] In addition, a significant number of detainees caused damage to their cells. Due to the nature of the incident and the extent of the damage, it has not been possible to put a precise figure on the number of detainees involved in the incident. Department-supplied figures put the number at around 73, all male, but it is more likely that, in total, somewhere between one-half and two-thirds of the male detainees were actively involved to some degree, and also some of the females.

1.3 Extensive damage was caused by some of the detainees to parts of the buildings, most notably the cells and living areas, as well as to some equipment and personal property. The worst of the damage resulted from windows being attacked from both the outside and the inside.

1.4 It is impossible at this stage to put an exact figure on the cost of the riot. Most official statements have put the cost of the damage alone at around $1.5 million,[4] though departmental advice to this Inquiry put the bill somewhat lower.[5] The real total cost is still unknown as it must include the measures that have been taken in the months that Banksia Hill has been only partially operational, including housing detainees at Hakea Prison. Many of these costs are ongoing at the time of writing (early June 2013).

1.5 The issue of total cost may well merit future examination; however, it must also be understood that financial costs are probably not the most serious issue. The cultural and emotional damage at a facility that was already under enormous stress is immeasurable and some serious challenges lie ahead. Reputational loss to the Department has also been serious.

1 See the *Report of the Inquiry into the Incident at Casuarina Prison on 25 December 1998* compiled by Smith L E [et al] (19 March 1999); Carter K W, 'The Casuarina Prison Riot: Official Discourse or Appreciative Inquiry?' *Current Issues in Criminal Justice*, Vol. 12, No. 3, March 2001.

2 Figures presented later in this report use the number 207. This is because one young person was received into Banksia Hill on the night of 20–21 January.

3 A phrase used by the former Commissioner for Corrective Services, Ian Johnson, in media comment on 21 January 2013.

4 In April 2013, the Premier, Hon Colin Barnett MLA put the damage at $1.5 million: see Taylor P, 'Boys in Jail Serious Offenders', *The Australian* (4 April 2013).

5 The Department told the Inquiry that the cost of returning Banksia Hill to its previous condition was around $401,000 and that the cost of relocating to Hakea was $425,000. The different figures probably reflect different methods of calculation. For example, there has been a good deal of 'target hardening' at the site, including the installation of grilles across much of the site. This has been a cost but it is not technically a 'repair' cost.

1.6 The incident had some very specific dynamics and features which set it apart from previous prison 'riots' in Western Australia. In particular, staff were not targeted with violence. However, for reasons discussed later, the term 'riot' is an apt description of the incident.[6]

1.7 The *Young Offenders Act 1994* (WA) governs the treatment of juveniles in contact with the criminal law in Western Australia. Subject to the terms of this Act and its Regulations, Banksia Hill is run by the Department's Youth Custodial Services (YCS) division. The Department also has responsibility for other aspects of youth justice services including prevention, diversion and the supervision of children on community based court orders, as well as for adult corrections. The vast majority of the Department's funding relates to adult offenders, especially adult male prisoners, and its activities and focus lean heavily in this direction.

1.8 The consequences of the riot for the detainees were dramatic. Seventy-three male detainees were immediately transferred to a nearby adult prison, Hakea Prison ('Hakea'). Within a week it had been decided that all of the male detainees, whatever their age or legal status, would be transferred to Hakea. These transfers were finalised by 8 February 2013.

1.9 Following pressure from a number of sources that decision was modified and it was decided that detainees aged under 14 would continue to be held at Banksia Hill. A number of older detainees were also held at Banksia Hill for specific purposes. They included detainees who needed to be held in 'observation', those appearing before the Supervised Review Release Board, and those appearing in court, whether in person or by video-link. Banksia Hill also continued to house female detainees.[7]

1.10 Staff anxiety, distress and deflation were all too obvious during our site visits immediately after the event. There had also been substantial evidence of serious staff issues and problems of leadership and direction for a lengthy period prior to the riot.

1.11 Just over three months before the riot Banksia Hill had become the state's only juvenile detention centre following the decision to turn the other juvenile facility, Rangeview Remand Centre ('Rangeview') into a prison for young men aged 18 to 24. Banksia Hill officially became the sole juvenile detention centre on 5 October 2012 ('the date of amalgamation'), with the transfer of the final group of Rangeview detainees. At the time of the riot, however, it remained in transition.

1.12 Banksia Hill had actually been in transition, to one degree or another, for over three and a half years. The announcement that Rangeview would have a different role was made in May 2009 and in January 2010 it was confirmed that a 'Public Private Partnership arrangement' would be used.[8] Amalgamation was originally anticipated for the end of 2011 but the project was beset with building delays and a range of associated problems. This had contributed to uncertainty and risk.

6 See [3.19–3.21].

7 A separate report will be published on the position of female detainees: see [1.47] below.

8 Hon Christian Porter, Minister for Corrective Services, *State Budget 2009-10: Young adults' prison addressing specific needs*, media statement (14 May 2009); Hon Christian Porter, Minister for Corrective Services, *Groundbreaking ceremony starts $30 million project to boost youth custodial services,* media statement (20 January 2011).

1.13 The old Rangeview site, now called the Wandoo Reintegration Facility ('Wandoo'), is operated by Serco Australia Pty Ltd ('Serco') pursuant to a contract with the Department. Wandoo was officially opened on 21 November 2012.

1.14 In late May 2013 the Department said it was actively working towards the return of all detainees to Banksia Hill by 15 July 2013. However, so many of the issues charted in this report remain unresolved that a mid-July return date for all detainees does not appear feasible, safe or prudent.[9] However, it is important to start the process as soon as possible. On 25 June 2013 the Department advised that a 'specific return date is not yet known.'[10]

1.15 Although the immediate trigger for this review was the 20 January riot, it examines a wide range of issues relating to juvenile justice, especially those relating to juveniles in custody. This should come as no surprise: there is always an element of spur of the moment opportunism in prison riots but they also invariably reflect systemic failings. Every other equivalent report of any value, in Australia or elsewhere, has come back to systemic issues.

1.16 This report is critical on many counts and raises some challenging questions for Department employees at all levels with respect to leadership, management and staff culture. However, this is in no way a negative reflection on the large number of staff who have demonstrated professionalism and commitment throughout an extended difficult period, not least those who showed bravery, leadership and skill on the night in question. They deserve respect, gratitude and support.

1.17 It is also acknowledged that the Banksia Hill redevelopment and the subsequent riot occurred at a time when the Department had to manage a large number of challenges and infrastructure expansion projects, especially in adult prisons. The $36 million budget for the redevelopment projects at Banksia Hill and Rangeview constituted around five per cent of a $655 million expansion program for adults and juveniles.

DETAINEES' RESPONSIBILITY

1.18 This report does not address the responsibility of individual detainees for what happened on the night. Those who are alleged to have committed criminal offences on the night should be dealt with formally, either by police charges or through the Department initiating action for detention centre offences under the *Young Offenders Act 1994*.

1.19 Whilst this report examines a wide range of factors which created a volatile situation, it must not be read as condoning the destructive behaviour of some of the detainees on the night.

9 This is a matter that the Inspector of Custodial Services is continuing to monitor.
10 Email advice to OICS from the Deputy Commissioner Community and Youth Justice (25 June 2013).

LEARNING, IMPROVEMENT AND PRIORITIES

1.20 This report focuses on evidence, facts, systems, processes and outcomes. However, it must be said that divisions between some staff and especially amongst senior departmental management were sometimes so marked that it was not always easy to separate problems from personalities. It would be a serious mistake, though, to blame a few individuals for the current state of affairs in youth custodial services or to believe that simply changing some faces will lead to improvement. Systemic issues need to be addressed.

1.21 This report does not simply reflect on the riot but makes broad strategic recommendations designed to improve services, outcomes and efficiencies in the youth justice sector. They include the establishment of a new agency with responsibility for youth justice. If youth justice remains with the Department, outcomes are very unlikely to improve unless it becomes more open, responsive and prepared to follow through on commitments.

1.22 Youth justice services – especially in a custodial setting – are inherently expensive and these costs must be factored in to government policies and planning. This report makes recommendations believed by the Inspector to be necessary, but it also has regard to budgetary realities. The bottom line is simple: additional resources will be required over the short to medium term to stabilise and 'reboot' the system, but better use must also be made of current resources.

1.23 In taking decisions about the future, it must be remembered that there are other priority areas in corrections, notably the neglected and deteriorating position of women prisoners. This issue has attracted less public attention but had started to gain increased traction during 2012.[11] Improvements to youth justice services should not obscure or subsume these other priorities.

1.24 Change and improvement will not happen overnight and there are no 'magic bullets'. However, it is important to set clear target dates for demonstrable improvement, and there is reason to be optimistic that with strong leadership this can happen. First, despite the problems of recent years, Banksia Hill was running well in the mid-2000s and many staff remain committed and ready to embrace positive change. Secondly, over recent years, a number of other jurisdictions, including Victoria and the Australian Capital Territory, have faced serious challenges in their youth custodial facilities which they have been able to turn around in less than two years by adopting an intelligent and holistic response.[12]

11 OICS, *Report of an Announced Inspection of Bandyup Women's Prison, Report Number 73* (August 2011); Standing Committee on Public Administration, *Omnibus Report – Activity during 38th Parliament*, Report 15 (November 2012).

12 Comrie N, *Review of Escape Incident at the Melbourne Youth Justice Centre on 19 May 2010* (unpublished); Ombudsman Victoria, *Whistleblowers Protection Act 2001 Investigation into Conditions at the Melbourne Youth Justice Precinct* (October 2010); ACT Human Rights Commission, *The ACT Youth Justice System 2011: A Report to the ACT Legislative Assembly* (July 2011). See [8.6–8.11].

AN EVOLVING STORY

1.25 This report and its supporting review papers reflect the situation in late May – early June 2013, four months after the riot. A great deal has happened in this time, the extent of which would not have been predicted in late January. Key developments include the following:

- The appointment of a new Minister for Corrective Services, Hon Joe Francis MLA on 21 March 2013, replacing Hon Murray Cowper MLA.
- The resignation of the Commissioner for Corrective Services, Mr Ian Johnson, on 26 April 2013, with the Deputy Commissioner Adult Custodial, Ms Heather Harker, appointed interim Acting Commissioner.
- Very proactive engagement by the President of the Children's Court and his colleagues in tracking the management of detainees after the riot.
- A Supreme Court challenge to the legality of the decision to transfer children to Hakea Prison.[13]
- Revelation of a more negative budget situation for the state than had previously been anticipated.
- Indications that the state government intends to give a sharper priority to prevention and diversion and to improved outcomes for prisoners and juvenile detainees on release.
- Evidence of growing interest across a number of government departments and accountability agencies in the issues faced in the Department of Corrective Services.
- Unprecedented levels of media interest, nationally as well as locally, in the housing of juveniles at an adult prison.

1.26 These changes, combined with stakeholder expectations, gave added impetus to the Inspector's view that a broad approach needed to be taken to the terms of reference. This view has been supported by the Minister and a number of other government agencies.

'DIRECTED REVIEWS'

1.27 The obligations and powers of the Inspector of Custodial Services ('the Inspector') are set out in the *Inspector of Custodial Services Act 2003* (WA). The Inspector must undertake regular inspections of prisons, juvenile detention centres and court custody centres and report to Parliament on these places at least once every three years. The Inspector may also review any aspect of a custodial service relating to those facilities and associated administrative arrangements.

13 *Wilson v Joseph Michael Francis, Minister for Corrective Services for the State of Western Australia* [2013] WASC 157. In this case the applicant challenged the lawfulness of the Minister's decisions to declare Units 5, 11 and 12 at Hakea Prison, to be a detention centre. This involved the circumstances which prevailed at the time the decisions were taken and whether the decision makers exceeded the power conferred upon them by the *Young Offenders Act 1994*. The court was not required to consider the appropriateness of the custodial regime put in place in the weeks following the riot and at page 8 of his judgement the Chief Justice stated 'Any assessment of the appropriateness of that regime and its duration must take account of the security risks created by the riot and its aftermath, including in particular the unexpected relocation of detainees to a facility which was not designed for their use, and the seriousness of the offences with which the detainees had been charged, or in the case of sentenced detainees, of which they had been convicted. Assessments of that character are best made by the Department and the Inspector of Custodial Services, not the court'.

1.28 As the Inspector is accountable to Parliament, and not to the Minister or Commissioner for Corrective Services, he or she is not subject to any absolute direction as to the scope, content or methodology of activities. However, s 17(2) of the *Inspector of Custodial Services Act 2003* permits a Minister to issue a written direction to the Inspector to carry out an inspection or review:

> The Minister may, in writing, direct the Inspector to–
>
> (a) inspect a prison, detention centre, court custody centre or lockup;
>
> (b) to review a custodial service in relation to a prison or detention centre or a custodial service (*CSCS Act*) or an aspect of that service,
> and report on a specified matter of significance.

1.29 Section 17(5) states that the Inspector must comply with such a direction unless, in the Inspector's opinion, there are 'exceptional circumstances for not complying'.[14]

1.30 On 21 January 2013, the then Minister for Corrective Services, Hon Murray Cowper MLA, announced that he had directed the Inspector to undertake a review of the 20 January incident. The terms of reference were announced on 24 January 2013. This is the first directed review to be undertaken by the Office of the Inspector of Custodial Services (OICS) since 2007.[15]

TERMS OF REFERENCE

1.31 Most official reviews of prison riots stop at the point the riot is over. They examine the incident and its surrounding circumstances with a view to reducing the likelihood of such incidents occurring again. Those issues form a key part of this Inquiry but it was clear that the riot had profound consequences in terms of the management of detainees and the confidence, resilience and morale of staff. The Inspector and Minister therefore agreed the following terms of reference:[16]

'… a full investigation into all aspects of the incident, including:

- Context of the incident
- Facts of any contributing/causal factors
- Security and integrity of the cells
- Security systems and infrastructure
- Security practices and protocols for all staff
- Adequacy of crisis/emergency management planning and crisis/emergency management response

14 If the Inspector refuses to comply with a direction, he or she must prepare written reasons for the refusal and publish those reasons in the Inspector's annual report: s 17(6).

15 Previous directed reviews have included OICS, *Report of an Unannounced Inspection of the Induction and Orientation Unit and the Special Handling Unit at Casuarina Prison*, Report No. 1 (March 2001); OICS, *The Diminishing Quality of Prison Life: Deaths at Hakea Prison 2001–2003*, Report No. 22 (March 2004); OICS, *Directed Review of The Management of Offenders in Custody*, Report No. 30 (November 2005); and OICS, *Directed Review into an Incident at Rangeview Juvenile Remand Centre and its implications for Management and Reporting*, Report No. 41 (April 2007).

16 Hon Murray Cowper MLA, letter to the Inspector (24 January 2013).

- Temporary housing of juvenile detainees at Hakea Prison
- To report to Parliament on the findings at the conclusion of the review.'

1.32 In addition, the Minister directed the Inspector 'to review staffing levels at the facility and report on the management of the incident and its impact on staff.'[17]

1.33 The importance of examining post-incident responses was reinforced when, within 24 hours of the terms of reference being announced, it became clear that the vast majority of the male detainees were destined for Hakea and that the minimum timeframe for the use of Hakea was five to six months.

1.34 The terms of reference refer to 'a *full* investigation into *all aspects* of the incident, *including*…' the specific points that are mentioned. This required a broad and flexible approach.[18]

TIMEFRAMES AND ONGOING ENGAGEMENT

1.35 This report and its supporting review papers reflect the position in late May/early June 2013 but they will not become public until early August. This reflects the fact that the *Inspector of Custodial Services Act 2003* includes a number of 'due process' protections.[19]

1.36 These protections generate significant delays between the drafting and release of reports. This is less than ideal, especially in a situation such as this. However, there are some advantages. First, all key parties are aware of the contents of the report well before publication, and can give feedback or alert the Inspector to possible errors. During the course of this Inquiry, the Inspector and staff have consulted with a wide range of interested parties. Within government, these have included the Minister for Corrective Services, the Department, the Department of Premier and Cabinet, the Public Sector Commissioner and the Department of Treasury.

1.37 These discussions with government have been important in promoting progress and dialogue. They have in no way impinged on the Inspector's autonomy or parliamentary accountability.

17 Hon Murray Cowper MLA, media release, 24 January 2013, *Terms of Reference for Banksia Hill Inquiry*. http://www.mediastatements.wa.gov.au/pages/StatementDetails.aspx?listName=StatementsBarnett&StatId=7157

18 See also Paragraph 1.26 above. The provisions of the *Inspector of Custodial Services Act 2003* would in any event have allowed the Inspector to undertake an own motion inquiry unconstrained by terms of reference. The existence of a directed review cannot prevent the Inspector pursuing other lines of inquiry if this is necessary in order to meet statutory obligations.

19 As a Directed Review under s 17 of the *Inspector of Custodial Services Act 2003*, this Inquiry is not subject to the same provisions as inspection activities undertaken under sections of the Act. In the case of inspections under ss 19, 21 or 22 which are tabled in Parliament, any party about whom a critical comment is made must have the opportunity to make submissions (s 37) and reports of such inspections must be sent to Parliament at least 30 days before they become public (s 35). Although these provisions do not apply to Directed Reviews under s 17, the Inspector complied with the spirit of the provisions by ensuring the draft report and draft review papers were sent to the Department for comment. The report and review papers were also sent to Parliament around one week in advance of tabling.

INSPECTOR'S POWERS

1.38 Directed reviews under s 17 of the *Inspector of Custodial Services Act 2003* attract the same powers and protections as the Inspector's other activities. Unlike a Royal Commission, the Crime and Corruption Commission and the Ombudsman, the Inspector does not have the power to compel people to give evidence. However, the Inspector's powers do include:

- The power to do 'all things necessary or convenient to be done for or in connection with the performance of' the functions (s 27); and
- Free and unfettered access to all relevant sites, employees, contractors and documents (ss 28–30).

1.39 It is an offence to hinder, resist, mislead, attempt to mislead, or to make false or misleading statements to the Inspector or those undertaking work on his or her behalf (ss 32 and 49). It is an offence for a person to be victimised for providing information to or assisting the Inspector (s 50). Victimisation includes intimidation, harassment, and any other acts likely to cause detriment. The offence also covers anyone who attempts such acts or incites another to engage in such acts. In the context of a section 17 review, a failure to cooperate with the inquiry would also, in effect, constitute hindering the Minister and the government.

1.40 The Inspector did not need formally to invoke these provisions. The Department established processes for sending requested information to the OICS and generally responded in a timely and professional manner. Many people willingly volunteered their time and assistance and most staff actively engaged in the process. This was greatly appreciated and essential to the Inquiry.

1.41 However, there were significant pockets of difficulty. The Inquiry team sometimes encountered problems obtaining accurate and detailed advice and the selective 'spin' being placed on less than positive situations was frustrating. Other key parties experienced similar frustrations, the President of the Children's Court telling the Inquiry: 'Frankly, senior management of DCS must stop giving things names or descriptions to create an impression of something which it is not.'[20] It was also most concerning to hear consistent and credible accounts of staff being told, in effect, to 'be careful what you say' or to 'follow the official line'. Ultimately such attitudes have served to undermine, not to enhance departmental credibility.

RELATED REVIEWS

1.42 Four other reviews are currently under way which relate to this report.

Office of the Auditor General (OAG)

1.43 Government allocated a budget of around $36 million to cover the amalgamation project, inclusive of some work at the Rangeview site. This was around five per cent of a $655 million custodial infrastructure program. The projected completion date was the end of 2011 but the project was beset with delays.

20 His Honour Judge D J Reynolds, Children's Court of Western Australia, letter (22 May 2013).

1.44 The management of capital works projects is an area of interest to the Auditor General. The Banksia Hill Redevelopment Project involved not only the Department but also the Department of Building, Management and Works and private contractors. This added layers of difficulty to the amalgamation and created significant confusion in terms of transparency and accountability.

1.45 Based on an assessment of his topic selection criteria the OAG decided to undertake a performance audit of the redevelopment of Banksia Hill to house both sentenced and remand male and female detainees. This audit was conducted contemporaneously with this Inquiry. The OAG's report specifically focussed on the following key questions:

- Was the planning and management of the project consistent with prescribed state government and good practice procedures?
- Were risks associated with the development project identified and managed appropriately?
- Were significant goals and targets achieved?

1.46 For reasons of efficiency, there was a small amount of data and information sharing between OICS and OAG. It was also considered sensible to release the two reports together. Tabling of the reports at the same time seeks to provide Parliament with a greater context and a more rounded view of developments at the facility. The OAG findings have proved to be consistent in every respect with those of this Inquiry and in that sense, the reports provide valuable mutual validation. However, the two reviews were conducted fully independently. The OAG report is separately published and stands in its own right.

OICS Review of Female Detainees

1.47 Female detainees in Western Australia generally number between 10 and 20. They were previously housed at Rangeview and were transferred to Banksia Hill on amalgamation. They have remained at Banksia Hill since the riot. As the primary focus of this Inquiry is male detainees, and it is three years since OICS last examined the detention of females,[21] there was a discrete inspection of their circumstances during May 2013. The report of this inspection will be published in the last quarter of 2013.

Western Australia Police (WAPOL)

1.48 WAPOL were closely involved, both in the emergency response to the incident on the night and in conducting follow up forensic evidence gathering and investigations with a view to laying criminal charges. Their review has essentially been concerned with investigating the individual criminal responsibility of the detainees for criminal damage or other offences on 20 January 2013. A number of cases have been progressing through the courts. WAPOL have willingly provided information and advice to this Inquiry and this assistance is greatly appreciated.[22]

21 OICS, *Report of an Announced Inspection of Rangeview Remand Centre*, Report No. 69 (December 2010).
22 Information provided by WAPOL included draft findings from their review, camera footage of the incident and radio recordings.

Department of Corrective Services Operational Review

1.49 The Department's Assistant Commissioner Professional Standards is conducting an 'Operational Review' into four key areas: dynamic security and intelligence gathering; risk profiling of detainees and resultant management regimes; implementation of previous business improvement recommendations; and primary response team philosophy and function.[23] At the time of writing, the Department's Operational Review had not been finalised. However, there is nothing to indicate that it will differ in any essential respect from the findings of this report.

INSPECTOR'S GENERAL FUNCTIONS

1.50 Most of the Inspector's activities are statutorily mandated, not discretionary. In particular, full inspections of prisons and juvenile detention centres must be carried out at least once every three years. Reports of these inspections are publicly tabled in Parliament and form part of the evidence base for this review.[24] However, three years is too long to leave a closed environment without scrutiny. OICS therefore adopts a 'continuous inspection' model which includes regular 'liaison' visits, tracking incidents at custodial facilities, and regular contact with the Department, service providers, key interest groups and families of prisoners.

1.51 An integral part of the system is the Independent Visitor Scheme, administered by the Inspector, under which members of the community, appointed by the Minister, regularly visit prisons and juvenile detention centres. The work of the independent visitors has proved invaluable not only in understanding the context of the riot but also in monitoring the position at Hakea and Banksia Hill subsequently.

1.52 The aims of the continuous inspection model include the ongoing identification of risks that exceed what could reasonably be expected in such an environment, and monitoring issues of safety and security, staff welfare, and the decent and humane treatment of prisoners and detainees. In accordance with the letter and spirit of the Act, the Inspector and staff have regular contact with the Minister, the Commissioner for Corrective Services and all relevant departmental staff.

23 The full terms of reference are as follows: *Dynamic Security/Intelligence Gathering*: What processes, if any, are in place to support these functions and how the natural linkages between security/intelligence gathering and other management processes are maximised. How performance is directly impacted by failure in these areas. *Risk Profiling of Detainees and Resultant Management Regimes*: The manner in which intelligence is used to assist in the profiling of higher risk inmates and consideration of the management options (disciplinary matters) as set out in the *Young Offenders Act 1994* and how those options are exercised. *Implementation (Degree of) of Previous Business Improvement Recommendations*: Identify how well embedded the lessons learned from previous incidents (including past security audits and compliance/directed reviews) were at the time of the incident. *Primary Response Team Philosophy and Function*: What was the level of understanding of the Primary Response Team concept within Banksia Hill Detention Centre. Consideration of the initial and refresher training given to Youth Custodial staff.

24 *Inspector of Custodial Services Act 2003* ss 19–20; http://www.oics.wa.gov.au/go/inspections

1.53 The last formal inspection of Banksia Hill took place in June 2011. Legally, therefore, another inspection was not required until June 2014. However, as Banksia Hill was in transition in June 2011 and faced significant risks and challenges, the Inspector indicated that the next inspection would be held in March 2013. The decision to bring forward the inspection date was reinforced as Banksia Hill's problems became increasingly apparent through the rest of 2011 and 2012.[25]

1.54 The 20 January 2013 riot meant there was no point conducting the full inspection scheduled for March 2013. However, issues of service delivery will need to be closely examined when the centre becomes fully operational again. Subject to the outcomes of this review and other developments, a formal inspection will therefore be conducted during 2014.

1.55 By and large, the other work of OICS has continued as planned. However, there have been some adjustments to timing to accommodate the pressures generated for the Department and this Office by the 20 January incident and its aftermath.

METHODOLOGY

1.56 This review was underpinned by a comprehensive methodology, including the examination of a significant number of relevant documents, interviews, surveys, workshops and observations from site visits.

Review Teams

1.57 The terms of reference intersect. However, in order to provide a specialist focus and to build in processes of challenge and validation across the various terms of reference, the Inquiry was divided into four focus areas which broadly reflect the terms of reference. These were:

- Emergency Management;[26]
- Security and Physical Infrastructure;[27]
- Management, Staffing and Amalgamation;[28]
- Post-Incident Management.[29]

1.58 Four small teams, consisting of two or three people including independent experts, were allocated primary responsibility for examining each area. The skills of selected independent experts were used to supplement OICS staff and to provide an important further level of independence and validation to the review.[30] Other OICS staff played a key role in obtaining input from interested parties and providing research support.

25 See Chapter 2.

26 This team examined the following terms of reference: 'adequacy of crisis/emergency management planning and the crisis/emergency management response' and including the initial transfer of detainees to Hakea Prison.

27 This team examined the following terms of reference, tied back to issues of strategic direction, leadership and facility design and modifications: 'security and integrity of the cells; security systems and infrastructure; security practices and protocols for all staff'.

28 The written direction to the Inspector included the request 'to review staffing levels at the facility and report on the management of the incident and its impact on staff'.

29 This team addressed not only the term of reference 'temporary housing of juvenile detainees at Hakea Prison' but also the management of the male detainees remaining at Banksia Hill. Female detainees are the subject of a separate report: see [1.47].

30 Section 31 of the *Inspector of Custodial Services Act 2003* permits the appointment and authorisation of experts. The experts who contributed to this Inquiry are listed in Appendix A.

1.59 A stand-alone review paper was produced on each of the focus areas, with the Security and Physical Infrastructure area resulting in two papers. In addition, a review paper was developed on the Legal and Administrative context in existence prior to, during and after the riot.

Submissions, Surveys and Interviews

1.60 Processes included a call for submissions; meetings with parents and families; surveys of staff; surveys of detainees; briefings, interviews and workshops with staff, detainees and head office personnel; and engagement with key stakeholders and service providers. Public submissions to the Inquiry have not been separately published but are available on the OICS website.[31]

1.61 The information solicited through these processes provides a rich resource and the positive engagement of all these people is gratefully acknowledged.

Data and Documentation Analysis

1.62 A significant number of relevant documents were sought from the Department and examined. Documents were used to substantiate information received in submissions, surveys and interviews.

1.63 Literature reviews and analysis in Australia and overseas.

Observation and On-Site Presence

1.64 OICS staff had a heavy on-site presence in both Banksia Hill and Hakea for the first month after the riot. This involved several visits a week including on weekends. Following this, at least one site visit a week was undertaken through to mid-April. Observations on the conditions of the detainees were recorded and OICS staff engaged with staff and detainees to get a broad understanding of the issues faced as a result of the riot and use of Hakea as an alternative site to house detainees.

Electronic and Digital Information

1.65 Electronic and digital information of the incident was examined. This included CCTV footage, camera recording from the police helicopter, radio traffic and recorded phone conversations from within Banksia Hill.

Inter-state Site Visits and Discussions

1.66 Visits were made to juvenile justice centres in South Australia, Victoria, New South Wales, Queensland and the Australian Capital Territory. The security ratings of the centres visited are comparable with those of Banksia Hill and accommodate similar juvenile populations, both sentenced and remand. The physical infrastructure, quality and extent of case management, and programs being offered to detainees were all examined to provide a comparison for Banksia Hill.

Other Sources

1.67 One of the advantages of establishing an Office of the Inspector of Custodial Services is that it can build its own independent records and sources. This familiarity and knowledge is invaluable in conducting an Inquiry of this sort. In addition, there are a number of

31 http://www.custodialinspector.wa.gov.au/

other independent sources, including a handful of court cases and the work of other independent agencies. The sources used during this review include:

- Published OICS inspection reports of adult prisons from 2001 and of juvenile detention centres from 2003;[32]
- Other OICS reports including a 2012 *Report of an Audit of Custodial Roof Ascents*[33] and a 2009 Issues Paper: *Remodelling Corrections for Juveniles and Young Men*;[34]
- Detailed records of liaison visits by OICS staff;
- Detailed records of visits by independent prison and detention centre visitors;
- Relevant cases decided by the Children's Court;[35]
- The 2008 report by the Auditor General: *The Juvenile Justice System: Dealing with Young People under the Young Offenders Act 1994*;[36]
- The work of the Ombudsman Western Australia; and
- The work of the Commissioner for Children and Young People including the paper published during the course of this review.

1.68 The Department's cooperation with the Inquiry and its staff, in providing an extensive array of documents and information, as well as facilitating numerous timely meetings and interviews with senior executives and officers at all levels, is acknowledged and sincerely appreciated. In addition, the Inquiry acknowledges and is grateful for the engagement and input of all of the other stakeholders and individuals who contributed to the Inquiry.

REPORT AND REVIEW PAPERS

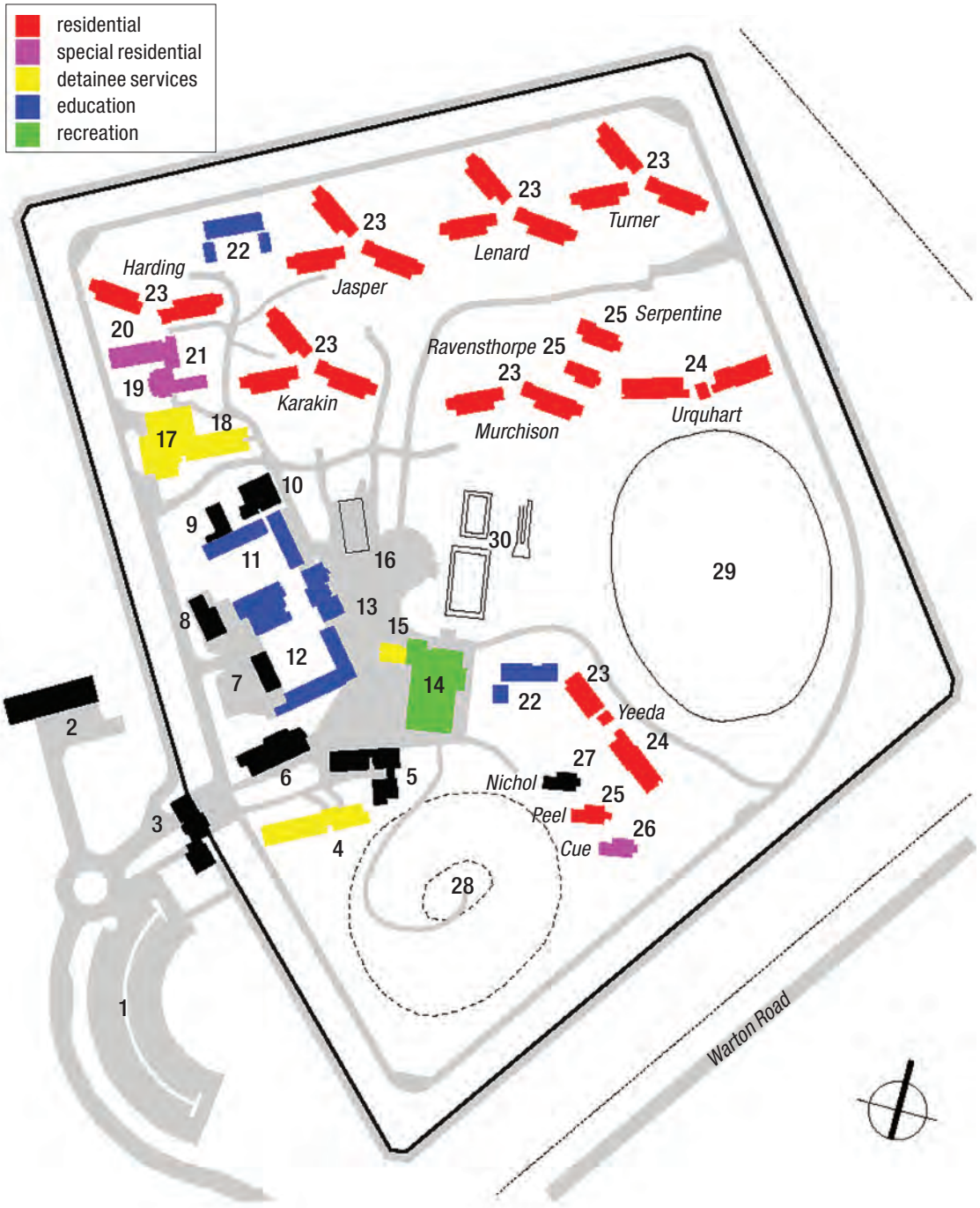
1.69 There were two main options in terms of reporting to Parliament. One was to produce a single very long report, in which all supporting evidence and details would be provided. The other was to produce a shorter main report supported by published review papers.

1.70 The second option was selected for three reasons. First, this report is not a summary of the review papers but contains a good deal of additional analysis. Secondly, while it is essential to provide the evidence base for reports, long reports tend to become unmanageable and gather dust on shelves. Thirdly, while it is not essential to know their detail in order to understand the report, the review papers serve as important stand-alone resources in their own right.

1.71 Copies of the draft report and review papers were provided to the Department for consideration and comment. The Department provided written responses and these have been taken into account in forming the views expressed in this report and supporting review papers.

32 All reports are available at www.oics.wa.gov.au/go/inspections. Juvenile detention centres did not originally come within the Inspector's jurisdiction but were added in 2003.
33 A summary is available at www.oics.wa.gov.au/go/reviews. The full version was not published because of some security concerns raised by the Department.
34 See, www.oics.wa.gov.au/go/publications-and-resources/issues-papers
35 These include *Department of Corrective Services v RP* [2012] WACC 5 and *State of Western Australia v JAB* [2013] WACC 3.
36 See, www.audit.wa.gov.au/reports/pdfreports/report2008_04.pdf

Figure 1: Aerial view of Banksia Hill Detention Centre.



1. Parking	9. Horticulture	17. Detainee reception	25. Self care
2. Stores	10. Staff	18. Health	26. Observation/isolation
3. Entry	11. Education	19. Observation	27. Staff
4. Case management	12. Vocational ed.	20. Arrestee wing	28. 'The Hill'
5. Visiting	13. Library	21. Management	29. Sports field
6. Administration	14. Gymnasium	22. Classrooms	30. Sports courts
7. Maintenance	15. Liaison office	23. Residential (single level)	
8. Workshop	16. 'The Mall'	24. Residential (two levels)	

Figure 2: Site Map.

Chapter 2

BANKSIA HILL 1997–2013

OVERVIEW

2.1 This chapter and Chapter 3 foreshadow the more detailed analysis in Chapters 4 to 6. This chapter reviews Banksia Hill's history and performance during the 16 years since it opened and discusses the risks that had been mounting from mid-2011. Chapter 3 provides an account of the 20 January incident before comparing it with previous prison riots in Western Australia. It concludes by asking whether a major security incident was predictable in late 2012 to early 2013.

2.2 The overall conclusions are clear and sobering.

- A major security incident was entirely foreseeable given the risk factors at Banksia Hill and the causes of previous riots.
- The Banksia Hill riot unfolded in ways that were not foreseeable but the starting point (a roof ascent which escalated) was all too common.
- In January 2013, Banksia Hill was at high risk and had been for well over 12 months. There were innumerable weaknesses in terms of direction, leadership, management and staffing. These were compounded, but not created, by the physical redevelopment of the site.
- The regime offered to the detainees was not sufficiently active or positive. This led to understandable restlessness and frustration.
- Serious incidents can never be completely prevented at custodial facilities but the risks must be actively assessed, intelligently analysed and mitigated. The Department had taken too little proactive action to mitigate the risks and to provide central support. Its failure to follow through on commitments had further exacerbated the risks.
- The fact that the incident was resolved without serious injury is a tribute to all those involved on the night but this should not obscure the fact that much more should have been done by way of prevention and preparedness.
- The Banksia Hill riot took a very different form from the riots at Fremantle Prison in 1988 ('the Fremantle riot') and Casuarina Prison in 1998 ('the Casuarina riot'). In particular, the detainees actively avoided violence towards people. Nonetheless, there are very striking parallels in terms of the causes of all three riots.

2.3 This is not a case of being wise after the event. The issues had been building over a long period and many people expressed that they were not surprised by the detainees' actions. Some staff said 'it was coming', 'it was the riot we had to have' or words to similar effect. The Inspector had raised concerns with the Department and successive Ministers throughout 2012 and the Department had given specific commitments to address certain matters which were not followed through. In August 2012, concerned at the haste with which the badly delayed amalgamation was being pushed, the Inspector advised that it be deferred and that immediate concerted action be taken over the next three months to improve Banksia Hill's readiness.[37] Of course there is no guarantee that this would have prevented the riot, but it would have reduced the risk.

37 See [2.30–2.33].

2.4 A new management team started at Banksia Hill in November 2012, right at the point of amalgamation. The team was so concerned at what it found that it developed a 240-point remedial plan.[38] By January 2013 the team had made some progress against its plan, but much remained to be done.

2.5 In terms of explaining what happened, the primary focus of the Department in public comment, including in its evidence to the Supreme Court, has been on opportunistic misbehaviour by detainees on the night, physical security deficiencies, and an assertion that detainees are now 'different' or 'worse' than they were.[39] However, the factors that caused and contributed to the riot run far deeper.

HISTORY AND DESIGN

2.6 Banksia Hill is only 16 years old. The *Physical Infrastructure Review Paper* (which accompanies this report) contains a detailed account of the site, along with diagrams and pictures which illustrate its development and its strengths and weaknesses. In line with the *Young Offenders Act 1994* and international conventions to which Australia is signatory, Banksia Hill was purpose-built as a juvenile custodial facility and therefore intended to provide something different from a standard adult prison.

Photo 1: Rear view of a residential unit.

38 DCS, *Juvenile Custodial Services Reforms – Tasks and Actions Report* (18 February 2013). The fact that the new team was able to identify as many as 240 points is telling in itself.

39 See [8.51–8.62].

2.7 As its name suggests, Banksia Hill is located on a raised site, and staff and detainees can see natural vegetation and landscape beyond the perimeter wall. It was designed to create a positive environment for detainees with a relatively open 'campus style' feel. The goals of the original design included clear management zones without oppressive fences, respecting the character of the landscape, utilising the natural benefits of the site, including an area of bush called 'the hill', and incorporating central open spaces into the centre's programs and activities. It was regarded as a national benchmark, won awards, and heavily influenced the design of juvenile detention centres in Queensland and the Australian Capital Territory.

Photo 2: View across the central mall.

2.8 When Banksia Hill opened in 1997 it had capacity for up to 120 young people but commonly housed in the region of 80 to 100. There were four general accommodation units, each with 24 beds, and each named after a white explorer (Jasper, Karikin, Lennard and Murchison) – a sad irony and unfortunate symbolism given that 70 per cent or more of Banksia's population is invariably Aboriginal. The general accommodation units have a central area where detainees and staff can mix and each cell has its own toilet and shower. The intent was to help detainees become more self-sufficient through tasks such as laundry and cleaning. There were also four self-care units and a unit (Harding) used for special purposes such as admissions, observation of at-risk detainees, and regression or punishment. Except for some 'buddy' cells,[40] there was certainly never any suggestion of double-bunking single cells – the very idea was anathema to the ethos and intent of the centre.

40 The aim of buddy cells is to allow prisoners and detainees to support each other whilst still having their own space. There are a number of different options, including larger-sized cells or adjacent cells with a door that can either be left open or locked closed.

Photo 3: Early interior furnishings of units.

2.9 In hindsight, some aspects of design and finishing could have been better considered. They include the need for more robust cells (in particular, fittings, windows, ceilings and observation and ventilation panels) and external protection to cell windows. It would also have been prudent for the designers to avoid low roofs adjacent to accessible walls and fences.[41]

2.10 Since 1997 there have been numerous additions to the site. In late 2009 the Turner Unit opened. Turner replicated the original general accommodation units and, despite the known problems of detainees climbing onto roofs, it had the same low roof. Two very differently designed double-storey units, Urquhart (males) and Yeeda (females), opened in 2012.[42] Contrary to the original intent and to accepted practice for juvenile detention in Australia, 38 single cells have now been retrofitted with double bunks to cope with detainee population pressures.

2.11 The *Physical Infrastructure Review Paper* shows that in many respects Banksia Hill's security challenges have been exacerbated by poor planning and incongruous ad hoc changes since 1997. Further changes have been made to the facility in the aftermath of the riot. Many of these again sit uneasily with the original design and may not entirely achieve their purpose.[43]

41 See the *Physical Infrastructure Review Paper.*
42 The Urquhart Unit opened in mid-December 2012, around nine weeks after the boys had moved. There had been extensive double-bunking of single cells prior to this date.
43 See Chapter 4.

1997 TO 2008

2.12 Like many custodial facilities, Banksia Hill has experienced peaks and troughs in performance and staff morale. The report of the first OICS inspection, conducted in 2005, was extremely positive. The previous Inspector said it was 'certainly one of the best-performing institutions within the remit of the Department of Corrective Services' and added: 'it is probably no coincidence that the Juvenile Justice Division … possessed a stable senior management team with a strong intellectual grasp of the objectives of detention and extensive corporate memory'.[44] Specific strengths in 2005 included detainees' perceptions of safety, an 'atmosphere of genuine positive regard' and a busy structured day. Areas identified for improvement included staff training and emergency management.

2.13 Banksia Hill's performance had markedly deteriorated by the time of the second OICS inspection in June 2008.[45] Progress against two-thirds of the 2005 recommendations had been less than acceptable, there had been a marked decline in staff morale, and increasing detainee numbers and inadequate staffing levels were leading to unscheduled lockdowns[46] and increased stress. The centre had also paid troublingly little attention to some marked security deficiencies. Although these were promptly fixed following OICS discussions with the then Minister, it demonstrated the lack of a proactive security culture. The inspection report called, amongst other things, for the recruitment of staff, an improved focus on Aboriginal detainees, the provision of improved throughcare to detainees and the development of incentives for good behaviour.

2009 TO 2010: PLANNING FOR A NEW ERA

2.14 Prior to the September 2008 state election the Liberal Party committed to establishing a young adult facility (YAF) if elected. Following the election, attention turned to the question of where the YAF might be located. In May 2009 it was formally announced that Rangeview would be converted to the YAF and that Banksia Hill would be expanded to become the state's sole juvenile custodial facility.

2.15 The remodelling of Banksia Hill was therefore not prompted by a business case about the facility's needs but by the desire to meet an election commitment. However, with a scheduled completion of late 2011, the Department had two and a half years in which to plan and deliver the project. Planning started well in 2009–2010 with consultative groups being established within the Department and positive engagement with interested parties. However, progress needed to be swifter and momentum was not maintained.[47]

44 OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 37 (September 2006) iv–v.

45 OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 58 (December 2008).

46 This report uses the terms 'lockdown' or 'lockdowns' to refer to situations where detainees are locked inside their cells. During non-lockdown times detainees will still be confined within their locked unit, unless allowed outside for recreation, education or otherwise.

47 See Chapter 4.

JUNE 2011 INSPECTION: SOME IMPROVEMENTS BUT STILL FRAGILE

2.16 The most recent inspection of Banksia Hill took place in June 2011, at which time amalgamation was still being slated for early 2012.[48] As the centre was in the midst of transition, OICS decided to conduct a targeted review of specific issues rather than a comprehensive review of all services. The intention was to undertake another full review in 2013 following amalgamation. The report found a noticeable improvement in the overall climate and atmosphere at the centre compared with 2008, one of the most significant improvements being that FTE staff numbers had increased. As a result, in June 2011 Banksia Hill appeared better placed overall than in 2008. However, the situation remained fragile.

2.17 The fragilities identified in 2011 bear very directly on this Inquiry:

- It was not clear that the amalgamated centre would have sufficient capacity for the detainee population.
- Despite the FTE numbers having improved, there were too many lockdowns of detainees, resulting mainly from staff shortages through issues such as accrued leave and workers compensation claims. These were causing disruption, frustration and risk. Unfortunately, as in 2008, the Department was not adequately recording lockdowns so it was difficult to establish the full extent of the lockdown practice.
- Responses to detainee misbehaviour were inconsistent, poorly documented and sometimes legally questionable.
- The quality of staff–detainee engagement was declining.
- There appeared to be a loss of momentum in respect of the change management processes.

2.18 Many of the Department's responses to key recommendations in the OICS report were dismissive or non-committal. One of the most important recommendations was that the Department 'reduce the number of scheduled and unscheduled lockdowns of detainees'. Its initial response was 'not supported'. This response was so contrary to the evidence that the Inspector invited the Department to reconsider. The Department did subsequently alter its response to 'supported in principle', but its support was heavily qualified and accompanied by the comment that lockdowns were already being kept to a minimum. This passive acceptance of the status quo was inconsistent with the objectives and principles of the *Young Offenders Act 1994* and out of line with good risk management.

2.19 Another recommendation was that the Department 'evaluate whether the responses to incidents at Banksia Hill and the consequences for such behaviour are sufficiently robust, with particular reference to incidents of violence'. This was 'not supported', the Department claiming that incidents were dealt with in a robust way 'on a case by case basis'. Recommendations regarding improvements to managing detainee misbehaviour, including the use of 'regression', generally received a lukewarm response at best.

48 OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 76 (March 2012).

JANUARY TO JUNE 2012: ESCALATING RISKS AND FAILING TO MEET COMMITMENTS

2.20 During the second half of 2011 and 2012, the Inspector became increasingly anxious about the risks at Banksia Hill for the following reasons:

- The responses to the inspection of 2011 appeared unrealistic and out of touch;
- Incidents were escalating in frequency and seriousness, including numerous roof ascents, some of which involved standoffs or serious assaults and one which resulted in a dangerous escape in August 2012 (see Appendix 3);
- Excessive 'lockdowns' due to staff shortages were having a negative impact on the regime for detainees;
- Divisions between staff and management were clear;
- There were frequent changes in management positions on site and in head office, with particular upheaval between December 2011 and April 2012;
- The building program was well behind schedule and unrealistic timeframes were being indicated for completion and testing; and
- Banksia Hill generally was not ready for amalgamation.

2.21 The decision of the President of the Children's Court in *Department of Corrective Services v RP*[49] on 22 March 2012 was another significant indicator of serious problems in youth custodial services. The Department had applied for an order under section 178 of the *Young Offenders Act 1994* that RP be transferred to an adult prison because of his behaviour at Banksia Hill, including two serious assaults on staff and a major roof ascent. His Honour Judge Reynolds declined to make the requested order. He fully acknowledged the seriousness of RP's behaviour but expressed major misgivings about the way he had been treated at Banksia Hill, including the various 'regression' and 'management' regimes to which he had been subject. Using unprecedentedly strong language, Judge Reynolds held that RP's treatment amounted to 'psychological subjugation' and was 'cruel and inhumane'.[50] His Honour also made particular note of the fact that RP had made real progress since being moved from Banksia Hill to Rangeview, and that the Department had not provided a clear plan for RP if he was transferred to an adult prison.

2.22 The case of RP should have heightened head office concerns about the management of detainees at Banksia Hill but, as with its responses to recommendations from the 2011 OICS inspection, there is no evidence of a reflective or proactive response. Despite the severe judicial criticism the Department did not institute its own internal investigation into the treatment of RP at Banksia Hill and downplayed the issues in its communications with staff.[51] In a custodial environment a lack of reflection, responsiveness and learning will elevate risk.

49 [2012] WACC 5.

50 *Department of Corrective Services v RP* [2012] WACC 5, [94].

51 On 24 April 2012 a 'broadcast' was sent to a wide cross-section of departmental staff. The broadcast identified RP by name, prima facie in breach of s 17 of the *Young Offenders Act 1994*. It acknowledged that it had no grounds for an appeal but quoted very selectively from the judgment. At no point did it explain the grounds of the decision so that staff and management might understand and reflect on it.

2.23 It is of grave concern that, at around the same time, the Department did not follow through on commitments that it had given to the then Minister. The challenges facing Banksia Hill featured prominently in meetings and briefings involving the Inspector, the two Ministers and the Commissioner throughout 2012. On 29 February 2012, the then Minister sought specific written advice from the Department as to the risk of further delays to the amalgamation and the strategies it would adopt to manage staff and union concerns. The Department provided the requested briefing two months later, on 26 April 2012. It advised that it had held a workshop in March and that the risk issues identified at this workshop included staff anxiety about change and concerns about safety, risks associated with the construction on site, the impact on staff and detainee morale of frequent lockdowns, gaps between staff and management expectations, and the difficulty of amalgamating two workforces. These risks were nothing new and should have been well-known but only three months earlier the Department had played them down.[52]

2.24 In its briefing to the former Minister, the Department committed to nine risk-mitigating strategies:

- Provide continuous information to staff about the progress of the building works by newsletters, emails and by senior management walking around the centres each day;
- Re-establish the staff consultative committees and working groups which were in existence in the early planning stages;
- Accelerate the planned staff interchange between the two centres, starting in the 'coming weeks';
- Work with staff to better understand and articulate their roles;
- Improve staff numbers by reducing the number of staff on workers compensation and sick leave;
- Set up a governance structure for the new position of Assistant Superintendent Compliance.
- Develop a new process for managing high-risk offenders;
- Be seen to be responding immediately to legitimate concerns about safety; and
- Update the risk register for the building program to include industrial issues.

2.25 Although the Department took some steps on some of these strategies, the actions and outcomes fell far short of what would reasonably have been expected by the Minister or, indeed, by Banksia Hill staff.[53] This placed the site and the Minister at further risk. The Inquiry also sighted other examples of poor follow through on Ministerial advice.

2.26 It is not the job of Ministers to run departments or to constantly follow up on assurances they have been given. The political accountability of Ministers is dependent on departments providing them with accurate, balanced advice, including the risks, and following through on commitments.

52 See [2.17–2.18].

53 For example, few staff exchanges happened; the creation of the new position of Assistant Superintendent Compliance was not actioned; the numbers of staff on workers compensation and sick leave increased further; the commitment to improved communication had no tangible effect and staff felt increasingly disempowered; and there was no evidence of improvement in the management of high-risk detainees.

JULY TO OCTOBER 2012: AMALGAMATION PROCEEDS

2.27 A new Minister (Hon Murray Cowper MLA) took on the corrective services portfolio on 21 March 2012. Again, the amalgamation featured as an area of high risk in discussions between the Inspector and the Minister, as well as between the Inspector and the Commissioner. As shown in Appendix 3, there were some very serious incidents during July and a dramatic high-risk escape in early August. The escape involved two detainees who left a supervised activity in the gymnasium and scaled a fence into the young women and girls' precinct, which was still under construction. They used a brick or rock to break into and steal a vehicle belonging to a building contractor, striking the contractor on the back of the head and ejecting him from the vehicle. They then used the vehicle to smash through two roller doors and the mesh gate in the front gate of the centre.

2.28 The August escape reflected not only extraordinarily high-risk behaviour, but also some serious security and safety issues. While the detainees could only escape because of weaknesses in the perimeter, this did not explain why they had not been better supervised and had been able to steal the vehicle. The Department's internal review of this escape identified basic procedural security failings as the main cause.[54]

2.29 Following the escape on 2 August 2012, prison officers from the Department's Emergency Support Group (ESG) officers were deployed to Banksia Hill. They guarded the damaged sally port and patrolled the perimeter of the construction site. Their presence continued for several weeks, until the completion of work to repair the sally port and install a new 3.6 metre high fence around the girl's unit. On 3 September 2012, the Department's monitoring officers commenced work at Banksia Hill. Their usual role is to monitor standards at privately operated prisons and this was the first time that they had been deployed to a public prison. They provided several reports per week to the Director State Security. The reports immediately raised serious concerns about the abilities of the Banksia Hill workforce.[55]

2.30 On 17 August 2012, the Inspector provided detailed written advice to the Minister regarding the risks at Banksia Hill. He advised that in his view the risks were such that amalgamation should be deferred by a minimum of one month from the scheduled time (early October 2012), preferably longer. This would have given closer to three months to amalgamation. Although this was still a relatively short time, it would have allowed more time for security testing, improved site and staff readiness, and the injection of immediate resources into issues relating to human resources and change management.

2.31 The 17 August advice included the following comments:

> If the only issue at Banksia was the buildings themselves, the timeframes to the units becoming operational would be extremely tight. By way of comparison, the rule of thumb in adult custodial has been that at least two months should be allowed between practical completion and occupancy. It is generally thought that this time is required for assessing and remedying faults and for thorough operational testing including scenarios, the development of local procedures and emergency plans, security testing by the ESG and staff training and preparation. Certainly, there has been a far longer

54 DCS, *Security Services Directorate Banksia Hill Juvenile Detention Centre Escape Review* (August 2012).
55 For further discussion on the work of the monitors see the *Security Review Paper*, Chapter 5.

lead in time at the adult prisons where new units have been added (Albany, Casuarina, Hakea and Karnet). It is also interesting to compare the new West Kimberley Regional Prison. That reached practical completion on 10 August but the prison will not be officially opened for two to three months.[56] Then, quite appropriately, it will be filled gradually, primarily with relatively compliant Kimberley Aboriginal men and woman. Even before the prison has opened, it has had a substantive superintendent and a number of other staff to support its development. Banksia faces more complex challenges, including the need to take larger numbers of less settled detainees and to amalgamate two staff groups with different cultures.[57]

2.32 The advice noted that deferring the handover of Wandoo would need to be negotiated because Serco had already made plans for staffing and physical redevelopment at the site, but that Serco had indicated its willingness to negotiate. The advice concluded:

> Without being alarmist, there are significant risks with the proposed transition dates. These factors include the physical and cultural readiness of Banksia for such a move, the associated risk of industrial action, and issues relating to the decent and humane treatment of detainees.
>
> Although nobody wants such an outcome, the accumulation of inter-related factors is such that, in my opinion, it is necessary for the Minister and the Department to consider whether the transition should be delayed by at least one month. Such a deferral will bring a potential financial penalty but it is a case of weighing a number of competing risks. Provided the time is used well, an extra month would allow some significant issues to be negotiated and progressed, time for Banksia to be better prepared, and time to mitigate the very real risk of industrial action.[58]

2.33 The Department was provided with a copy of this advice and asked for its views. Its advice to the Minister on 23 August 2012 acknowledged there were some issues with respect to staff and site readiness and said that these were being actively monitored. The former Commissioner noted that because of the risks there was likely to be a short delay in the transfers and that he was to be consulted before any transfers occurred. He also strongly emphasised the risk that 'Serco will be paid but not delivering the required service' if handover was deferred.

2.34 By this stage, the Department was obviously in a difficult situation in terms of balancing the various institutional and financial risks. However, it seems clear that the Wandoo contract timeframes were afforded too much weight compared with the Banksia Hill risks.

2.35 During the rest of August and September, a number of initiatives were taken to try to improve staff security awareness and practices. Overall, however, too little was done to address the issue of cultural fragility. Nor was there sufficient attention to basic practical necessities at the point of amalgamation, such as staff familiarity with the site, clarity about rosters, having basic necessities in the new Banksia Hill units, and tidying up at Rangeview.[59]

56 Given that West Kimberley Regional Prison is a new prison, the processes of testing are likely to take longer.
57 Inspector of Custodial Services, *Advice to the Minister for Corrective Services Regarding the Banksia Hill/Rangeview Amalgamation*, 17 August 2012.
58 Ibid.
59 See [6.69–6.72].

OCTOBER TO NOVEMBER 2012: DEPARTMENTAL U-TURN ON RISK

2.36 The Department's advice to the Minister on 23 August 2012 noted that the Commissioner was to be consulted before any transfers occurred so he was satisfied regarding the risks. It might have been expected that this would lead to a documented security assessment and formal sign-off prior to the move. The Department has not provided any such documentation.

2.37 The head office Security Directorate has commented that while some risks were present at the point of amalgamation, it was:

> '… pleased how Banksia had progressed in the lead up to the moves and did feel that they had 'turned a corner' i.e. movement control was improved, security training was well received and the formulation of the Security Committee and other initiatives was progressing well.'[60]

2.38 The female detainees were transferred from Rangeview to Banksia Hill on 29 September 2012 and the males between 28 September and 5 October 2012. The Deputy Commissioner Community and Youth Justice told the Inquiry that in early October he received verbal assurances from the Department's Security Directorate that the site was sufficiently stable. Apart from a roof ascent incident on 2 October 2012, the transition appears to have been relatively smooth.[61]

2.39 By 4.30 pm on Friday 26 October 2012, however, the Security Directorate had fundamentally altered its assessment. The Director emailed the Deputy Commissioner in chillingly prescient terms (emphasis added):

> The common themes relate to ongoing lockdowns due to perceived staff shortages, increased agitation amongst detainees and poor discipline and compliance to procedures amongst staff. *I'm of the view that this situation is at crisis point and the risk of a major incident is very real*. The decision making process regarding the allocation of staff and the justification for lockdowns seems to be geared towards the maintenance of the lockdowns…. There are also numerous documented cases where the monitors have observed staffing levels that would easily allow detainees to be unlocked.
>
> *From a risk perspective, every major prison disturbance in Australia in the last 60 years has been the result of a drop in the living conditions of inmates to a critical level. The warning signs* regarding a drop in hygiene, rolling lockdowns, lack of access to canteen, education and recreation, and poor staff discipline and morale *are all present at Banksia and all point towards the very real possibility of a major disturbance or industrial action in the near future*. Security Services have devoted a lot of time in delivering training and assisting with procedures, but I believe the issues at the centre are far wider (breakdown in discipline, communication/ relationships between managers and staff etc) and I would recommend that remedial action be taken ASAP.[62]

60 Email from Security Directorate to Inquiry (11 March 2013).
61 See Appendix 3.
62 Director Security Services, Department of Corrective Services, email (26 October 2012).

2.40 In November 2012, a departmental security assessment identified numerous matters requiring immediate remedial action and others requiring medium and longer term measures.[63] Some of these related to physical security but the issues ran far deeper and were often very basic. They included the movement control and supervision of detainees; staff/management communications; the lack of management visibility onsite; poor security management; staff shortages and lockdowns; and poor controls with respect to tools and other materials. The assessment found there was no security strategy, no searching strategy, no drug strategy and no strategy for the managing detainees over the hot summer months. It also found that the security function at Banksia Hill lacked 'any proactive capacity and its reactive response is limited and underwhelming.'

HOW COULD THIS HAPPEN AND WHERE DID IT LEAVE BANKSIA HILL?

2.41 Within just three weeks of the Department proceeding with amalgamation, its Security Directorate therefore believed Banksia Hill to be 'at crisis point' and considered that *'the warning signs … are all present … and all point towards the very real possibility of a major disturbance or industrial action in the near future.'*

2.42 The obvious question is how could amalgamation have been allowed to proceed only three weeks earlier? The Inquiry has not been given a satisfactory answer, nor can it find one. The Security Directorate told the Inquiry that its concerns reflected a deteriorating situation at Banksia Hill over the 'several weeks after the moves'. Similarly, in feedback on the draft report, the Department has said:

> It has to be appreciated that correctional facilities are dynamic environments and that the stability/temperature of a facility can change rapidly….In support of how things can change, one of the monitors commented that in their opinion 'the centre had taken a turn for the worse that week'.

2.43 The Inquiry fully understands that circumstances and risks can sometimes change rapidly. However, and all of the risk factors so eloquently articulated on 26 October 2012, were of depressingly long standing,[64] as were the issues identified by the November 2012 security assessment. The point is that these matters should have featured prominently throughout the redevelopment project, including in the thinking of the Commissioner's Executive Team (CET), in ministerial advice, and in decisions regarding the amalgamation date.

2.44 It is important to reflect on questions of knowledge and follow up at higher levels of the Department, not just on the Security Directorate. First, while some specifics may have changed, the fundamental underpinning problems had been evident for at least 12 months prior to amalgamation. Nobody in relevant senior executive positions should have been unaware and there was clearly a corporate, not just a security directorate responsibility.[65] Secondly, on a conservative count, there had been 36 key incidents from January 2010 to December 2011, including an escape, some serious assaults and numerous roof ascents.

63 DCS, *Security Assessment of Banksia Hill Detention Centre* (November 2012).
64 All of the examples of deterioration provided in the Department's response to the draft report reflected long-standing problems at the site. They were not recent aberrations.
65 See also [2.36] regarding the lack of formal documentation.

Internal reviews were undertaken into specific incidents but the situation called for a systemic analysis, commissioned by the executive, of what was going wrong at the centre.[66]

2.45 At the point of amalgamation in October 2012, Banksia Hill was therefore seriously exposed. The new management team, which had started in November 2012, had made some progress by the time of the January 2013 riot but they faced a colossal task. They could not reasonably have been expected to do more in this time.

66 See Appendix 1 and [4.63–4.76].

Chapter 3

WHAT HAPPENED ON 20 JANUARY AND WAS IT PREDICTABLE?

20 JANUARY 2013

3.1 On 20 January 2013 Banksia Hill was holding a total of 206 detainees. They ranged in age from 13 to 19 years and 185 were male and 21 were female.[67]

3.2 Such numbers meant the centre was crowded but at least it was operating with an almost full complement of staff for the day shift.[68] This followed considerable periods of staff shortages which had resulted in unscheduled lockdowns. It was hot (34 degrees) but in the words of one senior staff member, it had been a 'fantastic day'.

3.3 The normal lockdown time is 6.00 pm, but at 5.45 pm, staff around Lenard Unit noticed some unusual detainee interactions and signals. They contacted the shift manager who immediately advised staff in Lenard to commence the evening lockdown early. As soon as the process of lockdown had started three male detainees absconded from the unit.

3.4 The three detainees ran to the girls unit (Yeeda) where they scaled a management fence topped with barbed wire and climbed onto the roof. Emergency lockdown procedures were implemented whereby staff secured the remaining detainees in their cells. At the instruction of the shift manager, one staff member remained in each unit while other staff joined the recovery team to form a protective cordon around the girls unit. By this time, the detainees had 'armed' themselves with rocks – of which there was an abundant supply – and a metal aerial. In accordance with accepted practice, staff retreated to a safe distance and continued monitoring the actions of the detainees. The detainees remained on the roof for several minutes.

3.5 The three detainees then descended from the roof and ran past two officers who were making their way towards the cordon. They reassured the officers as they passed that they had no intention of hurting them. They then went towards the gatehouse where they encountered two youth custodial officers who were escorting visitors from the facility. As the detainees approached the gatehouse one of the officers verbally challenged the detainees, instructing them to get on the ground. This deterred the detainees who responded by changing direction and heading over to the administration area, where they climbed onto the roof of the education building. The visitors were escorted safely from the facility.

3.6 The detainees moved across the roof and one detainee threw a rock at a staff member with whom he had a previous altercation earlier that day. The rock missed the staff member.

3.7 The shift manager controlling the incident reminded staff to stay at a safe distance from the detainees. He instructed staff who had remained in the units to lock themselves in the unit offices. He also began notifying senior Department officers of the incident and requested assistance from the ESG.

67 The detainee profile is discussed at [3.22–3.23].
68 See [4.18–4.21].

3.8 While these events were occurring, the Primary Response Team (PRT), made up of Banksia Hill staff, was being assembled at Harding Unit. Within 15 minutes of the detainees absconding, the first team members had managed to congregate and were in the process of donning their protective gear. However, by this time the detainees had made their way across to Harding Unit where they proceeded to use loose pavers and debris to break a detainee out of his cell. The cell was breached in approximately 90 seconds, just moments before the PRT entered the cell.

Photo 4: Builder's rubble from around the site was easily accessed by the detainees during the riot.

Photo 5: Typical items available to detainees and used to cause damage to the buildings during the riot.

3.9 Two minutes later a fifth detainee was assisted to break out of his cell from a different unit. A sixth detainee was assisted to break out of another unit eight minutes after that. Some of the detainees headed towards the gatehouse where a rock was thrown against the gatehouse door. This raised concerns that detainees might attempt to escape. The shift manager therefore instructed the gatehouse to call the police to assist in securing the centre's perimeter.

3.10 In response to the detainees breaching their cells, the shift manager instructed staff to assemble at the staff amenities building for their safety and to ensure the security of keys that are carried by staff members. Where needed, the PRT assisted staff members to evacuate from the units. Once all staff members were accounted for the PRT formed a cordon around the staff amenities building.

3.11 The situation then escalated rapidly, with more and more detainees being assisted to break out of their cells. For the next hour and a half, detainees ran unimpeded around the centre causing considerable damage, especially to the living units. They formed and split groups fluidly, while assisting more and more detainees to get out of their cells.

A number of detainees broke out of their cells without assistance, sometimes making their way through A4-sized observation windows on the inside of the unit. Detainees did not attempt to injure staff or each other.

Photo 6: Example of cells breached via observation panels.

3.12 Approximately an hour after the first detainees had absconded, centre management and the ESG arrived at the centre. An incident control facility was activated above the gatehouse and assistance from the police helicopter was requested.

3.13 The ESG Superintendent took control of resolving the incident. He planned a response utilising all available resources, including the police and the canine unit. Extensive planning was undertaken on how to contain the detainees, prior to entering the facility.

3.14 Once entering the facility, ESG and the police executed a coordinated response that resulted in the reapprehension of the majority of detainees known to be out of their cells within 10 minutes. However while these detainees were being apprehended, other detainees continued to break out of their cells. It took a further four to five hours to secure all the detainees.

3.15 In total it was estimated that 61 detainees – one-third of the male detainee population – had broken out of their cells during the riot. In addition to the 61 detainees who had exited their cells, a significant number caused internal damage to their cells.

Photo 7: Cell damage.

3.16 Detainees apprehended outside of their cells were held on a basketball court. They were joined by detainees whose cells were no longer functional due to damage caused by themselves or others during the riot. In total, 73 detainees were held on the court until arrangements could be made to transfer them to Hakea. The transfers started just after 1.00 am.

3.17 While on the basketball court, medical staff provided attention to any detainees who had injured themselves during the riot. Many detainees had sustained minor cuts and grazes; however, one detainee sustained a deep cut to his leg which required hospital treatment. In addition, while awaiting transport to Hakea, there was an altercation between a detainee and an ESG officer that resulted in the officer being bitten.

3.18 Welfare checks of detainees still in their cells were first resumed in Harding Unit just after 10:00 pm, four hours after the incident began.

WHAT DID AND DIDN'T HAPPEN: 'RIOT', 'WAR ZONE', 'BOMB SITE'?

3.19 The 20 January incident involved mass disorder on a large scale and a loss of internal control for a period of between one and a half and two hours. It goes without saying that this is extremely serious. However, it is important to reflect rationally on what did *not* happen as well as what did happen. This is relevant to understanding the causes of the incident, why it took the course that it did, and to constructing appropriate responses.

3.20 The media, the Department and others have used the word 'riot' to describe the events of 20 January. Under Western Australian law, a 'riot' involves three or more people acting 'in so tumultuous a manner as to disturb the peace'.[69] This is a fair description of the seriousness of the incident and its affronting nature. However, the word 'riot' tends to conjure up images of arson, hostage taking, violence targeted at individuals, or escape attempts. Some of these ingredients were evident in the Fremantle Prison riot of 1988 and the Casuarina Prison riot of 1998 but none were present on 20 January:[70]

- The detainees' aim appeared to be property damage, especially in and to living units;
- There was no attempt to escape;[71]
- No fires were lit;
- Although staff were understandably traumatised by the riot, detainees did not target staff with violence;[72]
- There was no intent or attempt to take hostages;
- There is no evidence of gang related violence;
- There is no evidence of male detainees taking the opportunity to target other male detainees; and
- Although the female unit was badly damaged by the males who were running loose, and there have been some reports of verbal profanities by male to female detainees, there is no evidence of assaults or of specific threats to individual female detainees.

3.21 The physical damage caused at Banksia Hill – primarily damage to glass and windows – was unacceptable, affronting and costly. In addition, a large number of people were traumatised, including detainees as well as staff. Nothing in this report should be construed as condoning what happened or downplaying its seriousness and impact. However, terms such as 'war zone' and 'bomb site' are flamboyant and misleading.[73]

69 Section 62 of the *Criminal Code* (WA) states that a riot occurs when 'three or more persons, with intent to carry out some common purpose, assemble in such a manner, or, being assembled, conduct themselves in such a manner as to cause persons in the neighbourhood to fear, on reasonable grounds, that the persons so assembled will tumultuously disturb the peace, or will by such assembly needlessly and without any reasonable occasion provoke other persons tumultuously to disturb the peace'.

70 See [3.30–3.36] below.

71 One detainee threw a rock against the gatehouse door but this did not constitute an attempt to escape.

72 Only one assault charge has been laid. This arose when the detainee in question resisted being restrained by an officer. On other occasions, detainees avoided staff rather than directly confronting them. The lack of injuries is also a reflection on the strong focus on staff safety in the course of managing the incident: see Chapter 5 and the Emergency Management Review Paper.

73 These phrases were used by departmental representatives to describe the damage to the site when giving evidence to the Supreme Court and were widely used in subsequent media. Unfortunately this stoked public misconceptions.

DETAINEE PROFILE AND INVOLVEMENT

3.22 Appendix 4 provides important details of the detainees held at Banksia Hill on 20 January 2013 by age, legal status, gender and Aboriginality:

- There were 207 detainees, 186 male and 21 female.[74]
- 136 detainees were Aboriginal (66%) and 71 were non-Aboriginal.
- 106 were sentenced (51%), 99 were remanded in custody and two were arrestees.
- Aboriginal over-representation was most marked in the younger age groups:
  - The youngest detainees were 13 years of age. All were Aboriginal.
  - 65 detainees (31% of the total population) were 15 or younger. Fifty-two (80%) of this group were Aboriginal.
  - 24 detainees (11% of the total population) were already 18 years of age or more. Nine (37%) of this group were Aboriginal.
- The younger the detainee, the more likely they were to have come from outside the metropolitan area.

3.23 It has not been possible for this Inquiry to obtain accurate information about who was involved in the riot and the extent of their involvement because the Department has failed to maintain good records.[75] The tables in Appendix Four concern the 73 detainees who were transferred to Hakea Prison on the night. These figures are an under estimate of the numbers actually involved but they nevertheless provide a general guide.

- A higher proportion of non-Aboriginal detainees (38%) was involved than Aboriginal detainees (33%).
- The 17 year olds were by far the most active participants relative to their numbers. The 16 year olds were the next most active. The majority of 13 to 15 year olds and 18 to 19 year olds were not involved.
- Detainees from the metropolitan area were the most likely to be involved.
- Engagement in the riot spread across all living units, with Lenard Unit (the starting point) having the highest level.

CONTRIBUTING AND CAUSAL FACTORS: EXPLANATION AND DESCRIPTION

3.24 The terms of reference direct the Inspector to investigate 'causal/contributing factors' behind the incident. The term 'contributing factors' was deliberately chosen to reflect the fact that riots in closed institutions rarely involve a simple 'cause and effect' relationship. Instead, they reflect a complex interplay of factors. Invariably, this means that inquiries such as this must examine systemic longer-term issues, not just immediate site-based matters. The Smith Report into the Casuarina riot put the point as follows:

> The team has rejected the explanation that the causes of the riot can simply be traced to the events at Casuarina on Christmas Day. It is useful to think in terms of a continuum of explanation so that some causes are seen as proximal (specific) with

74 The figure of 206 has also been used as one male detainee was received into Banksia Hill on the night itself.
75 See [5.67–5.68].

> others being more distal… [T]he full picture has to be examined so that an understanding of how these factors interact can be appreciated.[76]

3.25 There was a strong element of opportunism in the way the riot unfolded on the night itself and it is important not to over-intellectualise what happened. However, it is also important not to confuse descriptions of what happened with explanations for those events. At best, descriptions explain *what* happened and *how* it happened, they do not explain *why*. As the Smith Report put it:

> In the analysis of the causes of any event, explanations can range from the general to the specific. There are dangers in explanations that focus too heavily at either end of that continuum. Explanations that focus only on those factors that are obviously involved (in this case the 'stolen drugs') offer not so much an explanation as a description of events.[77]

3.26 The McGivern Report into the Fremantle riot also made some pertinent observations. The Department had claimed that the riot was escape-related but McGivern found no evidence to support this. He noted that 'explanations' which are attractive to administering departments should be carefully scrutinised: 'The reasons why this explanation would be attractive to the Department are fairly obvious but are unacceptable'.[78]

3.27 Similar issues have arisen for this Inquiry. The Department initially used terms such as 'out of control parties' and 'mob mentality' and focused on the fact that detainees had been able to exit their cells. Such comments cannot *explain why*: (i) the riot occurred at Banksia Hill (and not in any other facility holding a potential 'mob'); (ii) it happened at this time in the institution's history; (iii) it took the particular form that it did (predominantly property damage); or (iv) why somewhere between one-half and two-thirds of the population chose to become involved in an incident that started with just three detainees climbing on the roof of a unit.

3.28 Another proposition which has been repeated as if it is proven fact is that detainees are now very 'different' from what they were and much harder to manage. This argument may be 'attractive to the Department' but, as discussed later, is highly problematic.[79] The Department has not been able to provide any evidence to support the proposition and the issue did not feature prominently in its planning for the redevelopment.

STAFF PERCEPTIONS OF CAUSES

3.29 Staff who responded to the survey conducted for this Inquiry overwhelmingly identified systemic factors as causing the riot. The top four factors were staff shortages, lockdowns, the amalgamation and poor leadership. Significantly, given much of the post-riot commentary, building weaknesses ranked much lower, 'detainee characteristics' was rarely mentioned, and few staff believed that a 'lack of defensive tools' was a factor.

76 Smith LE, *Report of the Inquiry into the Incident at Casuarina Prison on 25 December 1998* (1999) ('the Smith Report') [5.1.3]–[5.1.4].
77 Ibid, [5.1.1].
78 McGivern J, *Report of the Enquiry into the Causes of the Riot, Fire and Hostage Taking at Fremantle Prison on the 4th and 5th of January 1988* (1988) ('the McGivern Report') 21–22.
79 See Chapter 8.

Table 1: Staff Perceptions of the Causes of the Riot

Overall, why did you think the incident occurred?		
Theme	**Number of Responses**	**% of Responses**
Staff Shortages	46	47.9
Lockdowns	32	33.3
Amalgamation	25	26.0
Poor Leadership	21	21.9
Lack of Consequences	20	20.8
Cell/Centre Physical Security	19	19.8
Lack of Staff Consultation	18	18.8
Lack of Education/Programs/Recreation	16	16.7
Gender Mixing	14	14.6
Low Morale and/or Apathy	14	14.6
Overpopulation	14	14.6
Lack of Policies/Procedures	12	12.5
Remand/Sentenced Mixing	12	12.5
'Welfare' Mentality	11	11.5
Centre Design	10	10.4
Heat	10	10.4
Building and Construction	9	9.4
Inconsistent Detainee Management	8	8.3
Training	8	8.3
'Prison Guard' Mentality	7	7.3
Staff Culture	7	7.3
Staff Failings - Supervision and/or Interaction	7	7.3
Age of Detainees	6	6.3
Burnout	6	6.3
Detainee Attributes	6	6.3
Lack of Defensive Tools	5	5.2

LESSONS FROM OTHER WESTERN AUSTRALIAN RIOTS

Comparison of Key Findings

3.30 Fortunately prison riots are rare and there has been no previous incident of comparable magnitude in Western Australia's juvenile custodial facilities. Consequently, there are no previous equivalents of this report. However, it is valuable to compare the causes and dynamics of the Banksia Hill riot with the riots at Fremantle Prison in 1988 and Casuarina Prison in 1998.

3.31 The Smith Report provided a table comparing the factors involved in the Casuarina and Fremantle riots. The issues in black in the following table are taken from the Smith Report. The factors in blue have been added to better summarise the causes and dynamics at Banksia Hill.[80]

Table 2: Banksia Hill, Casuarina and Fremantle Riots Compared

Feature/Factor	Fremantle 1988	Casuarina 1988	Banksia Hill 2013
Crowding[81]	Yes	Yes	Yes
Strained infrastructure	Yes	Yes	Yes
Boredom – lack of occupation	Yes	Yes	Yes
Festive (summer) season	4–5 January	Christmas Day	20–21 January
Outside normal routine	Yes	Yes	Yes
Escalation in serious incidents over preceding period	Yes	Yes	Yes
Significant gain of inmate power before the riot	Yes	Yes	No overt 'power play' but numerous serious incidents which challenged authority and a lack of clear and consistent responses
Negotiation with officers before the riot	Yes	Yes	No
The sequence of events during the day in question added to existing discontent	Yes	Yes	No
Less than sufficient staff	Yes	Yes	Not on 20 January but this had been a significant problem over preceding months

80 For evidence and further discussion, see the accompanying review papers.
81 See [4.18] for discussion of 'crowding' and 'overcrowding'.

Feature/Factor	Fremantle 1988	Casuarina 1988	Banksia Hill 2013
Fires lit by prisoners	Yes	Attempted	No
Standoff between prisoners and staff prior to riot	Yes	Yes	No
'Ringleaders'	Yes	Yes	Started by a few key players but no apparent 'organised ringleaders'
Mob mentality	Yes	Yes	Yes
Fairly spontaneous exploitation of opportunity ('not planned apart from a degree of haphazard planning on the day')[82]	Yes	Yes	Yes
Focused grievance	Yes	No	Not focused on a specific 'grievance' but underpinned by a very strong sense of frustration (especially about the frequency of lockdowns)
Multiple sites of attack	No	Yes	Yes
Surprise element[83]	Yes	No	No (roof ascents were common)
Hostages taken	Yes	No	No (and no attempt)
Aboriginal dimension	No	Yes	Only in that they constitute 70% of the detainee population
Loss of internal control	Yes	Yes	Yes
Physical damage	Yes	Yes	Yes
Staff assaulted	Yes[84]	Yes[85]	No
Assaults on other prisoners/detainees[86]	-	-	No
Attempt to escape	No	No	No
Easy access to improvised tools and weapons	No	No	Yes

82 The Smith Report used this phrase of both Casuarina and Fremantle: Smith Report [4.4.2].
83 This appears to refer to the start of the incident.
84 Fifteen officers were injured including some who suffered serious burns: McGivern Report, 11.
85 Twenty-one staff and two prisoners needed hospital treatment: Smith Report [3.1.1].
86 The McGivern and Smith Reports do not say much on this issue.

Feature/Factor	Fremantle 1988	Casuarina 1988	Banksia Hill 2013
Access to drugs or attempts to access drugs	No	Yes	No
Problems in terms of head office direction, structure and morale	-	Yes	Yes
Poor communication, collaboration or continuity within the directorate and across the department	-	Yes	Yes
Instability in local management over preceding period	-	-	Yes
Facility in transition	Functions and roles evolving	Functions and roles evolving	In major transition
Inadequate central planning	Yes (new prison desperately needed)	Yes (prison crowded and being asked to fulfil too many roles)	Yes (key problems included poorly managed amalgamation and lack of clear philosophy and procedures)
Staff 'fragility' or uncertainty	-	Yes[87]	Yes
Poor security culture	-	-	Yes
Problems with responses to prior incidents (and limited options for managing misbehaviour)	Yes	Yes	Yes
Previous incidents had started in a similar way	No	No	Yes (frequent roof ascents)
Staff responded bravely and well in the immediate crisis	Yes	Yes	Yes
Limited emergency management planning or culture	Yes	Yes	Yes
Poor coordination between prisons and police	-	Yes	No
Mismatch between facility design, management philosophy and prisoner profile	Yes	Yes	Yes

87 The Smith Report characterised staff attitudes as 'resigned resentment'.

'Tinderbox' and 'Spark'

3.32 The matters set out in Table Two with respect to Banksia Hill are discussed more fully in the following chapters but some contrasts and similarities are immediately apparent.

3.33 The table shows that the dynamics of 20 January 2013 at Banksia Hill were very different from the Fremantle and Casuarina riots.[88] There were no assaults on staff, no assaults on other detainees, no serious injuries, no fires, and no hint of hostage taking. There was also good collaboration between police and the Department.

3.34 Turning to the question of cause, the Smith Report analysed the Casuarina riot in three stages: systemic neglect (stage one) led to a 'tinderbox' (stage two), which was ignited by a 'spark' on the day (stage three). It is useful to refer to this analogy in comparing the three riots.

3.35 Table Two shows that the 'sparks' were somewhat different for each riot. All three riots involved a 'fairly spontaneous exploitation of opportunity', but at Casuarina and Fremantle staff-prisoner tensions had been building for some time and immediately before the riots, there had been 'stand offs' and negotiations about prisoners' concerns. At Casuarina and Fremantle, the sequence of events on the day had specifically contributed to the tension and both riots had identifiable ringleaders. None of these features was present at Banksia Hill. In fact the preceding day had been positive, detainees generally avoided confronting staff and the starting point – three boys on a roof – had a depressing familiarity.

3.36 The dynamics and sparks therefore differed at Banksia Hill. However, Table Two shows that it was certainly a 'tinderbox'. There is a striking alignment between the stress factors in all three riots. These included staff shortages, crowded and strained infrastructure, lack of a normal busy routine due to the summer or holiday season, increasing numbers of serious incidents, staff fragility, a facility in transition, poor management and leadership, and poor communication, collaboration and continuity at head office level.

CONCLUSION: WAS A RIOT PREDICTABLE?

3.37 There was no obvious immediate 'spark' for the Banksia Hill riot on 20 January but it began as an all too common and totally predictable event: a roof ascent. It then escalated in ways that surprised staff but all the key stress factors were there. As shown in Chapter 2, the stress factors had also existed at Banksia Hill for some considerable time.

3.38 In summary, the risks had been building for at least 18 months prior to the riot. Combined with poor governance and inadequate follow-up, those risks were very high when the Department decided to proceed to amalgamation in October 2012. The problems were so entrenched that the new management team, which started in November 2012, could not have been expected to have resolved them by the time of the riot.

88 See also [3.20] above.

3.39 The Smith Report's summary of the systemic neglect which created the tinderbox at Casuarina 1998 is reproduced below with some changes to the names of department and divisions.[89] It directly mirrors the situation at Banksia Hill:

> The stage was set … [over the preceding five years] … and involved the gradual decline in the ability of the … [Department] to provide a structure, resources or direction for the good management of prisons…. [T]he complex [corporate] structure … distanced those in senior positions … from responsibility for the state of prisons.
>
> In this period, many of the conflicting divisions … were formed and a growing sense of mistrust and defensiveness grew. At the end of this period, a concern with economies led to a diminution of training … To exacerbate these problems, the ensuing period saw the changes in … senior management positions interspersed with long periods of acting arrangements. The [relevant division] lacked continuing clear direction which set the scene for the creation of the tinderbox.

89 Smith Report, [5.3.2].

Chapter 4

STABILITY, SECURITY AND A SENSE OF DIRECTION

OVERVIEW

4.1 In his landmark 1991 inquiry into prison riots in the United Kingdom, Lord Justice Woolf emphasised that stability in a custodial environment comes from striking the right balance between order, control and justice.[90] Stability also hinges on having a clear sense of direction. Banksia Hill has not struck the right balance and instability has been the inevitable consequence.

4.2 By contrast, Western Australia's best performing custodial facilities have struck the right balance. Albany Regional Prison exemplifies this. Strong leadership and good proactive management give the prison a clear sense of direction and purpose. Staff know what they are doing, why they are doing it and what the rules are. There is a strong focus on keeping prisoners occupied, and on positive staff–prisoner relationships, and staff play a central role in the case management of prisoners. Prisoners can earn incentives for good behaviour and poor behaviour attracts a firm, fair and consistent response.[91] Detention centres are not prisons but in terms of basic people management there are many lessons in this for Banksia Hill.

4.3 Casuarina Prison provides another pertinent example. Following the 1998 riot, management fences were erected around the accommodation units. These fences provide a degree of physical separation but nobody would seriously suggest that this is the reason there has not been another riot. That is down to the fact that the prison has worked hard to provide an active structured day for prisoners, in addition to intelligently managing a complex prisoner mix through a focus on dynamic security.[92]

4.4 Security in a custodial facility comprises three related elements:

- **Physical Security** – integrated physical structures and mechanical and electronic systems.
- **Procedural (or Process) Security** – effective systems and processes to ensure the coherent, consistent and coordinated application of measures such as controlling movements around the site, searching of people in custody and screening of visitors.
- **Dynamic (or Relational) Security** – a busy regime and a positive, professional engagement between staff and people in custody so that staff can understand the issues and garner good intelligence.

4.5 All three elements must be balanced and dynamic security is the essential linchpin. Austere physical 'target hardening' and confrontational procedural security cannot stand alone and such approaches generally exacerbate risk.

90 Woolf L J, *Prison Disturbances April 1990: Report of an Inquiry* Part II of Report with Tumin S London HMSO UK (1991) [1.149].

91 See for example; *OICS, Report of an Announced Inspection of Albany Regional Prison*, Report No. 78 (August 2012); OICS, *Report of an Announced Inspection of Boronia Pre-release Centre for Women*, Report No. 79 (September 2012); OICS, *Report of an Announced Inspection of Pardelup Prison Farm*, Report No 82 (January 2013); OICS, *Report of an Announced Inspection of Acacia Prison*, Report No. 71 (May 2011); OICS, *Report of an Announced Inspection of Wooroloo Prison*, Report No. 80 (October 2012); OICS, *Report of an Announced Inspection of Hakea Prison*, Report No. 81 (January 2013).

92 OICS, *Report of an Announced Inspection of Casuarina Prison*, Report No. 68 (November 2010); OICS, *Report of an Announced Inspection of Casuarina Prison*, Report No 49 (May 2008); OICS, *Report of an Announced Inspection of Casuarina Prison*, Report No. 28 (June 2005); OICS, *Report of an Announced Inspection of Casuarina Prison*, Report No. 11 (October 2002).

4.6 Some security considerations are so basic that they should apply at all sites. However, custodial facilities vary widely and the precise balance must reflect factors such as security ratings, gender and age. It follows that a facility such as Banksia Hill must be clear in its purpose and practices. The main findings of this report are as follows:

- There are some design and infrastructure issues. Amalgamation and onsite construction also posed obvious risks. However, it would be wrong to 'blame the buildings' as Banksia Hill's problems have straddled all three components of security.
- Banksia Hill did not have a clear operating philosophy.
- Key rules governing its operations were out of date or inaccessible.
- Dynamic (relational) security was poor.
- There was a complacent security culture, evidenced by some very basic physical and procedural security lapses.
- Too many issues were left unaddressed even after they had been identified.
- Banksia Hill lacked effective and consistent head office support.
- Early on, the vision and planning for amalgamation were intelligent and structured; however, the subsequent lack of coordinated, consistent direction and poor engagement with staff elevated the risks.

4.7 The findings of this chapter are generally consistent with the findings of previous reviews by the Department itself. They are also unlikely to be at odds with the findings of the Operational Review currently being conducted by the Professional Standards Division of the Department. Unfortunately, the evidence is that previous Departmental reviews have either been ignored or not properly followed up. That must not be allowed to happen again.

STABILITY AND DYNAMIC SECURITY: CONDITIONS, REGIMES AND INCENTIVES

Dynamic Security

4.8 Dynamic security has declined at Banksia Hill since its days of high performance in the mid-2000s. The report of the 2011 OICS inspection highlighted a decline in staff–detainee engagement and the Department's security assessments in late 2012 highlighted this.[93] It was also widely acknowledged in the run up to amalgamation that Rangeview had better dynamic security than Banksia Hill.

4.9 By the second half of 2011 and early 2012, Banksia Hill appeared to be in a vicious circle. Physical and procedural security failings were leading to serious incidents, some of which involved risk to staff. These failings were not properly addressed, thus enhancing staff concerns and reducing dynamic security interactions.

93 OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 76 (March 2012); DCS, *Security Assessment of Banksia Hill Detention Centre* (November 2012); Director Security Services, DCS, email (26 October 2012).

Conditions and Regimes

4.10 Stable custodial facilities provide decent conditions and keep people in custody busy with constructive activities. In addition, the *Young Offenders Act 1994* specifically requires the Department to provide a positive rehabilitative regime for juvenile detainees. This Inquiry, submissions to the Inquiry and previous inspection OICS inspection reports have identified numerous areas for improvement with respect to conditions and regimes. They include reducing the number of lockdowns; improving detainee access to education and programs; improving food quality; improving the quality of bedding; and ceasing the doubling up of single cells.

4.11 When asked in June 2013 about returning to detention at Banksia Hill, detainees being held at Hakea following the riot gave some sobering responses. They said they did not like being at Hakea and would ideally like to return to Banksia Hill. However, they said they would prefer to stay at Hakea if frequent lockdowns continued at Banksia Hill because the quality of the bedding and the cells at Hakea were better.

Incentives and Security Ratings

4.12 Stable and secure custodial facilities balance incentives for good behaviour with clear, consistent and confident responses to misbehaviour. Detainees should understand that behaviour has consequences, and that these can be positive not just negative. As already noted, Banksia Hill does not have a strong record in this regard and improvements need to be made.[94]

4.13 One of the stronger incentives in adult prisons is the ability to work toward a lower security rating, and therefore potentially to be placed at a minimum security prison. Security ratings also allow the management of individuals to be more fully informed and better targeted at-risk and need.

4.14 Adults spend much longer in custody on average than juveniles and the rapid turnover at juvenile facilities does make security classification more challenging. However, the differences between adult and juvenile facilities are striking and indefensible. At the time of writing, around eight per cent of adult prisoners were rated maximum security, 61 per cent were rated medium security and 31 per cent were rated minimum security.[95] By contrast, on 20 January 2013, 176 detainees at Banksia Hill (85%) were rated maximum security, 30 were rated medium security (14.5%) and one was rated minimum security.

4.15 The issue of security classifications in juvenile custodial is far from new. There have been a number of previous attempts to implement such systems but in marked contrast to the adult system, they have never been consistently applied. The *Making a Positive Difference* philosophy recognised the need for more nuanced security classifications but nothing had been put in place for amalgamation.

94 See [4.2] above.
95 OICS, *Report on the Flow of Prisoners to Minimum Security, Section 95 and Work Camps* (January 2013).

4.16 Significantly, since March 2013, the profile at Banksia Hill has changed markedly. In early June, five detainees (3%) were rated minimum, around one-third were rated medium and two-thirds were rated maximum. This is a welcome move in the right direction but work in this area needs to be further developed and sustained.

4.17 The acknowledgment that many detainees are not maximum security also has implications for the future because Banksia Hill is currently the only detention centre in the state. This is discussed again in Chapter 8.

CAPACITY AND CROWDING

4.18 The Smith Report into the Casuarina riot made an important observation about overcrowding:

> 'The term 'overcrowding' is actually an oxymoron, because the condition that spells mismanagement is 'crowding' – that is too many people in a facility or space. It accurately describes the condition that existed at Casuarina Prison on Christmas Day and in the days leading up to it – too many prisoners for the available facilities. With proper management and planning, staffing, services and facilities can be increased to cope with growing numbers so that while numbers grow access to services remain at adequate levels. Overcrowding is thus not really about gross numbers – it is about management and resource capacity.[96]

4.19 In terms of gross numbers, the Department puts Banksia Hill's capacity at 260 following the opening of the Urquhart and Yeeda Units in 2012 and the installation of bunk beds in 38 single cells across the site. However, the figure of 260 is misleading. It is wrong for juvenile detainees to be required to share cells which were intended for one person in order to manage numbers. They should only be sharing a cell if it was designed for this purpose and if there are reasons for them to be sharing. In addition to issues of bullying, privacy and cell size, air circulation has always been an issue at Banksia Hill even when the cells have been occupied by one person.[97]

4.20 Discounting the double bunks, the total capacity of Banksia Hill is 222 and 36 of these beds are for females. This leaves a male capacity of 186. However, even this figure is an overstatement as it includes the 36 beds in the Harding Unit which are intended for specific purposes not as general accommodation. On 20 January, with a population of 185 males, the male sections of Banksia Hill were certainly crowded.

4.21 In summary, Banksia Hill's capacity for male detainees does not adequately meet current demand, let alone future growth. The double-bunking of single cells should be an occasional emergency measure at most, not a routine practice.

96 Smith L E, *Report of the Inquiry into the Incident at Casuarina Prison on 25 December 1998* (1999) ('the Smith Report') [5.2.4.6].

97 OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 76 (March 2012).

ESCALATING SERIOUS INCIDENTS

4.22 It has already been noted that serious incidents at Banksia Hill had been escalating from 2010 onwards.[98] Examples include the following:

- An escape on 29 August 2010;
- Numerous roof ascents, several of which escalated to the point of items being thrown at staff and the Department's Emergency Support Group (ESG) being called to the site;
- A number of serious assaults on staff, especially in late 2011;
- A dangerous and high risk escape involving stealing a contractor's vehicle on 2 August 2012;
- A roof ascent and a two-hour standoff involving three youths armed with sporting equipment on 8 January 2013.

4.23 These incidents involved demonstrable failures in all three components of security. The 2010 and 2012 escapes were tied into the building redevelopment but, as identified in the Department's own reviews, they revealed flaws in procedural security, not just physical security issues. The roof ascents were made possible because of the design and construction at some parts of the site but they were triggered by detainee boredom and frustration and not just opportunism.[99]

PHILOSOPHY AND DIRECTION

Development

4.24 As noted earlier, the decision to amalgamate Banksia Hill and Rangeview (and to remodel Rangeview as a young adult facility) was not triggered by a departmental business case but by an election commitment. Once the decision to amalgamate the two centres had been made, there were obvious time pressures but there was also a real opportunity to plan for a better future. In 2009–2010, considerable energy and effort were devoted to planning and intentions were good. Significant stages included the following:

- **October 2009:** a Communication and Consultation Plan referred to the development of a new operating model designed to reflect the diversity of the Western Australian youth custodial population and to improve outcomes.
- **March 2010:** the Commissioner signed off on a Project Implementation Plan which had been 12 months in the making. This discussed 'the formation of working groups and a robust communication and consultation plan' for the research and design of a new operating model for youth custodial services with a strong focus on throughcare, intensive intervention programs and an active and constructive day. It noted that revised Youth Custodial Rules would be required.

98 See Appendix 3 for more detail on these incidents. The Inspector provided the sections of Appendix 3 relating to the period to 3 August 2012 to the Minister for Corrective Services on 17 August 2012 and the information was also provided to the Department: see [2.30] above.

99 OICS, *Audit of Custodial Roof Ascents* (December 2012).

- **November 2010:** the Commissioner's Executive Team (CET) endorsed a document dated September 2010 called *Making a Positive Difference to the Lives of Young People in Youth Custodial Services* (the *Making a Positive Difference* philosophy).
- **April 2011:** CET endorsed a revised version of the *Making a Positive Difference* philosophy dated December 2010. This was still not a fully polished document but it encompassed all key areas and contained some important ideas about detainee management.

Problems

4.25 It took two years from amalgamation being known to final CET endorsement of the *Making a Positive Difference* philosophy. This was too long and it meant that instead of the philosophy driving the planning, key decisions regarding physical redevelopment came 12 months before the philosophy was approved.[100]

4.26 By the time CET endorsed the *Making a Positive Difference* philosophy in April 2011, there were only six to nine months left to the projected amalgamation date. This should have reinvigorated immediate staff engagement. However, staff engagement drifted and they were never 'brought on side' with the philosophy.[101]

4.27 The philosophy of a custodial facility should drive staffing models as well as building decisions. The evidence does not show this to have been the case. In September 2010, in reaction to the August 2010 escape, Youth Custodial Services did develop a business case proposing that the staff–detainee ratio in Western Australia be brought more into line with other jurisdictions. However, the business case did not progress beyond CET.[102]

4.28 By mid-2012, despite having CET endorsement, the *Making a Positive Difference* philosophy seemed to be fading and other improvised philosophies and mantras were emerging.[103] For example, the staff orientation plan dated August 2012 referred to the philosophy of 'safety, purpose and respect' and an October 2012 departmental Newsletter stated:

> The philosophy of Safety, Purpose and Respect has been the focus of the redevelopment … with these values taken into consideration at every stage of the project… We are embedding the philosophy into the culture of the centre with new trainees being introduced to the concepts from the outset.[104]

100 For example, the design of the Urquhart Unit predated the development of an operational philosophy: for further information see this Inquiry's *Security Review Paper.*
101 See also Chapter 3 and OICS, *Report of an Announced Inspection of Banksia Hill Detention Centre*, Report No. 76 (March 2012).
102 The business case would have needed more development if it was to be successful: see [8.51] below.
103 For further information refer to Chapter 4 of this Inquiry's *Security Review Paper.*
104 DCS, *Youth Custodial Services Redevelopment Project News Update Issue 28* (October 2012).

Consequences

4.29 The consequences were confusion and a lack of clarity and consistency. Two examples from February to March 2013 are particularly telling. First, the Department's training academy was still teaching new recruits on the basis of a syllabus and material from 2008: material developed at a time when there were two distinct juvenile institutions and no hint of amalgamation. Secondly, the Deputy and Assistant Commissioners with responsibility for youth justice (who had started their new roles in March and November 2012 respectively) told the Inquiry that no operating philosophy was in evidence in November 2012. They subsequently explained that they were aware of the *Making a Positive Difference* philosophy but said it was not known to staff and was not being used. In other words, it had no practical relevance.

GOVERNING RULES

4.30 Stability and preparedness at a custodial facility require policies and procedures to be developed in line with the operational philosophy, and for these to be known and applied. The Juvenile Custodial Rules (JCRs), made pursuant to the *Young Offenders Act 1994*, had needed revision for some time and amalgamation made this essential, especially with females and remandees moving to Banksia Hill.

4.31 The task of revising JCRs should have been completed several months before amalgamation to ensure dissemination to staff and appropriate training. It would be reasonable to have expected the rules to be in final draft form, ready for discussion with staff, by January 2012 given that amalgamation was expected mid-year. However, new Youth Custodial Rules (YCRs), replacing the old JCRs were not approved by the then Minister until 27 August 2012, less than six weeks before amalgamation.[105] This gave too little time for the introduction and bedding down of the new rules.

4.32 The situation then went from bad to worse. Once approved on 27 August 2012, the YCRs should have been known to and applied by staff, including during the riot. However, although the Department told the Inquiry that some hard copies had been placed at Banksia Hill after Ministerial sign off, it did not inform staff of the new rules until a broadcast on 22 February 2013 and the rules were not placed on the Intranet (the resource generally used by staff to access rules and standing orders) until 5 March 2013. The Department told the review team it had taken this time (27 weeks) to format the YCRs following the Minister's sign off.

4.33 Legal vacuums create far higher risks than poor formatting. Some of the new YCRs contain changes that were pertinent to the management of the incident and its aftermath, including the use of restraints. Basic governance requires policies and procedures to be promulgated, understood and implemented. Staff and management are at operational and legal risk if they are either not known or not applied.

105 Some of the YCRs may be of doubtful legal validity. For further information refer to this Inquiry's *Legal and Administrative Context Review Paper.*

4.34 The YCRs are supported by Standing Orders, some of which relate specifically to the management of critical incidents. However, by and large, the Standing Orders have not been updated since 2009. They therefore refer to the old JCRs and are not aligned with the new YCRs.

PHYSICAL AND PROCEDURAL SECURITY

4.35 The *Physical Infrastructure Review Paper* and the *Security Review Paper* illustrate a litany of problems. Although some involve design or construction problems, more fundamentally they reflect a poor security culture, a lack of common sense and poor governance and follow-up. In essence, security was neither focused nor balanced.

Photo 8: Retrofitted security around unit office windows.

Staff Security Culture

4.36 Staff complained, amongst other things, that they had repeatedly expressed concern about the security of unit offices and nothing had been done. The offices have undergone significant target hardening following the riot.

4.37 However, questions must also be asked about staff adherence to basic security requirements. Despite some efforts by management, and some very critical findings by a departmental security assessment in November 2012, staff had continued to take items into operational areas that were not permitted. They included mobile phones and medications (the risks of which are obvious), car keys and tinned food (both of which could be used to make weapons or tools), bags and wallets. On the night of the riot, detainees rifled through staff possessions.

4.38 A 2009 management instruction clearly stated that items such as phones, wallets, lighters, keys and medications were not permitted within operational areas and were to be secured in the staff amenities area.[106] Staff who breached such instructions were potentially subject to disciplinary proceedings under the *Young Offenders Regulations 1995*.[107] However, despite this being a long-term problem no staff have been disciplined, at least since January 2012. The Department also advised the Inquiry that it had reimbursed at least one officer for the cost of personal items stolen during the riot. Staff who take personal items on site must change their behaviour and the Department must be less passive about taking disciplinary action for breaches of management instructions.

4.39 The Inquiry team found staff office stations to be in poor shape and cluttered. There appeared to be no secure storage and, as a result, items such as scissors were left unsecured. Medical kits were poorly maintained and despite reminders, staff were not always complying with requirements regarding uniforms and identification. Again, these are simple matters which must be addressed.

4.40 Staff complained to the Inquiry that there are gaps in CCTV coverage of the site. However, the Department was not able to provide the Inquiry with a CCTV coverage map so it is not possible to confirm this. Maps of CCTV coverage should be available for every custodial facility.

4.41 Inquiry team members experienced for themselves a telling example of the security culture. Having observed a flashing red light on the roof of a building, they approached a number of staff to ask what it meant. The majority of staff approached did not know that it indicated that a duress alarm had been activated in the vicinity. This showed a dangerously lax culture marked by a lack of observation, curiosity and initiative, and possibly a lack of training.

Rubble and Debris

4.42 As Appendix 3 shows, building rubble and debris have featured prominently in the 2010 and 2012 escapes and in the more sustained and violent roof ascents. Although it appears that some measures were taken to improve construction site cleanliness after each of these incidents, the final clean-up was not sufficiently thorough. Walking through the site after the riot, the review team observed numerous rocks, bricks and other discarded debris that were barely buried, half buried or in plain view.[108]

106 Juvenile Custodial Services Instruction 02/2009.
107 *Young Offenders Regulations 1995* (WA) Part 8 Division 3.
108 For further information refer to Chapter 5 of this Inquiry's *Physical Infrastructure Review Paper.*

4.43 However, it would be wrong to blame the new construction for the problem of readily accessible building materials. Loose-laid pavers had been in place for many years in high-risk parts of the site, including right next to the high-security Harding Unit. It was this old debris that was used to break the fourth detainee out of Harding and it was the surprise success of this enterprise which gave impetus to the whole incident.[109]

Photo 9: An example of building rubble found by the Inspector during a visit to Banksia Hill.

Photo 10: Unfixed pavers were easily accessed by detainees to use as tools.

4.44 Unassembled metal bed frames, left loose in the unoccupied self-care unit, were also accessed by detainees and were used to cause damage. They could alternatively have been used as ladders or weapons.[110]

4.45 Again, these failings are extremely basic. They confirm that the poor security culture was not caused by the redevelopment though it was undoubtedly compounded by the rush to amalgamation in the spring of 2012.

109 Ibid.
110 Ibid.

Cell Integrity, Unit Office Integrity and Recent 'Upgrades'

4.46 The terms of reference include consideration of cell security and integrity. The damage caused during the riot shows that the cell windows were less robust than staff or detainees had believed, and that they were especially vulnerable to external attack from unsecured, readily accessible rubble. As a result, a program of retrofitting grilles akin to those found in some maximum security adult prisons has been carried out.[111]

4.47 It was understandable that some measures would be taken to target harden cells and offices but it is vital to repeat the point that stability and security are about balance not buildings. A number of specific questions also arise with respect to the Department's prior testing and the nature of the 'upgrades'.

Photo 11: A Harding Unit window breached after external attack.

Photo 12: A Harding Unit window with retrofitted grille of the type used in adult facilities.

4.48 The Department's security assessment in November 2012 did not identify these weaknesses, concluding simply that: 'the accommodation units are adequate to house and contain detainees'.[112] However, this appears to be in direct contradiction to a report in June 2009 where the Emergency Support Group (ESG) recommended that:

> As a means of preventing repetitive window damage, 'crim mesh' be installed to cell windows that are susceptible to being broken from the outside by detainees. These will need to be identified on a priority/risk basis.[113]

4.49 If the ESG's 2009 recommendation had been implemented, at least in respect of high-risk cells such as those in the Harding Unit, it would have interrupted the momentum of the 20 January incident. The Department was unable to find any record of the 2009 report having been formally considered by management or of any follow-through in respect of the report's recommendations.

111 Ibid.
112 DCS, *Security Services Directorate, Security Assessment – Banksia Hill Juvenile Detention Centre – Final* (November 2012).
113 DCS, *Cell and Window Security Test Banksia Hill Detention Centre* (June 2009).

4.50 The Inquiry reviewed a number of physical infrastructure tests conducted by the ESG and concluded that there was no consistent methodology regarding test design, consultation, the testing of assumptions and follow-up.

4.51 The grilles that have been retrofitted to cell windows and unit offices in the aftermath of the riot are modelled on those used at maximum-security prisons. The *Infrastructure Review Paper* shows that they fit uneasily into the juvenile detention centre environment and affect general amenity and feel. They also encourage a separation of staff from detainees, embed a sense of constant risk, and send a powerful psychological message to staff and detainees.

4.52 Members of the Inquiry team visited juvenile detention centres in New South Wales, Victoria, Queensland, South Australia, and the Australian Capital Territory. None except Queensland used grilles over cell windows or staff bases. Some of them had experienced serious security challenges but had elected for a holistic response with priority on dynamic and procedural security.

Photo 13: Grilles retrofitted to Urquhart Unit cell windows.

4.53 There are also some specific issues with the design and fitting of the additional fortifications:

- The solution is over-constructed for what was needed.
- The solution does not prevent damage to the glass from graffiti or other vandalism. The Department may therefore face significant future repair costs. Other solutions such as crim-mesh would have better served the purpose.
- Very heavy steel framing has been fixed onto single-skin domestic scale brickwork.[114]
- Some of the retrofitting has undermined existing physical security.[115]
- Some of the retrofitting of bars around the unit offices has impacted dynamic security by reducing line of sight and staff–detainee interaction but has done little to enhance resistance to physical attack.[116]

114 It may have been preferable to attach the frames to the steel columns in the cavity onto which the windows are fixed.

115 For further information refer to this Inquiry's *Physical Infrastructure Review Paper* [5.105].

116 Ibid [6.106].

Climate Control and Fans

4.54 The cells and living areas do not have good climate control. This has been a longstanding issue at Banksia Hill. Because of poor airflow, detainees are issued with fans. During the riot, fan motors, wrapped in socks, proved to be a popular tool for damage and attempted break-outs. They could also have been used as weapons. In response to the draft report the Department said that it now intends to install air conditioning.[117]

Roof Ascents

4.55 The spark for the riot was an opportunistic roof ascent by three detainees – a problem which was all too common at Banksia Hill. A review in 2012 emphasised that whilst physical security deficiencies meant that roofs were vulnerable to access by detainees across much of the site, the main causes of roof ascents were boredom, unhappiness and conflict.[118]

4.56 The *Infrastructure Review Paper* shows that roof access had sometimes been made easier as a result of post-1997 modifications. And in 2009, despite the known issue of low rooflines in the existing accommodation blocks, the same design was used for the new Turner Unit.

Management Fences: Weaknesses and Risks

4.57 The *Physical Infrastructure Review Paper* shows numerous weaknesses with the internal management fences, including that fences abut walls in a way that made climbing far easier;[119] the design of gates in the fences provides obvious weak points;[120] and some of the fences are not on a concrete plinth and could be dug under and crawled through.[121]

Photo 14: Lack of height continuity in management fencing. Detainees were able to easily climb the wire fence and access the lower brick wall, bypassing the barbed wire.

Photo 15: Detainees were able to tunnel under the fence due to soft sand and the absence of a concrete plinth.

117 DCS response to draft report dated 17 July 2013. It provided no evidence that funding had been sought or approved.
118 OICS, *Audit of Custodial Roof Ascents* (December 2012) 3.
119 For further information refer to this Inquiry's *Physical Infrastructure Review Paper* [5.37].
120 Ibid, [5.38].
121 Ibid, [5.43], [5.84] and [5.104].

4.58 Given these weaknesses, the V-shaped barbed wire on top of the fences could be avoided by detainees intent on scaling the fence. However, CCTV footage of the riot showed detainees did not always even avoid the wire. It did not prevent access but did generate risks of injury.[122]

4.59 Simply put, some of the fences are easy to climb but designed in a way that can cause injury, either from a fall or from barbed wire entanglement.

Photo 16: CCTV footage showed the fences being scaled at speed.

Emergency Services Access

4.60 Fire is one of the highest risks in a custodial facility and any redevelopment at a site should take account of fire strategies and the need for access by emergency vehicles. The management fence installed following the August 2012 escape was designed without reference to the Department of Fire and Emergency Services (DFES) and this creates issues with respect to turning space for large vehicles.

4.61 At the request of the Inquiry, DFES carried out an inspection of the Banksia Hill site, including access for large fire appliances and fire hydrant coverage. DFES found that the 'ability for responding crews to undertake fire-fighting activities at the complex does not pose any operational concern.' However, it made a number of recommendations which include procedures, consultation regarding future development and infrastructure.[123]

122 Ibid, [5.48]–[5.50].

123 Department of Fire and Emergency Services, *Banksia Hill Detention Centre Inspection Findings and Recommendations* (8 April 2013). The Inspector has provided a copy of the report and recommendations to the Department.

Other Physical and Procedural Security Breaches

4.62 Other physical and procedural security failings were also evident in the months preceding the riot. Many of them were depressingly basic:[124]

- Custodial facilities must be able to account for people and yet, somehow, an incorrect detainee count continued for a period of three days in November 2012.
- Line of sight from unit offices, a key requirement at any site and part of the fundamental design intent at Banksia Hill, had been obscured by notices placed on office windows.[125]
- Perimeter checks are not properly logged and there is uncertainty about the frequency of such checks.
- Banksia Hill has not adopted sufficiently robust practices with respect to the screening of visitors.
- Low shrubbery makes searching for concealed items difficult.
- External clothes lines on the outside of units are solid enough to support a detainee's weight and to be used as a ladder.

Photo 17: Notices placed over unit office windows, reducing line of sight and hindering staff/detainee engagement.

124 For further information refer to Chapter 6 of this Inquiry's *Security Review Paper.*
125 Ibid [5.32]–[5.33].

INTELLIGENCE REPORTS AND ANALYSIS

Levels of Intelligence Reporting

4.63 Justice Intelligence Services (JIS) in head office is responsible for converting information received into intelligence, so this can be used to inform custodial facilities of risks. Youth Custodial Services makes little use of the intelligence systems and the Inquiry found that many staff were unaware of the process for reporting intelligence matters.

4.64 This report has shown that Banksia Hill was a facility at high risk in 2012. Over 1,400 incidents were recorded on the Total Offender Management System (TOMS) database but only 5 per cent were accompanied by intelligence reports. Rangeview had a somewhat higher JIS reporting rate (7.5%). The adult prisons have a JIS reporting rate, ranging between around 25 per cent at minimum-security prisons to 75 per cent at maximum-security prisons.[126]

4.65 Detention centres are not prisons and intelligence reporting may be less relevant in youth custodial. However, the levels of reporting appear too low. Following the August 2012 escape, the Security Directorate provided training to staff and the number of intelligence reports increased for two months afterwards. However, reports were always low in number and they fell back again thereafter.

Proactive and Systemic Analysis

4.66 It seems clear that there is room for the intelligence reporting from Banksia Hill to JIS to be improved. However, there are some important caveats. First, the value of such reports will depend on what is done with them and what is fed back to the site. This has been a matter of complaint at a number of adult prisons over recent years.

4.67 Secondly, the lack of intelligence reports is no excuse for the Department's apparent lack of risk awareness. Appendix 3 contains a conservative count of 53 key incidents from January 2010 to January 2013. This should have prompted a proactive high-level review of what was going wrong across the centre, and this should have examined and addressed the systemic issues. Instead, there were reactive ad hoc reviews of specific incidents and belated attempts to improve staff use of intelligence reports followed by a dramatic U-Turn on risk in October 2012.

4.68 The failings identified in this chapter raise some obvious further questions. First, what was Banksia Hill's security team resourcing? Secondly, what central support was given?

SECURITY TEAM RESOURCING

4.69 Despite the risks at Banksia Hill, it has been given very limited security resources. At the time of the riot, its security 'team' consisted of one person, the Security Manager. Prior to amalgamation, Rangeview had its own Security Manager and Banksia Hill had employed a Project Security Officer during the building process. On amalgamation, one person became responsible for the entire facility.

126 For further information refer to this Inquiry's *Emergency Management Review Paper.*

4.70 A security assessment by the Department in November 2012 noted: 'the security function at Banksia Hill lacks any proactive capacity and its reactive response is limited and underwhelming'. Questions need to be asked about how this situation could be revealed within weeks of amalgamation and why it was not averted or addressed earlier. This comes down, ultimately, to a lack of proactive central support.[127]

4.71 One would have expected the Security Manager to have been integral to responding to the 20 January riot. However, he was not on-call and was not formally notified. He did come in after he heard about the incident through other channels.

CENTRAL SECURITY SUPPORT AND COORDINATION

Promises

4.72 It is obviously important to have a coordinated approach to security at the detention centre. The risks were identified by OICS and the Department as far back as mid-2008:

> A recent change to the structure of the Department had seen the statewide security directorate take responsibility for security in the juvenile custodial estate. At the time of the inspection there were plans to implement a coordinating security manager position for the juvenile estate based in head office and permanent security officer positions to be implemented at each centre.[128]

4.73 The December 2010 *Making a Positive Difference* philosophy document emphasised that while YCS had responsibility for ensuring security at the new centre, the Security Services Directorate in head office also had a key role. The aim was to ensure that a statewide security framework would encompass all custodial functions of the Department, while ensuring Banksia Hill retained its identity as a detention centre not a prison. It said that the YCS executive was 'fully supportive' of this and that there would be 'significant developments over the coming year prior to the final amalgamation'.

Outcomes

4.74 Despite the commitment to support YCS security functions more coherently from head office, a departmental representative advised the Inquiry in March 2013 that:

> The Security Framework has never been implemented at Banksia Hill; in fact it's only just at the pilot stage, occurring at Bandyup. The plan has always been to roll out the Framework (once endorsed) to Adult Custodial first and then to Community and Youth Justice. I believe the reference within the *Making a Positive Difference* report is an extract from the Security Framework CET submission.

4.75 Central security support was obviously important to Banksia Hill's stability and the Director Security Services was a member of the Project Control Group (PCG) for the Youth Custodial Transition Project. The Director Security Services position is located in the Adult Custodial division not in Youth Custodial. Meetings were generally held in head office for convenience but the Director had been directed at some point by his

127 See [4.74]–[4.76] below.
128 OICS, *Report of Announced Inspection of Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 58 (December 2008) 12.

superior, the Deputy Commissioner Adult Custodial, to attend PCG meetings only when required. He rarely did so even though the risks at Banksia Hill were high and the PCG frequently considered security matters.[129]

4.76 Outcomes are, of course, far more important than meetings. Unfortunately, the outcomes speak for themselves. A departmental security assessment dated November 2012, some weeks after amalgamation, found Banksia Hill still had no security strategy, no drugs strategy, no searching strategy and no strategy to manage the facility over the coming hot summer months. Such obvious failings should not have been allowed to occur and, if they did, they should have been identified and rectified much earlier.

CONCLUSION

4.77 Stability in a custodial facility requires the right balance between physical, procedural and dynamic security. Banksia Hill had not achieved that balance. It was an unstable facility exhibiting high and obvious risks.

4.78 In the aftermath of the riot, the Department has devoted a good deal of money and time to physical target hardening but this is not a balanced solution. Unless there are fundamental improvements to dynamic security and adherence to basic procedures, the risks will remain. Indeed, they are likely escalate.

4.79 As discussed in Chapter 2, the Department failed to give balanced advice about risk to successive ministers in 2012. It also failed to follow through on commitments it had made.

RECOMMENDATIONS

Recommendation 1

The regime at Banksia Hill should be re-engineered so as to reflect a clear and consistent philosophy that accords with legislative requirements relating to juvenile detention. This philosophy should emphasise that the ultimate purpose is, as far as possible, to rehabilitate the young people and prepare them for release back into the community.

To that end, and in order to improve safety and security, there must be a stronger emphasis on the provision of a full and active regime and positive rehabilitative programs, including:

- education;
- skills training;
- recreation and sport; and
- counselling and offender programs.

129 Between May 2012 and July 2012 the Director Security Services attended six out of fifteen meetings. Between the August 2012 escape and the October amalgamation he attended none of the ten meetings. The situation is confusing. It appears that agendas were not prepared in advance of PCG meetings and meeting minutes do not record when attendance was required. However, they do show that security matters were frequently discussed.

Recommendation 2

The conditions of detention at Banksia Hill should be enhanced so as to meet improved standards of decency and dignity, including:

- minimisation of lockdown arrangements;
- cessation as far as possible of double-bunking (other than necessary buddy-cell arrangements);
- effective climate control measures, particularly in summer;
- improved dietary standards; and
- attention to standards of bedding and clothing.

Recommendation 3

The balance between physical, procedural and dynamic security should be re-calibrated in ways that are consistent with the above objectives and the Department should develop and promulgate a statement as to how these matters should be balanced.

Recommendation 4

The Department should review its criteria and processes for making security ratings, ensure that these processes are consistently applied, and spell out in Youth Custodial Rules or elsewhere the operational and regime implications for each level of security.

Recommendation 5

The Department must ensure that the Youth Custodial Rules and Standing Orders relating to Banksia Hill are brought fully up to date. It should also institute processes for ensuring that they are regularly reviewed, remain relevant to changing circumstances and effectively communicated with staff with the provision of appropriate training.

Recommendation 6

The staff culture in relation to dynamic and procedural security should be addressed as a matter of urgency, with a particular emphasis on training needs and ongoing reinforcement. Where appropriate, the Department should be prepared to invoke disciplinary provisions if individual staff members fail to comply with requirements.

Recommendation 7

Physical security assessments should be regularly undertaken at Banksia Hill by the Department's Emergency Support Group or other independent experts. The testing should reflect practical risk not just the physical strength of a structure. Where weaknesses are identified, appropriate remedial measures should be taken in a timely way and in a manner consistent with detention centre philosophies. All decisions and actions should be clearly recorded.

Recommendation 8

It is recommended that the Department undertakes a comprehensive assessment of how dynamic, procedural and physical security weaknesses are contributing to the high number of roof ascents by detainees and implements appropriate remedial measures.

Recommendation 9

The Department should ensure that it engages proactively with the Department of Fire and Emergency Services with respect to fire fighting capability at every site where new units or fences have been built or where other major construction activity has occurred.

Recommendation 10

The Department should examine ways to enhance its intelligence capacity through improvements to proactive as well as reactive information gathering/analysis.

Recommendation 11

The Department should resource and develop the on-site Security Team at Banksia Hill. Subject to ensuring that juvenile detention facilities are not equated with adult prisons, enhanced central security expertise should also be provided.

Chapter 5

EMERGENCY MANAGEMENT: PREVENTION, PREPAREDNESS, RESPONSE AND RECOVERY

OVERVIEW

5.1 The 20 January 2013 riot was not the type of incident to trigger the state's *Emergency Management Act 2005* but it did constitute an 'emergency':

> An event … which endangers or threatens to endanger life, property or the environment, and which requires a significant and coordinated response.[130]

5.2 Good emergency management requires a holistic approach, not merely a 'good effort' at the point the emergency unfolds. In recognition of this, nationally and locally accepted frameworks for emergency management comprise four elements: prevention, preparedness, response and recovery (PPRR). This chapter and the accompanying review paper adopt the PPRR framework.

5.3 The response to the unfolding emergency on the night of 20 January was generally good and in some respects it was exemplary. Many individuals demonstrated courage, strength of character and good judgement. They all deserve the community's respect, admiration and gratitude. Incident management on the night was marked by intelligent and pragmatic decision making, with a strong focus on staff safety. It is a credit to all that nobody was seriously injured in such a volatile situation. It must also be emphasised again that an important element of this outcome was that the detainees were intent only on property damage. Finally, coordination and cooperation between the Department and the Western Australia Police (WAPOL) was good. However, there were some gaps in the response and, as always, there is room to learn from experience.

5.4 In incidents of this sort, luck usually plays some role with respect to both incident management and outcomes, and that was certainly true on this occasion. However, the point of the PPRR model is to minimise the role of luck. And on the night, although the response was good, Banksia Hill was poorly placed in terms of prevention and preparedness.

PREVENTION/MITIGATION

5.5 Prevention refers to stopping or reducing the risk of an emergency occurring. The majority of this report comes back, at its core, to questions of prevention. Chapters 2 and 3 showed that Banksia Hill was objectively at significant risk of a serious incident occurring and Chapter 4 illustrated numerous basic procedural and dynamic security problems.

5.6 In the four months since the riot, there has been discernible target hardening through the installation of grilles but the focus needs to be far broader. Without improved regimes and better dynamic security Banksia Hill will remain at fundamentally high risk of further serious incidents. And there is a risk that future incidents will involve injury to staff or detainees.

130 Emergency Management Australia, *Emergency Management: Concepts and Principles* (www.em.gov.au). See also State Emergency Management Committee Western Australia, *Emergency Preparedness Report 2012* (www.dpc.wa.gov.au). The riot also resulted in the Commissioner formally declaring an 'emergency'. This did not have any effect in terms of the legal principles under which the centre was to operate but allowed the payment of additional allowances to staff involved in some of the immediate recovery work.

PREPAREDNESS

5.7 Preparedness refers to activities undertaken by an agency so it is ready to respond to an emergency. The preparedness principle is clearly stated in relevant departmental documents and in training programs.[131] It is obviously not possible to plan in advance for all contingencies and, as stated earlier, this riot took a very particular course. However, questions must be asked about Banksia Hill's general preparedness to respond to roof ascents, riots and their consequences.

5.8 The following section examines preparedness in terms of emergency management planning, evacuation plans, operational procedures, training and staff familiarity/ confidence. On every count, the Department has failed to meet reasonable expectations. This added to legal and operational risk.

Banksia Hill Emergency Management Plan

5.9 Banksia Hill, like other custodial facilities, has an Emergency Management Plan (EMP). It is based on the Australasian Inter-Service Incident Management System and sits within the Department's Emergency Management Framework. Although the site has been in transition since 2009 and underwent major change in 2012, the EMP is dated May 2011. It should have been updated to take account of amalgamation and on the night of 20 January, some of the deficiencies became clear. The most obvious of these was that the EMP still had detainees moving to Rangeview in the event of evacuation (see below).

5.10 EMPs at custodial facilities in Western Australia are supposed to be live documents under constant review by the Security Manager, subject to an annual review (at a minimum) and amended as necessary. The fact this did not happen represents a failure not only on the part of the local management and security team but also on the part of those responsible for preparing the centre for amalgamation. Intriguingly, the minutes of the Project Control Group meeting in May 2012 stated that emergency contingency management rules had been 'updated'.[132] Given the EMP remains out-of-date this is a clear oversight by the Project Control Group.

5.11 In November 2012, a security review by the head office Security Directorate stated that the adequacy of Banksia Hill's emergency management procedures would be examined. No such examination had occurred by 20 January 2013.

5.12 There does not appear to be a consistent system for head office tracking or oversight of EMPs. This needs to be re-examined. Local knowledge and responsibility are essential to developing usable plans, but some degree of central oversight is necessary in three areas: quality assurance, timely updates, and ensuring coordination in the event of simultaneous emergencies at more than one site.

131 For further information see Chapter 6 of this Inquiry's *Emergency Management Review Paper.*
132 DCS, *Project Control Group CET84 - Youth Custodial Transition Project Minutes* (14 May 2012) 3.

Knowledge of Emergency Management Plan

5.13 EMPs are only useful if the right people are aware of their contents. This must include, at a bare minimum, anyone who is likely to be in the position of being the officer in charge of the site. The Shift Manager at Banksia Hill on the night of 20 January, who had initial responsibility for the riot, was not aware of the plan. Despite this he did an excellent job, but that is hardly the point. More generally, staff training and awareness was a serious deficit.

Evacuation

5.14 The EMP stated that, in the event of evacuation, detainees would be taken to Rangeview and set out in some detail which route would be taken and how security and safety would be preserved. This plan was totally unviable. At the time of the riot, Rangeview had become Wandoo: a minimum security young adult male prison with a limited capacity of only 80. To complicate matters further, Wandoo is privately operated.

5.15 Banksia Hill is now a mixed gender facility. After the riot, the male detainees were taken to Hakea Prison. Banksia Hill's EMP still contains no plans for the evacuation of female detainees and it is far from clear where they could be readily accommodated.

5.16 Banksia Hill is not alone in having an out of date and unworkable evacuation plan. Bandyup Women's Prison, a maximum security facility, houses upwards of 270 prisoners. The only other dedicated women's prison is Boronia Pre-release Centre, a small low security facility. Bandyup's current evacuation plan is to take the women to the Corrective Services Academy, the former Nyandi minimum security women's prison. At most the Academy might provide a temporary holding place, but even this is doubtful.

5.17 Evacuation plans for male prisons are better developed, and the fact that there are several male prisons makes this easier. However, it is pointless at best and foolhardy at worst to have unworkable evacuation plans in EMPs. As shown by the events of 20 January, on the spot decisions needed to be made about where to house detainees (particularly female detainees) in the aftermath of the riot. Such decisions are of concern to the government and the public and should be the subject of well thought-out plans that are readily operationalised in the event of an emergency.

5.18 In evidence to the Supreme Court, the then Commissioner said that the new units at Hakea and Casuarina Prisons were always part of a 'specific contingency plan':[133]

> **Was that by accident or is there some form of plan in - - -?**
> Look, it's not by accident in the sense that the units 11 and 12, and we'll probably come to that very shortly, when they were constructed and when they were placed within Hakea, as the same applied to Casuarina, it was specifically for two purposes, one to deal with the prisoner population but secondly as a contingency plan should anything ever happen of this type, nature. So the fact that what was fortunate is that the unit 5 prisoners had been moved to the new unit I think only a matter of days before this incident took place.

133 *Wilson v Joseph Michael Francis, Minister for Corrective Services for the State of Western Australia* [2013] WASC 157 [115–116]. The same position was stated in a Departmental newsletter (Department of Corrective Services, *Inside Out* (February/March 2013) Volume 15, Issue 1, 2).

Can you describe to us the decision-making process that led to the use of Hakea units 11 and 12?

Sure. Coming back, first of all, to the original concept of units 11 and 12 and for similar units at Casuarina Prison, they were designed, specifically designed and placed so they could become a contingency plan should we lose a unit or a site, whether that be a female site or a young offenders' site, whatever, so that was a specific contingency plan so, first of all, it lends itself to be that type of facility in the first instance. We then looked – and there has been some evidence given about various meetings. There were numerous meetings with numerous people, high-level meetings, staff meetings, considering every possibility that we could look at to see what was the best option for us.

5.19 However, it cannot reasonably be said that there was a 'specific contingency plan':

- No such role for the units at Hakea was articulated until well after the incident. It emerged in response to suggestions that the Department had been 'lucky' that there had been units available at Hakea and that there had been a lack of planning.[134]
- The Department was unable to provide to the Inquiry any evidence of planning for the new units to undertake a contingency role for women or children.
- The management teams at Banksia Hill, Hakea and Bandyup do not appear to have turned their minds to how Hakea might hold women or children and it is, in the Inspector's opinion, ill-equipped to do so.
- Although the Hakea site lent itself well to the construction of new units,[135] the Department has consistently rejected the view that the units should have been planned to meet specific needs or roles. It has stated that the new units were simply to provide more beds.[136]
- Decisions taken with respect to perimeter security at Hakea militate against the use of the new units as a contingency for women and children, who need to be separated from male prisoners. The new units were constructed outside the old perimeter wall. This offered the Department an opportunity to make them semi-autonomous, and to inject flexibility, by retaining the old wall and constructing adequate access points between the old and new areas. Instead, it was decided to remove the old wall and to replace it with a chain link management fence, with access through a gate. This makes adequate separation of children and women extremely problematic.[137]

134 Coordinator, Custodial Inspections, DCS, email (14 May 2013).
135 Indeed, in 2009 the Inspector advocated this at a time when this option was not on the drawing board.
136 OICS, *Report of an Announced Inspection of Hakea Prison*, Report No. 81 (November 2012).
137 The review team is not aware of how far the option of semi-autonomous units was taken in the Department at the time the units were developed. There would have been some drawbacks with maintaining the old perimeter wall, including physical divisions at an already divided site and reduced sight lines. The cost of building a separate gatehouse into the new area (an optional extra) would also have been significant. However, the long term benefits for the system as a whole in respect of the ability to safely accommodate women and children in circumstances of evacuation at other facilities or to target the needs of specific groups such as young adults or those with mental health problems, might well have outweighed the costs.

Policies and Procedures

5.20 As discussed earlier,[138] Banksia Hill was operating in something of a legal no man's land with respect to the Youth Custodial Rules (YCRs). Rules approved by the Minister in August 2012, which should have been operational immediately, were not published to staff for around seven months. At the time of the riot, staff were therefore operating on the assumption that the obsolete Juvenile Custodial Rules (JCRs) applied. Given that the changes affected 'live' issues such as the use of restraints, this was obviously unacceptable and posed significant legal and operational risks.

Training

5.21 It would be patently unreasonable to expect scenario training to have been conducted which precisely mimicked the scenario that unfolded on the night: the specifics were not predictable. It is also important to recognise that no amount of training can displace the need for intelligent spur of the moment decision making at the time. However, it is reasonable to expect staff to be adequately prepared for riotous behaviour in general and for other serious incidents involving a challenge to authority – hardly isolated phenomena at Banksia Hill. The spread of the incident was also not dissimilar to a situation which might foreseeably arise if keys were lost or stolen and used to release detainees from cells.

5.22 The *Emergency Management Review Paper* examines training opportunities, culture and deficits in Youth Custodial Services in some detail. A significant number of training courses were provided to Banksia Hill staff in 2012, predominantly through two satellite trainers. The main areas of focus included mandatory training (CPR, First Aid and Gatekeeper), use of force, administration, and working with female offenders. However, there were a number of issues and deficits, including the following:

- Only 24 per cent of staff survey respondents felt they had adequate training for a riot situation, a sentiment that was repeated during onsite consultations with staff.
- Emergency management training only reached around a quarter of staff, with 50 staff attending a total of 88 courses (mainly fire extinguisher training, control room training and training for the Primary Response Team (PRT)).
- Staff shortages limit training opportunities and the small group of staff who work only nights receive little or no ongoing training.
- There are no dedicated training facilities at Banksia Hill despite the expansion project. Training and drills therefore occur in less than ideal circumstances and in plain sight of detainees.
- Detainees are locked down every Wednesday afternoon for one and a half to three hours, the sole justification being staff training. In itself this is a concern as it impacts on the total time available out of cell for detainees.[139] Compounding this, it emerged that training has not been properly prioritised and that the lockdown periods have frequently been used for other activities such as staff meetings and union meetings. Staff estimated that actual training occurred on average only once each month.

138 See [4.30]–[4.34] above.

139 A situation strongly criticised by the Children's Court President Transcript of Proceedings, *State of Western Australia v BAJG* (Unreported, the Children's Court of Western Australia, KT35/12, Reynolds J, 27 March 2013) 48.

5.23 Scenario-based training is always important in a custodial setting, never more so than at a time of major site changes, the amalgamation of two workforces and escalating serious incidents. It has been sorely lacking. The Department's Emergency Management Framework requires a minimum of six emergency management training exercises each year, including a minimum of five desktop exercises and one live simulation. The Banksia Hill EMP covers 12 incident types, including major disturbances and evacuations, and each one of these must be tested at least once every three years.

5.24 A 2012 training schedule obtained from the Department stated that Banksia Hill was to conduct three desktop exercises and six live scenarios that year. The records show that only one desktop exercise and two live drills were actually conducted across both Rangeview and Banksia Hill. These three exercises all occurred in May 2012, prior to amalgamation. They covered only fire and perimeter breaches and none addressed roof ascents or major disturbances. Furthermore, only seven staff members were involved (less than 4%) in scenario training in 2012 and one reported that he had last been involved in such training in the 1990s.

5.25 A further problem is that there is no record of the quality or otherwise of scenario-based training in Youth Custodial Services. In adult prisons, a report form must be submitted to head office with a full description of the exercise, debrief notes and proposed improvements. It also appears that WAPOL has never been on-site for an exercise despite the importance of emergency interaction.

New Staff

5.26 Staff transferring to Banksia Hill from Rangeview needed an effective orientation in order to be familiar with the site and its policies and practices. While some attempts were made to orient staff, these were not sufficient. As discussed earlier, staff were unanimously critical of the amalgamation processes in October 2012 and in January 2013 still felt ill-prepared for a major incident.

RESPONSE

5.27 This section of the report examines central themes with respect to response management and the roles of key parties. It is best read alongside the timeline in Appendix 1. The operational review being conducted separately by the Department's Professional Standards Division will also impact on future decisions and actions in this area.[140]

Australasian Inter-Service Incident Management System (AIIMS)

5.28 The Department uses the Australasian Inter-Service Incident Management System (AIIMS) for managing critical incidents in prisons and detention centres. AIIMS is designed to be applied in an all hazards – all agencies environment. It consists of three principles:

- *Management by objectives* to ensure that everyone is working to a common goal;
- *Functional management structures* to carry out the various functions required in the circumstances, to be headed by a single incident controller; and

140 See [1.49] above. At the time of writing the Department's operational review had not been finalised.

- *Span of control* to dictate the number of groups or individuals that can be successfully supervised at one time, with appropriate delegation.

5.29 On the night, there was a strong sense of people working towards the common goal of resolving the incident safely and securely and of mutual support and cooperation. However, both those holding senior positions on site and those in the head office incident control facility have frankly acknowledged that command and control level communication was not always good and that there was some role confusion.

Initial Response to Detainees Out of Bounds

5.30 The initial response to three detainees absconding and accessing the roof was timely and appropriate. The Shift Manager was the initial incident controller, for around an hour, and he showed commendable skill and professionalism. He gave directions to instigate a lockdown of all other detainees and to activate the local Primary Response Team (PRT). The Director Youth Custodial and other centre management staff were promptly notified. The Shift Manager also instigated obtaining assistance from the Department's Emergency Support Group (ESG), located at the nearby Hakea Prison, and the police.

5.31 The Shift Manager prioritised staff safety and facility security. As the incident began to escalate, staff were removed from the units to the safety of the staff amenities building, thereby also ensuring key security. When all the staff were accounted for, the PRT formed a cordon around the staff amenities building. Staff felt that they had a good understanding of their roles and responsibilities and that instructions had been clear.

5.32 The ability of staff at Banksia Hill to respond to this critical incident was, however, restricted by a poorly promulgated operating philosophy, the physical infrastructure of the site such as internal barriers, and staffing capabilities. These issues are further discussed in Chapter 4 and the *Security Review Paper.*

Incident Control Facilities

5.33 The Assistant Commissioner Youth Justice Services, the Director Youth Custodial and the Assistant Superintendent Banksia Hill all arrived onsite at around 6.50 pm, approximately one hour into the incident, a timely response. They assumed control of the incident and established the Banksia Hill Incident Control Facility ('the Banksia ICF') above the gatehouse.

5.34 The Banksia ICF is a reasonable-sized room with several whiteboards and computers. However, it has only two phones. This created communication difficulties on the night even when supplemented by radios and staff mobile phones. The Banksia ICF also has no direct access to camera footage, which must be accessed via cameras in the control room around 50 metres away. Staff were constantly crossing a bridge over the sallyport in order to relay information. A number of other issues also emerged, including the adequacy of cell-call monitoring.[141]

141 See [5.46] below.

5.35 Use of the Banksia ICF was a new experience. No staff member could recall any previous occasion when it had been used and no training (which would have identified its weaknesses) appears to have taken place using the Banksia ICF.

5.36 Another incident control facility was established at head office at around 8.10 pm. Its role was to get any needed resources to Banksia Hill and to make decisions that fell outside local control, such as the decision to move the children to Hakea.

5.37 When it became clear that detainees would be evacuated to Hakea, an incident control facility was established there at around 9.50 pm. It coordinated the movement of the detainees into Hakea on the night and remained open for a number of weeks to coordinate modifications and arrangements to house children in the adult prison.

5.38 By and large, apart from the communication and incident monitoring problems experienced at Banksia, there appears to have been good coordination between the ICFs at Head Office, Banksia and Hakea.

Roles and Responsibilities of ESG and Local Management

5.39 The first group of ESG members arrived shortly after local management. Their arrival highlighted some important questions about incident control. On 11 January 2013, following a debrief in respect of another incident at Banksia Hill, the then Commissioner sought to clarify the respective roles of the ESG and local management at Banksia Hill. He directed that:

> Once the ESG are activated and attend the scene, the incident scene is to be formally handed over to them and they take responsibility for the management of the incident until it is resolved and handed back. The officer in charge of the facility will continue to manage the other parts of the facility not affected by the incident.[142]

5.40 The former Commissioner's direction seems to have been based on responsibility for physical areas. Where an incident is confined to a specific area, such as a cell extraction, the suggested division of labour between ESG and local management makes sense and seems eminently workable. However, the 20 January incident spread across the whole of Banksia Hill. The ESG Superintendent and the Director Youth Custodial interpreted the former Commissioner's direction to mean that the ESG was responsible for rounding up those detainees who were out of bounds and the Director for 'the rest of the facility'. However, this left some questions and gaps, not least in terms of who was responsible for undertaking detainee welfare checks (see below) and understanding who took what decisions on the night.

5.41 The risks of split responsibilities can be illustrated by an event which occurred at around 10.20 pm. By this time most of the errant detainees had been rounded up and the site was relatively safe. A female detainee was suffering an asthma attack and needed immediate medical assistance. The Director Youth Custodial took responsibility for this, directing the PRT to escort medical staff to the unit. This was sensible, pragmatic action, but it is not clear where responsibility would have lain an hour earlier when the site was still being brought under control.

142 Commissioner, DCS, email (11 January 2013).

5.42 The AIIMS framework emphasises the importance of having a single incident controller. It would appear that at the point that it became clear that this was a whole-of-site event, a single incident controller should have been appointed. If this had been the ESG Superintendent, as seems to have been contemplated by the former Commissioner's direction, he could have delegated specific roles to the Director Youth Custodial. Alternatively, the Director Youth Custodial would be the incident controller with the ESG Superintendent taking on a forward command role.

Detainee Safety and Welfare

5.43 Although at least one-third of the detainees were running loose at one time or another, this left two-thirds still in their cells. Some were female, some were vulnerable and some were scared. Others were frustrated and smashing up their cells. It was obviously important to ensure a sharp focus on the welfare and safety of those detainees who were still in their cells. Although concerned about their own safety, staff also generally remained genuinely concerned about the welfare of the detainees. Some commented, with sadness, that those detainees who had not been involved had effectively been 'abandoned'.

5.44 Welfare and safety checks are a routine and critical part of detention centre management. They are especially important for vulnerable groups and individuals. On 20 January, 24 detainees were under the age of 15 and 21 were female. In total, 32 individuals (25 males and seven females, comprising over 16% of the total population) had been formally identified as being 'at-risk' due to factors such as vulnerability, mental health and threats of self-harm.

5.45 Departmental policies require that in normal circumstances, at-risk detainees are checked every 15 minutes. Even allowing for the fact that these were far from normal circumstances, there were long gaps between checks. Some of the detainees who were identified to be at-risk were kept in the Harding Unit separate from the mainstream population. The first post-incident welfare checks in the Harding Unit were conducted just after 10.00 pm, around four hours after the incident began. There are no accurate records of when welfare checks in other units were conducted but they appear to have been conducted after the Harding Unit checks. Six male detainees who were identified as at-risk were not in the Harding Unit: there is therefore no record of when, if at all, these boys were checked during the evening of the riot.

5.46 Given the split roles outlined above, responsibility for welfare checks seems to have fallen to the Director Youth Custodial. However, staff under the Director's control were no longer in a position to carry out physical checks without support. There is evidence that the Shift Manager and staff wanted to check on detainee welfare, especially of the girls, but that they felt unsafe and unprepared to do so.

5.47 All cells are equipped with a cell call system. Detainees who are intent on self-harm are not likely to access this system but the welfare of those who do access it can be monitored remotely to some degree. Under normal circumstances, cell calls are directed to the unit office. However, the unit offices were not secure enough for staff to remain safely there and cell calls were therefore directed to the central control room. The control room operator carries out numerous functions, not least in an emergency and did an outstanding job

on the night. As the incident unfolded, two additional staff assisted the operator, one taking responsibility for cell calls. This was an intelligent on the spot solution to the need to monitor high cell call traffic but it would be sensible for plans to include designating specific responsibility for cell call monitoring and for the passing on of information to the incident controller should a detainee appear to be at-risk.

5.48 The welfare of detainees, not least those who were vulnerable and at-risk, remained an issue high in the minds of people on the night and was a source of anxiety to many staff. Fortunately, on the night, detainees did not seek to attack other detainees but that may not always be the case. Systems need to be improved to ameliorate potential risk.

Primary Response Team: Timeliness and Roles

5.49 The PRT consists of staff who are rostered to normal roles in the centre but are specifically trained in primary response. They gather to form the PRT should the necessity arise. When the first three detainees accessed the roof and the original 'Code 2 – Out of Bounds' call was made, PRT staff were required to assist in locking detainees in their cells and then to proceed to the Harding Unit or the gatehouse to don protective gear. This process was relatively timely, taking around 15 minutes.

5.50 While the PRT was kitting up, members of the recovery team and other staff tracked the movements of detainees and formed a cordon around the girls' unit. As the roaming detainees had access to rubble and a metal aerial, the Shift Manager directed staff not to attempt to intervene.

5.51 On 20 January, the PRT was relatively inexperienced and comprised around 50 per cent probationary officers. They acted professionally but a lack of experience appears to have limited their confidence and capacity to be proactive.

Emergency Support Group: Timeliness

5.52 Six members of the ESG arrived onsite at 7.04 pm, approximately one hour and twenty minutes after the initial call out. As it was a weekend, they needed to be called in via pager. The time it took was not unexpected or unreasonable; however, as the incident had by this time escalated well beyond a roof ascent, the ESG Superintendent sensibly awaited additional resources and a solid plan before deploying. Once the ESG and the police deployed at around 8.00 pm, the incident was swiftly resolved: they had detained 25 detainees within five minutes and a further 10 detainees in the five minutes following.

5.53 However, it is of concern that around one and a half hours had elapsed from the time the PRT set up its cordon around the staff amenities building to the time that ESG and the police were deployed. This means that the detainees who had escaped their cells had free rein for well over an hour.

Police: Timeliness, Roles and Collaboration

5.54 Police assistance was initially requested by the gatehouse, under direction of the Shift Manager, just after 6.30 pm, when one of the six detainees then out of cell threw a rock at the gatehouse door. At this stage, WAPOL's role was solely external to the facility to guard the perimeter against any possible escape attempt.

5.55 The first police arrived at 6.50 pm and the Police Air Wing (Polair) was on scene by 7.20 pm. The police presence also included the Canine Unit, the Tactical Response Group, Police Transport Southern, the Traffic Enforcement Group and the Regional Operations Group.

5.56 The police subsequently played a key role in managing the incident inside the facility along with the ESG and other departmental staff. In line with agreed protocols embodied in a 2007 memorandum of understanding (MOU) between the Department and WAPOL regarding major incidents, incident control was maintained by the ESG. The agencies worked well together and police assistance was instrumental in apprehending the detainees in a timely and safe manner. Polair proved particularly valuable in providing intelligence about detainee movement, to some extent compensating for the limitations of CCTV camera and monitoring.

5.57 Although collaboration was good, record keeping needs to be improved, a point acknowledged by all parties. It is particularly important to be able to account for decisions to deploy police inside a facility and the MOU refers to the ESG incident controller and a Police Liaison Officer negotiating the type of assistance that is required. However, neither the ESG nor Banksia Hill management have a clear recollection of when it was decided that police assistance would be required internally. There are also no records regarding discussions of the type of assistance required. In essence the ESG seems to have utilised whatever resources turned up at the centre.

5.58 There is no suggestion that the police dogs were ever off leash or presented any danger to those involved, but it is timely for the Department to review its protocols regarding the use of police dogs. Tasers cannot be used without prior approval from a senior level in the Department (in this case the Commissioner gave such approval at 7.37 pm, just over 30 minutes after the ESG had arrived). There does not appear to be any protocols regarding the approval and use of dogs by the police canine squad however detainees tended to perceive the presence of Tasers and the presence of the dogs as equally threatening. It would be prudent to develop guidelines.

Calls for the PRT to be Armed

5.59 Since the incident there have been calls for staff, or at least the PRT, to be equipped with weapons such as batons, pepper spray and Tasers. There appears to be two main rationales. The first is deterrence/prevention and assumes that this will help prevent such incidents occurring. The second is to respond to incidents in a more timely manner. Such reactions are not unexpected in the aftermath of a serious incident. However, there are strong countervailing arguments, including the following:

- The deterrence/prevention arguments do not accord with the views of staff respondents to the survey. Fewer than seven per cent of youth custodial officers regarded 'lack of defensive tools' as a factor behind the incident. They saw staff shortages, lockdowns, the pressures of amalgamation and poor training as far more significant causal factors.
- It is also far from clear that this would have assisted a more timely resolution of previous incidents at Banksia Hill.

- The 20 January incident was resolved without recourse to such weapons.
- Weapons may escalate rather than reduce risk, especially as juveniles have been able to arm themselves with rubble due to years of inattention to obvious risks.
- Rule 65 of the 1990 United Nations *Rules for the Protection of Juveniles Deprived of their Liberty*, though not technically binding, states that 'the carrying and use of weapons by personnel should be prohibited in any facility where juveniles are detained.'

5.60 In summary, the case for arming the PRT has not been made out and broader and more nuanced responses are required. They should include better training, improved regimes and a better focus on dynamic, procedural and physical security and de-escalation. There have been too many failings in all these areas.

Navigating the Facility

5.61 The response involved Banksia Hill staff, the ESG and WAPOL. Some of these people had had limited exposure to the site and radio traffic on the night evidenced some problems with navigation and clarity of communication. For example, different staff referred to the same unit by different names. In addition, no up to date site maps were available making it difficult for Polair to effectively communicate information about detainee locations to those on the ground.

Decision to Transfer to Hakea on 20–21 January

5.62 Hakea Prison is close to Banksia Hill. By good fortune, on 20 January it had an empty unit (Unit 5) because the prisoners housed in that unit had only recently been moved to two new units, 11 and 12. Unit 5, located in the main part of the prison, was the adult self-care unit and probably the best of the older units.[143] The majority of the detainees transferred on the night itself were placed in Unit 5 but some were initially placed in Unit 12.

5.63 Placement of juveniles at Hakea was subsequently upheld by the Supreme Court, essentially on the basis that it was a necessary emergency response. However, it was unprecedented and controversial. It was also not something for which there had been any prior contingency planning. It would be reasonable therefore to expect a clear record of who made the decision to transfer children to Hakea, when that decision was made, the reasons behind the decision, and any other options considered.

5.64 There is in fact no departmental written record and the Inquiry did not get a clear sense of who made the decision and precisely when. It would appear that the decision was taken by someone in the incident control facility at head office sometime before 8.30 pm, less than 20 minutes after that facility was established.[144]

143 OICS, *Report of an Announced Inspection of Hakea Prison*, Report No. 81 (November 2012).

144 In responding to the draft of this report, the Department stated the decision was made by the Assistant Commissioner in the Head Office ICF in consultation with the former Commissioner and the Deputy Commissioner Community and Youth Justice. However, there is no log of who made this decision and when. The Inquiry asked numerous senior managers from Head Office and the management teams at Banksia Hill and Hakea who had made this decision and their responses varied. In the Supreme Court hearing (*Wilson v Francis*) counsel for the applicant stated the decision was made by the Assistant Commissioner in the ICF but the former Commissioner stated the decision was made by the Deputy Commissioner. When questioned during the court proceedings, the Commissioner, Assistant Commissioner for Youth Justice Services and Director of Youth Custodial Services each stated that they did not make the decision.

5.65 Decisions have to be taken promptly in circumstances such as this, there were limited options available and Hakea may have been the 'least worst option' at the time. However, once again, the lack of documentation contravenes basic principles of transparency and accountability.

Allegations of Mistreatment

5.66 A number of allegations have been made of mistreatment of detainees during their apprehension at Banksia Hill and their transfer to Hakea. This Inquiry is limited in how far it can pursue such claims and CCTV footage is far from complete. However, logs were examined and both detainees and staff were interviewed. In some cases where detainees had alleged mistreatment, follow-up interviews were conducted. When appropriate, people making the allegations were advised to contact agencies with specific investigative capacity such as the Corruption and Crime Commission.

RECOVERY

5.67 Recovery from an emergency incident refers to the ability for people to return to their routine prior to the incident, ideally including improvements. Much of the recovery is still to occur, including the return of detainees and staff to Banksia Hill. This will be a long-term challenge. This section of the report examines just three elements of recovery relating to the immediate aftermath.

Record Keeping of Detainee Involvement

5.68 Poor record keeping has already been referred to many times in this report. It has also been a longstanding problem at Banksia Hill, especially in the context of how the centre has responded to detainee misbehaviour.[145] It should be standard practice to record critical incidents and many incidents of far lesser magnitude than the riot are routinely recorded. However, despite at least 70 detainees being involved, only three (the original roof ascenders) were formally linked on TOMS to the riot at the time of writing, some four months after the riot. It is probably too late for this to be rectified and some of the young people will now have been released.

5.69 The Department was unable to advise the Inquiry how many detainees took part in the riot and could not inform the Children's Court and the Supervised Release Review Board whether particular individuals were subject to investigation, charges or adverse findings. In contrast, WAPOL was able to provide information that police had interviewed 116 persons of interest in relation to the riot. As a result, 30 juveniles and five adults have been charged with criminal damage and 17 have pleaded guilty. Obviously the police have an important and independent role to play but it is clear the Department should have kept itself better informed.

145 OICS, *Report of an Announced Inspection of Banksia Hill Detention Centre*, Report No. 76 (January 2012).

Debriefs

5.70 Debriefs provide many benefits, including the opportunity for reflection and learning and a chance to focus on staff welfare and centre recovery. Early in the morning of 21 January, a short 'hot' debrief took place. Essentially it was an immediate staff welfare check and, as it was 5.00 am, it was kept deliberately short.

5.71 A 'cold' debrief was conducted just over two weeks later on 6 February. Minutes were taken but they do not record who was present and they were circulated only to the Banksia Hill management team.[146] A number of staff commented on the value of the cold debrief but overall, they believed it had been poorly organised for such an important event. Staff who were not present, including a large number who had been on duty on the night, felt left out.[147]

5.72 Although the police were integral to the response and the Department of Fire and Emergency Services and St John Ambulance also attended, no inter-agency debriefs have been conducted.[148]

Reducing Psychological Impact

5.73 There is no doubt that the 20 January riot had a profound impact on staff wellbeing and confidence. Emotional reactions were strong and included frustration, anger and fear.

5.74 The Department offered counselling to all staff, with representatives from its Welfare and Support and Employee Assistance branches available on site for two weeks post-incident. However, it was clear well after that time that many people were still struggling to come to terms with what had happened.

Photo 18: View from a damaged unit window across the new Yeeda facility.

146 Coordinator, Custodial Inspections, DCS, email (18 April 2013).
147 For further information see this Inquiry's *Emergency Management Review Paper.*
148 This breaches the terms of Standing Order 20 and the spirit of section 6 of the Banksia Hill Emergency Management Plan.

5.75 Overall, the Department made a strong and concerted effort to support staff in the aftermath of the incident. However, recovery and the rebuilding of resilience are longer-term issues. At the time of writing many of the underpinning fragilities remained unaddressed even though the return of detainees from Hakea to Banksia Hill was officially slated to be complete by mid-July.

RECOMMENDATIONS

Recommendation 12

In order to improve emergency management preparedness the Department should:

(a) ensure that emergency management plans at all adult and juvenile facilities are regularly reviewed, fully up to date, and include viable emergency evacuation plans; and

(b) Improve staff training in emergency management and keep clear records of the findings and recommendations arising from scenario training and reviews of critical incidents.

Recommendation 13

The Department should examine and implement improvements to its systems and processes for conducting safety and welfare checks of detainees and prisoners in the event of incidents of mass disorder such as that which occurred at Banksia Hill on 20 January 2013.

Recommendation 14

In order to improve its emergency management responses the Department should:

(a) Further develop its protocols regarding the roles of the on-site Superintendent and the Emergency Support Group (ESG) Superintendent, especially in situations involving a whole-of-site incident;

(b) Evaluate the resources needed by the ESG to improve response times at weekends and evenings; and

(c) In consultation with WA Police, evaluate the opportunities for improved site navigation capacity during emergency situations.

Recommendation 15

Staff generally, and the Primary Response Team (PRT) in particular, should be provided with better training for responding to unfolding incidents and de-escalation techniques. This should occur in the context of more general training in dynamic and procedural security (see recommendation 6). The PRT should not be equipped with weapons such as batons, pepper spray and Tasers.

Recommendation 16

The Department should examine the lessons to be learned from events in the youth custodial system since 20 January 2013 with respect to recovery from emergencies. In particular, it should ensure that debriefs are organised for all staff and that longer term strategies are implemented to rebuild staff confidence and resilience.

Chapter 6

MANAGEMENT, STAFFING AND AMALGAMATION

OVERVIEW

6.1 Prisons and detention centres are profoundly human environments where success and failure depend on people and relationships, not on bricks, concrete and bars. It goes without saying that having the right built environment is important but history shows that well-designed and well-maintained facilities will fail if human relationships fail, and that poor physical facilities can sometimes be successful. This is why performance, safety and security can fluctuate at individual prisons depending on personnel and morale. Banksia Hill itself is testimony to this.[149]

6.2 As with previous riots, issues of leadership, management, staffing and workplace culture played a major contributing role. These issues were compounded by poor management of the amalgamation but, as already noted, the issues have a longer history. If Banksia Hill is to have a better future, those who work in youth justice and those holding head office management positions with respect to strategy, human resources, finance and corporate services must reflect on the contents of this chapter and action its findings in a measured and holistic way.

6.3 The problem of high levels of staff absenteeism due to workers' compensation claims and personal leave has become public since the riot as a result of media reports on cases in the Supreme Court and the Children's Court. However, it is not a recent phenomenon. Nor is it simply a matter of some staff being prepared to 'rort' the system. The point is that if rorting occurs, it can and should be addressed by the employer. The employer should also be proactively monitoring and addressing the causes of workers' compensation claims and unscheduled absenteeism.

6.4 A number of elements have compounded to create the current malaise, including the following:

- Low staff morale and increasing disillusion and disaffection on site (dating back many years and exacerbated by some serious incidents at the centre in the past three years);
- Inconsistent local management (too many personnel changes at critical times, a poorly equipped local management team, and inadequate support from head office);
- Lack of clear and consistent philosophies and out of date procedures;[150]
- Extremely poor management of the amalgamation of Rangeview and Banksia Hill, including two distinct staff cultures;
- Fractured relationships between staff and management on site at Banksia Hill; and
- Fractured relationships, factionalism and low morale in the Department's head office.

149 See [7.45] from this Inquiry's Management, Staffing, and Amalgamation Review Paper. In comparison, the Eastern Goldfields Regional Prison has performed well despite the impoverished state of its infrastructure, owing to the uniformity of purpose among all staffing groups and its effective leadership. See OICS, *Report of an Announced Inspection of Eastern Goldfields Regional Prison*, Report No. 72 (June 2011).

150 See [4.5] and [6.56].

6.5 It must be understood that such matters are not just financial or managerial irritants: they involve serious risk. First, they impact adversely on the regime at Banksia Hill and therefore on safety and security at the centre itself. Secondly, they affect the centre's ability to operate in a way that will reduce community risk through positive interventions in the lives of young people, something which is required by the *Young Offenders Act 1994*.

METHODOLOGY AND SOURCES

6.6 The *Staffing, Management and Amalgamation Review Paper* which supports this chapter has a robust methodology. It includes a survey of Banksia Hill employees (with a high response rate), meetings and workshops with relevant groups of staff, meetings with specific individuals and stakeholders, discussions during site visits, and document analysis. There was also a survey of prison officers who worked in the juvenile custodial estate post-riot and evidence from other quarters. Additional independent sources include surveys and reviews by the Auditor General, the Public Sector Commission and RiskCover, as well as previous OICS reports.

6.7 The key findings of this chapter were so alarming that relatively early on, there were formal briefings to the former Commissioner, the two Deputy Commissioners and four of the Department's Assistant Commissioners ('Youth Justice', 'Professional Standards', 'People and Organisational Development' and 'Finance and Infrastructure').[151] The Inquiry team was not persuaded, at least during March and April 2013, that all members of the Department's executive fully appreciated the seriousness of the issues and the urgency of action needed to address them.[152]

MORALE AND CONFIDENCE

Banksia Hill

6.8 The results of the OICS survey given to Banksia Hill staff indicated widespread discontent among Banksia Hill employees. Over half of the staff considered themselves at least 'dissatisfied' with their working life. Only 2.6 per cent of youth custodial officers (YCOs) considered themselves 'very satisfied'. Similarly, less than a third of survey respondents stated that they generally felt safe in the workplace. As documented in the *Management, Staffing, and Amalgamation Review Paper*, morale issues existed long before the riot occurred, with one YCO describing it as a 'contagious apathy'.

6.9 However, despite the clearly evident low morale of staff, many displayed resilience and optimism for the future, with the survey's high response rate indicative of their belief that things could get better. This is an area on which the Department can positively build.

151 Deputy Commissioner Community and Youth Justice, Deputy Commissioner Adult Custodial, Assistant Commissioner Professional Standards, Assistant Commissioner People and Organisational Development and Assistant Commissioner Finance and Infrastructure. On the Department's corporate structure see [6.12]–[6.15].

152 For example, despite the intent to move detainees back to Banksia Hill mid-May, it was not until the 22 April 2013 that approval was given to commence a recruitment process for more YCOs, and their training will not be complete until late 2013.

Other Parts of the Department

6.10 OICS has a strong database of staff surveys at individual custodial facilities through its general inspection activities. It has no statistical database with respect to head office staff but the departure of numerous experienced staff and numerous confidential communications had pointed to some very significant issues in recent years.

6.11 The Public Sector Commission (PSC) worked with the Department in mid-2012, as part of its regular monitoring program, to gauge employee perceptions across a broad range of human resource management and conduct areas. This work confirmed deep levels of negative perceptions by employees about the Department, particularly amongst head office staff.[153] Employee perceptions in areas of relevance to this Inquiry were significantly more negative than is typically observed across the public sector. These included low job satisfaction levels, poor communication by senior management, a sense of not being valued and of views not being listened to or respected, perceptions of unfairness and favouritism in recruitment and promotion, high levels of perceived bullying, and a lack of faith in procedures to deal with misconduct, discipline and grievances. The problems were more marked in some areas than others but spread throughout the organisation.

THE DEPARTMENT'S CORPORATE STRUCTURE

6.12 Being the Chief Executive Officer of the Department, the Commissioner bears ultimate responsibility for the policy, strategy, actions and culture of the Department. Compared with other broadly equivalent departments, a very large number of Deputy and Assistant Commissioners – 11 substantive positions in total – sit under the Commissioner. Two are Deputy Commissioners and nine are Assistant Commissioners. Some of the Assistant Commissioners report directly to the Commissioner and others to one of the Deputy Commissioners. The Western Australia Police, a bigger and more complex organisation, also has a Commissioner, two Deputy Commissioners and nine Assistant Commissioners.

6.13 The new structure is highly centralised and arguably inflated. The Community and Youth Justice area has one Deputy Commissioner to whom two Assistant Commissioners report. The Assistant Commissioner Youth Justice is responsible for youth in detention and the community, and the other Assistant Commissioner is responsible for adult community corrections. The adult custodial area also has a Deputy Commissioner position supported by two Assistant Commissioner positions: the Assistant Commissioner Adult Custodial Operations and the Assistant Commissioner Custodial Services.[154] Another five Assistant Commissioners provide Department-wide support: these are the Assistant Commissioners for 'Offender Services', 'Policy and Strategy Services', 'Professional Standards', 'People and Organisational Development' and 'Finance and Infrastructure'.

153 Surveys conducted as part of OICS inspections at particular prisons ask different questions but again reveal low morale and a chronic lack of confidence in head office.

154 Another supernumerary Assistant Commissioner position was used in 2012, with responsibility for special projects such as overseeing Enterprise Bargaining Agreement negotiations.

6.14 An original proposal to restructure the Department to a two deputy structure was supported by PSC in principle in March 2012. However, the former Commissioner of Corrective Services decided not to proceed with that structure, and a revamped structure was later approved by him in April 2012. There were significant delays in filling many of the newly created positions, with the remaining occupants taking up their roles in February 2013. A restructure had been on the cards since 2011 following the exodus of many experienced, usually disillusioned, senior personnel. The avowed purposes of what became termed the 'realignment' included improved integration and reduced 'silos', streamlining operations, reducing duplication, greater accountability for decision making and promoting a 'joined up' approach.[155]

6.15 The new structure has not been in force long enough to reach a definitive conclusion on its merits, but there is no tangible evidence that it has reduced silos or improved services, efficiencies and outcomes. Indeed, judging by the evidence received during this Inquiry it may have in fact done the opposite. Morale and clarity of direction appear to have declined rather than improved. It has not come across as a supportive culture and the Department's executive presented as seriously, possibly irreparably divided.

6.16 Serious enough in themselves, such problems create further risk. Echoing the views expressed in previous chapters, the 1995 Learmont Inquiry into prison security in the United Kingdom put the point as follows:[156]

> Management is about planning, organising and controlling … The … shift for which people are craving calls for leadership – the ability to create a vision of how things could be, producing alignment, generating energy, and inspiring people to achieve the overall aims and objectives of the Service…
>
> Without the kind of leadership which generates enthusiastic commitment to the purpose, direction, values and beliefs of the organisation, we will get, at best, only compliance from prison staff…
>
> Effective security will be delivered only when all the staff in the establishment feel in tune with the values demonstrated by the Leadership, are clear about and have commitment to the goals, and feel personally accountable for implementing procedures.'

6.17 The disillusionment and uncertainty that pervade the Department will require strong leadership and management by the new Commissioner. That person's appointment also provides an opportunity to rethink the most appropriate corporate structure for the Department. Any such rethink must include a focus on improving services to prisoners and detainees, better connecting management with staff, and improving correctional outcomes despite financial constraints.

155 DCS, *Organisational structure: Explanatory notes* (February 2013).

156 Sir John Learmont, *Review of Prison Service Security in England and Wales and the Escape from Parkhurst Prison on 3 January 1995* (HMSO: London, 1995) 79.

6.18 New South Wales provides a relevant comparison. There are some differences, in that juvenile justice is not the responsibility of the Corrective Service Department in that state.[157] However, it has around twice the number of custodial facilities, almost double the number of prisoners and a much larger number of people serving community orders. It also has a head office structure of a Commissioner and six Assistant Commissioners, all of whom report directly to the Commissioner and have a sharp focus on outcomes not just process.[158]

MANAGEMENT INSTABILITY IN YOUTH CUSTODIAL SERVICES

6.19 As the timeline in Appendix 2 shows, the last few years have seen numerous staffing changes at all levels of management. Three separate projects underpinned the amalgamation: CET74 (converting Rangeview to a prison for young adults); CET84 (the amalgamation of Rangeview and Banksia Hill); and the capital works program. The timeline illustrates the following points:

- Excluding Project CET74, in May 2009, when the amalgamation was formally announced, six roles were being occupied by five distinct people. Project CET84 was the responsibility of the Director Youth Custodial and was separate from the role of Superintendent.
- In mid-2010, the role of Banksia Hill Superintendent had been collapsed into that of Director Youth Custodial. The Director now had three roles: Director, Superintendent and CET84 project manager.[159]
- This is essentially how things remained. However, there were multiple changes of personnel across roles. In total, up to the time of the riot, there were six changes in the role of Superintendent/Director involving five different people. Three of the changes occurred in the pivotal amalgamation year.
- There was particular upheaval from December 2011 to April 2012 (at which time it was still being said that amalgamation would occur by mid-2012). Two Deputy Commissioners swapped roles, the Assistant Commissioner changed, the role of Director/Superintendent changed twice, and a new manager was appointed to oversee the capital works program.
- Immediately after amalgamation, both the Acting Director and the Acting Assistant Commissioner Youth Justice were replaced.

157 There are also geographical differences but this is not relevant given the centralisation of services in Western Australia. Regionalisation was an option for the 2011–2012 realignment but was not adopted.

158 Prior to 2012 the New South Wales Department of Corrections had a structure much closer to that in Western Australia but a review identified its weaknesses (in all essential respects the same as those identified in this report): see Knowledge Consulting, *Independent Review to Identify the Most Appropriate Organisational Management Structure for Corrective Services NSW to Meet the Government's Policy Objectives, including the Reduction of Reoffending* (also called the 'Hamburger Review'). Hamburger also emphasised the distinction between leadership and management.

159 The Department refutes that the Director was the project manager for CET84 for any appreciable length of time. However, determining the identity of the project manager was a source of considerable confusion throughout the Inquiry, requiring numerous document requests to reconcile contradictory information received from the Department. The Director at the time of the amalgamation informed the Inquiry that he (and his predecessor) performed the function of the CET84 project manager. This information aligns with the final document request received.

6.20 Such frenetic change is a recipe for problems in terms of direction, communication, continuity and institutional stability. This proved to be the case. It was one of the reasons the amalgamation was badly handled and one of the contributing causes of the riot.

BANKSIA HILL ORGANISATIONAL STRUCTURE

6.21 Prior to July 2010, Banksia Hill had a Superintendent who reported to the Director Youth Custodial. The Superintendent had direct personal responsibility for the site and the Director had a more strategic and corporate role. In July 2010, the two positions were merged with the Director taking on both operational and strategic responsibilities.[160]

6.22 At the time, OICS voiced concerns at the risks, given Banksia Hill's transition status and the challenges of amalgamation,[161] and the capacity of any one person adequately to take on both roles. These fears proved well founded.

6.23 At the time of the riot, the following organisational structure was in place:

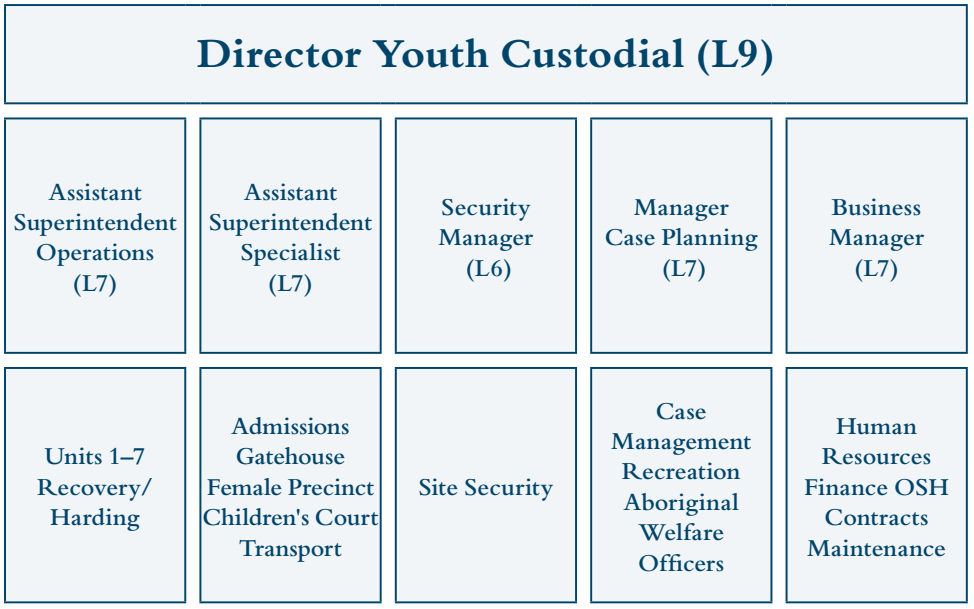


Figure 3. Organisational structure at Banksia Hill at the time of the riot with responsibilities of each position.

6.24 Well before the riot, the Deputy Commissioner Community and Youth Justice and the Assistance Commissioner Youth Justice had identified the need to review the organisational structure. They developed a proposed model reflecting their priorities, with the Business Manager component of their proposed model implemented a week prior to the riot. This model may well have needed some negotiation and discussion but it should have been a priority in the last quarter of 2012. Instead it seems to have disappeared into a bureaucratic quagmire, compounded by personalities.

160 The Superintendent's position was formally abolished on 1 November 2012.
161 The Inspector and his staff regularly voiced these concerns at the time and over the following two years.

6.25 Even the added urgency created by the riot did not speed things up much, with important positions, such as that of Manager Governance,[162] not being approved in the March CET meeting. There was little or no evidence of progress on the revised organisational structure until after this Inquiry presented the Department with its initial findings. A revised organisational structure was finally approved by the CET in May 2013. It is hoped that the new structure will be bedded down within the near future but it comes very close to the intended return of detainees to Banksia Hill.

STAFF SHORTAGES

6.26 As previously discussed, Banksia Hill staff firmly believe that staff shortages and associated lockdowns were the most significant contributing factors behind the riot. Almost everyone consulted for this review agreed with this, though some layers of the Department's bureaucracy did not appear to appreciate the depth of the problem. The issues are of long standing and reflect a number of factors, discussed below.

YCO Staffing Ratios

6.27 The starting point for the number of youth custodial staff is dictated by the 1:8 staff to detainee ratio under which the Youth Custodial Services (YCS) operates. This ratio refers to the number of youth custodial officers per unlocked detainee. This is the least favourable ratio in Australia and New Zealand with those jurisdictions ranging from 1:3 to a 1:5. Ratios in this range promote closer relationships between staff and detainees, permit closer attention to detainees' individual needs, facilitate active dynamic security, and allow different indoor and outdoor activities to be facilitated at the same time. The Brisbane Youth Detention Centre provides a salient comparator because its design was inspired by Banksia Hill. However, it has a staff ratio of one officer to every four detainees, which is twice the number of officers used at Banksia Hill.

6.28 This ratio informs the number of operational staff required for detainees to be unlocked from their cells. In a normal living unit of 24 detainees, this means that three YCO's are required for all detainees to be unlocked from their cell. If sufficient staff numbers are not available, rolling lockdowns occur. This results in only a subset of detainees being unlocked at any given time. Hence, if there are two staff members, 16 detainees may be unlocked initially. Then half of those detainees are locked down, and the other half are joined by those that are yet to be unlocked. After the same time period, the eight detainees that have been unlocked during both time periods are locked down, while the rest of the detainees are unlocked. The rolling process continues until there is sufficient staffing.

6.29 However, staffing levels were not sufficient in the lead-up to the riot, which resulted in excessive lockdowns. The issue of staffing ratios is discussed again later but it is necessary first to examine the reasons behind the lack of staff.

162 This position will be responsible for the administration of complaints, local investigations, training and development, and compliance with policy/legislation.

FTE Levels

6.30 As of 20 December 2012, there were 248 paid FTE at Banksia Hill.[163] Of these, 199 were youth custodial staff, comprising 18 senior officers, 35.7 unit managers and 145.3 YCOs. The remaining FTE were primarily management and administrative staff.

6.31 Given that the level of paid FTE slightly exceeds the approved level of 246, some members of the head office executive told the Inquiry that Banksia Hill is adequately staffed. Unfortunately, such paper-based number crunching bears no relationship to reality. The reality is that Banksia Hill has suffered from very serious staff shortages, that this has seriously impacted on regimes, and that it is a long-standing problem that has not improved.

6.32 In the month prior to the riot, on average, out of approximately 80 uniformed staff rostered each day, 22 staff members were absent.[164] On some days up to 30 staff members were absent. While additional staff were brought in to cover the shifts through overtime, on average the facility was still down 15 uniformed staff every day. Letting detainees out of cells for education, programs, or recreation for any appreciable length of time becomes impossible in such circumstances. One of the more poignant comments from a staff member was that 'this would be a great place to work if everyone turned up'.

Not a New Problem

6.33 Staff shortages in an organisation generally reflect three main factors: workers' compensation claims, personal leave and staff attrition. In terms of attrition, this review concluded that, at least in the period preceding the riot, the overall separation rate in youth custodial services was not outside the range of reasonable expectations. The more serious issues by far were the amounts of workers' compensation claims and personal leave.

6.34 OICS reports on youth custodial facilities have repeatedly raised concerns about staffing shortages, and especially their impact on regimes for detainees, overtime levels and workplace stress. The June 2010 inspection of Rangeview found that staff shortages were leading to some critical functions, such as reception, admission and orientation, being acutely under-staffed. It recommended action to address these deficiencies. The 2011 inspection of Banksia Hill described the staffing situation as fragile, despite extra recruitment drives in 2010, and warned of the risks arising from excessive lockdowns flowing from staff shortages.

6.35 Although the Department has adopted some measures to try to address the problem of staff shortages, these have not prevented further escalation. The situation at Banksia Hill, 'fragile' in 2011, reached crisis levels by 2012. Unfortunately, issues of unscheduled absenteeism also afflict some parts of the adult custodial system as well as youth custodial.[165]

163 Full-Time Equivalent (FTE) is a unit that indicates the workload of an employee in a way that makes workloads comparable across various contexts. For example, an FTE of 1.0 means the person is equivalent to a full-time worker and an FTE of 0.5 means the person works a half time load.

164 See [5.32] from this Inquiry's *Management, Staffing, and Amalgamation Review Paper.*

165 Bunbury Regional Prison reported even higher levels of unplanned leave than Banksia Hill in 2012.

Workers' Compensation: Trends, Costs and the Department's Understanding

6.36 All employees have a right to workers' compensation leave. It must also be acknowledged that the nature of the work undertaken at prisons and detention centres is such that there is probably an increased chance of injury compared with many other working environments. However, as shown by a recent review by RiskCover that was instigated by the Department,[166] Departmental staff take a high level of worker's compensation leave even compared with other large 'high risk' agencies. The Department ranked in the bottom half of all the highest risk agencies against all comparative measures.[167]

6.37 Recent reviews by RiskCover, the Office of the Auditor General (OAG) and Ernst and Young have examined aspects of the management of workers' compensation in the Department but have not articulated the trends in detail and have not attempted to unpick the causes.[168] The Review Paper which accompanies this report has undertaken this exercise, at least in a preliminary way. Its sobering findings include the following:

- At 31 December 2012, one month before the riot, 48 Youth Custodial Services employees (20% of the workforce) had active workers' compensation claims. Two-thirds of these claims involved loss of time injuries.
- Claims appear to have grown further since that time but the Department's record keeping is very confusing and the Inquiry team was provided with quite different figures by various departmental representatives.
- The proportion of claims involving mental stress escalated from 10 per cent in 2010 to 33 per cent in 2012.
- Between 2008 and 2012, across the Department, the proportion of 'severe' claims (in other words, claims involving 60 days or more off work) has risen from 20 per cent to over 38 per cent. This adds greatly to the costs. Twenty per cent would be a more typical level across public sector organisations.
- From 2008 to 2012, estimated claim costs in YCS rose by more than 60 per cent, from less than $942,000 in 2008 to over $1.5 million in 2012.
- In 2012, the number of days lost to workers' compensation claims ran to an average of more than 126 hours per FTE in YCS. Only one facility (Bunbury Regional Prison) was higher. The state average in custodial facilities was also high – around 80 hours.

166 RiskCover is the Department's worker's compensation insurance provider.

167 RiskCover, *Department of Corrective Services Worker's Compensation and Injury Management Systems Review* (February 2013).

168 RiskCover, *Department of Corrective Services Workers' Compensation and Injury Management System Review* (February 2013); Office of the Auditor General Western Australia (OAG), *Management of Injured Workers in the Public Sector* (May 2013); Ernst and Young, *DCS's OSH Framework and Worker's Compensation Processes* (August 2010).

6.38 Reflecting these problems, the Department's insurance premium for workers' compensation has doubled over the past three years to $23 million (around three per cent of its annual operating budget). This has been a major impost given that the Department has struggled to stay within budget, has needed to find cost savings, and has consequently identified many areas of services to prisoners for severe cuts.[169]

6.39 Despite the seriousness of the situation and the escalating costs and risks, the Department keeps limited statistics and does not appear sufficiently proactive or well informed. Individual facilities do not have KPIs for workers' compensation or injury management and despite the glaring problems only one internal audit has been undertaken over the past five years. Regretfully, this was also limited in scope being largely process-focused.[170]

6.40 In addition to providing inconsistent numbers of individuals on worker's compensation leave, senior departmental management were unduly pre-occupied with individuals who were 'rorting the system', with each senior manager providing a different, vivid anecdote of an individual who had made a dubious claim. Staff mentioned the frequency of sprains and strains, and suggested the need to improve staff fitness, however little mention was made of the unprecedented growth in mental stress cases over the past three years.

6.41 Recent reports by the OAG and RiskCover have found that the Department has not been sufficiently informed or proactive and has failed to comply with its statutory obligations with respect to injury management. The OAG found that the Department is one of four agencies which does not prepare a return to work program for all employees who are legislatively required to have such a program. Indeed, it had established return to work programs for less than half the affected staff.[171] The OAG also found that the Department was the only agency to have failed to include any 'return to work indicator' in its annual reporting.[172]

Sick Leave and Other Personal Leave

6.42 The term 'personal leave' refers primarily to sick leave and carer's leave. It does not include annual leave and public holidays. Sick leave accounts for the vast majority of personal leave. It is an important safeguard for employee welfare but can have a serious impact on costs (the absentee's salary plus costs of covering that position) and service delivery.[173]

6.43 Public sector agencies tend to have higher rates of sick leave absenteeism than private sector organisations. It can also be anticipated that people working in corrections (like police) face stresses and risks that may increase the likelihood of absenteeism. However, even taking these considerations into account, the Department appears to have high and poorly managed rates of sick leave.

169 For example, funeral attendance by prisoners has been significantly affected and is the subject of a soon to be released audit by this Office.

170 Ernst and Young, *DCS's OSH Framework and Worker's Compensation Processes* (August 2010).

171 OAG, *Management of Injured Workers in the Public Sector* (May 2013). The Department of Education has a similar record.

172 The Auditor General did note, however, that a number of agencies do not understand their exact annual reporting obligations.

173 Australian National Audit Office, *'Absence Management in the Australian Public Service'*, Audit Report No. 52 (June 2003).

6.44 Again, this is not a new problem but it has been escalating. In 2005, OICS noted that prison officers had sick leave rate that was 60 to 100 per cent higher per FTE than the public sector average.[174] This Inquiry has not been able to locate recent personal leave data across the whole public sector to undertake the same comparison. However, personal leave use in the Department has increased very markedly, from an average of 81 hours per FTE in 2004–2005 to 126 hours by 2012.

6.45 The levels of unscheduled leave at Banksia Hill itself have attracted judicial and media interest as a result of the Supreme Court and Children's Court hearings. However, the average of 107 hours per FTE in 2012 is actually less than the adult prison average. It may be noted that the maximum entitlement for YCOs is 114 hours compared with 140 hours for adult custodial officers.

6.46 It is also of particular concern that 31 per cent of youth custodial staff took more than their annual entitlement in the year preceding the riot, with eight per cent of employees taking in excess of 200 hours.

IMPROVING INJURY AND LEAVE MANAGEMENT

6.47 Such levels of workers' compensation and personal leave indicate a cultural malaise which requires holistic central management. In particular, the increase in stress-related claims from 2009 should have been known to the Department. It is a strong indicator of poor morale, increasing fear and lack of faith in management. This creates something of a vicious circle, with the remaining staff becoming increasingly stressed and frustrated by their colleagues' absences.

6.48 Figures provided to the Inquiry by senior people with responsibility in relevant areas have been very inconsistent but workers compensation claims have increased since the riot. The Inquiry was told that by mid-April, 60 out of 199 YCOs had an active claim. It was also told by one senior executive in May that the number had topped 70 but other departmental executives said the figure was 53. In a sense, exact numbers no longer matter once these sorts of levels are reached.

6.49 It is also accepted that there are still high levels of unscheduled personal leave absenteeism. Figures provided to this Inquiry and to the Children's Court have put the figure in the region of 15–18 youth custodial staff on the day shift – around 20 per cent of the full daytime roster of 59 YCOs.

6.50 Comparisons with the private sector and between adult and juvenile facilities are not straightforward but the differences between the privately operated Acacia Prison and Banksia Hill, especially with respect to workers' compensation, are so stark that they must be recorded:

- The level of workers' compensation leave at Banksia Hill (126.6 hours per FTE) is 10 times higher than that at Acacia (10.3 hours per FTE).
- Annual personal leave at Banksia Hill (107.3 hours) is double that at Acacia (50.3 hours).
- Acacia has five times the number of people in custody and more FTE, but Banksia Hill has three times the amount of unplanned leave.

174 OICS, *Directed Review of the Management of Offenders in Custody* (November 2005).

6.51 While Acacia houses adult prisoners rather than juveniles and there may be some workforce differences, it cannot be argued that these factors alone explain these figures. As OICS reports have previously noted, Serco has been more proactive and successful in its management of these issues than the Department.[175] In fact it has no choice: if the situation at Acacia came anywhere near to that at Banksia Hill, Serco would be unable to meet its contractual obligations and the Department's contract management team would be calling out for wholesale change, even re-tendering.

6.52 The Department's corporate approach to workers' compensation at its own facilities has been unrealistic and too hands-off. The view appears to have been, in essence, that it is primarily a matter for local sites to manage. The corporate workers' compensation team consists of only three people, each with an average caseload of 140 claims. They can do little more than track and report – active management of claims is impossible. At site level too, the management teams are not adequately resourced for the task. At Banksia Hill, the new management team, which came in during November 2012, found that human resources staff were unable to provide a budget, report on overtime or develop a business case. Ironically, but perhaps predictably, this was partly due to workers' compensation claims and personal leave on the part of people working in that section.

6.53 Clearly, more needs to be done in terms of understanding the extent, nature and causes of workers compensation claims at different custodial facilities (both adult and juvenile) and to address and report publicly on these issues. Injury and personal leave management is a matter of employee welfare and it should be core departmental business. While the Department has recently begun strengthening its relationship with RiskCover and has developed a number of plans to reduce worker's compensation claims, it is currently paying the price for years of neglect, particularly in the youth custodial domain. This report, read alongside the reports by RiskCover and the OAG show that a sharper, fairer and more effective system with strong central direction is urgently needed.

6.54 In summary, the combined impact of workers' compensation levels, personal leave levels and the Department's failure to adequately manage the issues is an ethical and financial disgrace.

STAFFING: YCO ROLES, FTE LEVELS AND SHIFT ARRANGEMENTS

6.55 The preceding discussion has focused on the need to manage personal leave and workers' compensation in a way that better meets employee welfare needs and departmental obligations. However, it should also prompt government to commission a comprehensive and comparative independent review of staffing levels and shift arrangements. This will need to be tied to a consideration of the philosophy and role of YCOs.

Philosophy and Roles

6.56 As noted elsewhere in the Review Papers,[176] there has been something of a tension between a security approach and a welfare approach when it comes to the management of detainees. This stems from differences in training, the attempted merging of two distinct cultures in the amalgamation, and the lack of a promulgated underlying philosophy to guide staff.

175 OICS, *Report of an Announced Inspection of Acacia Prison*, Report No. 71 (May 2011).
176 See [2.3] from this Inquiry's *Emergency Management Review Paper.*

Uncertainty about the proper role of YCOs was evident in the staff survey. Similar proportions of staff believed that an excessive focus on security had caused the riot as those who believed there had been a lack of emphasis on security. The 'identity crisis' and low morale resulting from the lack of an underlying philosophy will need to be resolved as a priority.

Staff to Detainee Ratios

6.57 The Department does not appear to have developed a comprehensive business case for a different staff to detainee ratio as an integral element in the initial planning for the Banksia Hill redevelopment. In September 2010 a business case was developed that proposed a 1:4 ratio. This business case, which was catalysed by the August 2010 escape,[177] included the following comment:

> Not addressing these areas of concern could potentially compromise the ongoing safety and security of the facility, with the most serious ramifications being compromised safety and wellbeing of staff and young people.[178]

6.58 It appears that CET rejected this proposal. It was certainly never put to Treasury.

6.59 Absenteeism has been so high for so long that it is not easy to know how well the centre would run if all necessary staff were at work on a sustained basis on the current 1:8 ratio. However, irrespective of absenteeism, OICS has previously argued that a lower ratio is at least required in some high-need operational areas. This review has firmly reinforced that view. For example, in areas such as the Harding Unit, admissions, and the female unit, a ratio closer to 1:4 would be appropriate.

6.60 It must be acknowledged, however, that a lower ratio is not a panacea. It will not lead to an improved regime unless there is a drop in absenteeism. If a ratio of 1:5 was introduced but current absenteeism levels continued, lockdowns would simply 'kick in' when staff numbers fell beneath the new ratio.

Shift Arrangements

6.61 Banksia Hill operates on a 12-hour shift arrangement. This is not the norm across Australia and was not the arrangement in Western Australia prior to the opening of Banksia Hill in October 1997. It was a system brought over from the adult custodial sphere and was subject to extensive criticism in the previous OICS Directed Review of the prison system.[179] There is strong evidence that the 12-hour shift system adversely impacts on the ability of staff to develop and maintain positive and supportive relationships with detainees, partly because staff tend to be 'on' for only three days at a time.

177 DCS, *Business Case: Banksia Hill Detention Centre Redevelopment Project* (CET 84) (September 2010) 3.
178 DCS, *Business Case, Banksia Hill Youth Detention Centre Redevelopment Project* (CET 84) (September 2010) 7. There were some problems with the evidence base for this submission: see [8.54] below.
179 OICS, *Directed Review of the Management of Offenders in Custody* (November 2005).

6.62 Staff in other jurisdictions stated that a 12-hour shift system increased risk to both staff and detainees, with incidents more likely to occur at the end of the shift when staff were tired. In contrast, staff in jurisdictions with an eight-hour shift system believed that it promoted greater knowledge of detainees, greater continuity of contact, and allowed for later lockdown hours (for well-behaved detainees).

6.63 It is also possible that whilst often preferred by staff, the 12-hour shift may deter some people from working in youth custodial services. Furthermore, the evidence presented in this chapter does not suggest that the 12-hour shift reduces absenteeism. A number of submissions to this review, including a submission from the President of the Children's Court, have raised the same concerns.[180]

6.64 It is not within the scope of this review to examine these issues in any more depth but they should be the subject of a further independent review of staffing in youth custodial services.

AMALGAMATION: READINESS AND (MIS)MANAGEMENT

6.65 The story of the Banksia Hill amalgamation is essentially one of how initial promise, vision and hard work in 2009 and 2010 came seriously unstuck during 2011 and 2012. It became a case study in how not to manage change. The reasons are multi-faceted and include issues at the site and at head office.

6.66 As noted earlier, around a quarter of staff surveyed believed that the amalgamation and poor leadership directly contributed to the riot. More generally, it was clear that amalgamation remained an open wound for a large proportion of the workforce. Many thought the decision to close Rangeview was politically motivated and offered only risk to Banksia Hill. They seem to have had little idea of, and certainly little support for, the potential benefits. This had undoubtedly contributed to low morale and high absenteeism.

Promising Start

6.67 As discussed earlier at the start of the amalgamation project in 2009–2010, there was drive and enthusiasm and many of the building blocks for transition were put in place.[181] For example, work was commenced on an operating philosophy based on the ethos of rehabilitation and on procedures to support this philosophy. Staff were encouraged to have a say and meetings and intranet systems were set up to enable this, and implementation schedules and monitoring and reporting processes were set in place in early 2010. At that time, it was anticipated that amalgamation would occur in late 2011. It was recognised that many challenges lay ahead, including the amalgamation of two different workforces and the need to accommodate a bigger number and wider range of detainees but the signs were promising.

180 Judge Reynolds, President of the Children's Court of Western Australia, submission to OICS (22 May 2013).
181 See [2.15] above.

Subsequent Decline

6.68 Unfortunately, by the first half of 2011, there were signs of slippage and of a need to actively re-engage staff.[182] From here, the situation declined further up to the time of amalgamation in October 2012.

6.69 The employee survey results and discussions with staff demonstrated an unequivocal condemnation of the period leading to amalgamation and of the actual mechanics of amalgamation. Not a single survey respondent believed that preparation for amalgamation had been adequate. The survey examined a number of specific aspects of 'preparedness' including training, policies and procedures, the daily regime, intelligence gathering, information sharing and working across centres. Over 40 per cent of staff considered that they were 'very unprepared' on all these counts.

6.70 The key problems, many of which have already been canvassed, included that:[183]

- Overall, there was a lack of staff 'buy in' to the new centre – generally they felt they had not been listened to in terms of philosophy, design and operations. They were not 'on side' with the amalgamation and showed increasing apathy and fear.
- There was no dedicated change manager and poor change management processes.
- The building delays and uncertainties regarding completion dates were much more than a problem in themselves; they absorbed excessive energy and detracted from other significant matters.[184]
- The number of serious incidents escalated in 2011 and 2012.
- The working groups, which had been meeting sporadically in early 2011, had completely ceased to function by November 2011.[185]
- There were constant management changes, including simultaneous changes in three key positions (Deputy Commissioner, Assistant Commissioner and Director) in April/May 2012, a critical period given that amalgamation was still slated for mid-year.
- The handover in April/May 2012 was marked by extremely poor communication between the senior managers in question.
- Finalisation of the *Making a Positive Difference* philosophy had taken too long and it was either not known or not embraced by management and staff. At the point of amalgamation there was therefore no overarching set of agreed goals, or policies and procedures to meet those goals.[186]
- Change management had been very poor, especially with respect to managing the amalgamation of two workforces with different cultures.

182 See [2.17] above and this Inquiry's *Management, Staffing, and Amalgamation Paper.*
183 For further details see the *Management, Staffing and Amalgamation Review Paper.*
184 See: OAG, *Performance Audit: Banksia Hill Redevelopment Project* (August 2013).
185 Management at the time justified this on the grounds that the building delay had created such cynicism on the part of staff that it was not worth persisting with them. In fact the building delays made the proactive engagement of staff even more important.
186 See [4.24]–[4.29].

Lack of Corporate Support

6.71 Despite the problems and risks at Banksia Hill, head office appeared uninterested and disengaged from the amalgamation project. Key personnel failed to attend many of the project control meetings, stymieing the decision making process and leaving too many areas of risk unaddressed.[187] No change management experts were provided, with the Director left to juggle multiple roles simultaneously. A crucial project coordinator role assisting the Director in progressing the amalgamation was abolished at the end of 2011. This position was re-established in May 2012; however the five month absence of a role dedicated to progressing the amalgamation in the year it was planned to occur can only be described as a fundamental error.

The Move from Rangeview

6.72 Some examples from the time of amalgamation show not only a lack of strategic and cultural preparedness but also a lack of professional attention to obvious practicalities. The Rangeview site was left in a mess. Cabinets of confidential documents were left behind with no apparent plan to transfer them, and wet laundry, dirty laundry, food and office supplies were carelessly binned. Staff were uncertain of their rosters and claimed that numerous other issues were unresolved.

6.73 One of the most telling examples of poor preparation relates to the critical challenge of transferring the Rangeview workforce to Banksia Hill. Rangeview and Banksia Hill had housed different detainee groups and over the years somewhat different cultures had developed at each site. Amalgamation required strong attention to this issue. It was originally intended that staff would be encouraged to swap and work at the other site so as to gain first-hand knowledge of the challenges of working with a different detainee group and an understanding of the physical environment.

6.74 The idea of 'staff exchanges' was eminently sensible and in the first part of 2012, assurances were given to the Inspector and also the then Minister that this would happen.[188] It never did. Instead, the majority of Rangeview staff simply arrived on the allotted day, and were given an 'orientation passport' which was to be stamped as they were shown around the site.

6.75 Despite the orientation passport tour, the orientation process for staff arriving at Banksia Hill was perfunctory, inadequate and risky. Some Shift Managers, who can be the most senior people on site at times, and responsible for coordinating emergency responses, said their orientation was just 45 minutes. Not surprisingly, 83 per cent of staff survey respondents believed that there was inadequate preparation for staff working across centres.

187 When a new officer started as project co-ordinator in May 2012, he began recording meeting apologies. Between May 2012 and the amalgamation, the Assistant Commissioner Corporate Support was absent in 75% of meetings, and the Human Resources Director was absent from 50% of meetings. No proxies were recorded as being provided for these positions. Even if proxies attended, the lack of senior corporate 'buy in' at a time of such risk defies rational explanation.

188 See [2.25] above.

PERFORMANCE REVIEWS AND MANAGEMENT

6.76 Performance reviews allow areas for improvement to be identified and areas of strength to be recognised. This can feed into training to cover any deficits and to the Department identifying good performance and talent.

6.77 In YCS, performance reviews have been almost non-existent for non-probationary staff. Some reported they had not had any kind of performance conversation, formal or informal, for over ten years. Although a performance review template was developed, it had been used with fewer than seven per cent of staff.
The result was to exacerbate staff's sense of disenchantment. Many reported that they only receive feedback if they make a mistake and that there is little or no encouragement to 'go above and beyond'.

OTHER ISSUES

6.78 The **Management, Staffing and Amalgamation Review Paper** makes a number of other findings and suggestions for improvement.

- A review of the case planning team is required. It appears to be critically under-resourced and the absorption of the Rangeview liaison role into the case planning team without additional resourcing was seen by many as unsustainable, particularly as this was previously a 24-hour service. Due to the lack of resources, Aboriginal Welfare Officers spent most of their time performing administrative duties or airport transfers rather than supporting detainees.
- The award arrangements for education staff need to be finalised as long-term rolling contracts are eroding the morale of the team.[189]
- Occupational safety and health (OSH) resources need to be reviewed. The head office OSH team consists of less than three FTE and there is no substantive OSH position at Banksia Hill.
- A re-invigoration of the unit manager role is required. Individuals commonly acted in the role for short periods (contributing to instability), the duties were unclear and the selection process and criteria were poor.
- New strategies are required to raise the quality of recruits and to improve the number of Aboriginal YCOs. Given the difficulties in attracting Aboriginal custodial staff and getting them through the recruitment process, the suggestion of having non-custodial Aboriginal 'aunties' and 'uncles' in the units (raised in the previous Banksia Hill inspection) should also be seriously considered.[190]

189 This was a live issue at the time of our discussions with staff, however as of 21 June 2013, staff have been provided with permanent positions under the PSGOGA.

190 OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 76 (March 2012).

RECOMMENDATIONS

Recommendation 17

The senior management structure of the Department should be reviewed with a focus on improving correctional outcomes, efficiencies and service delivery. This process will require external direction and needs to be commenced urgently. Depending on the results of this review, a revised structure can then be implemented soon after the appointment of a new Commissioner and in consultation with that person.

Recommendation 18

(a) Appointments to all management positions at Banksia Hill should be finalised; and
(b) Adequate head office support must be provided in areas such as finance and human resources.

Recommendation 19

There should be an independent review of FTE staffing levels in Youth Custodial Services, taking into account comparative data about the numbers and deployment of staffing in other Australian juvenile detention facilities and prevailing standards. This needs to be undertaken as a matter of urgency.

Recommendation 20

The above review should examine the drawbacks and benefits of the 12-hour shift system currently pursued in the juvenile detention system and alternative models.

Recommendation 21

The above review should investigate the present arrangements for and use of personal leave and the causes for and impact of workers' compensation claims in the Youth Custodial area.

Recommendation 22

The Department should ensure that structured formal performance reviews are regularly conducted with staff in order to identify areas for improvement and areas of achievement.

Recommendation 23

It is recommended that the Department review the adequacy of its policies, procedures and resources in the following areas: (i) case planning; (ii) occupational health and safety; (iii) the roles and training of unit managers; and (iv) the employment of more Aboriginal people, including as mentors for young people.

Chapter 7

POST-INCIDENT MANAGEMENT OF DETAINEES

OVERVIEW

7.1 There are two distinct time periods relating to the management of detainees following the riot. The first of these periods is the immediate aftermath of the riot, defined as the two weeks from 21 January to 4 February 2013. During this period, 73 male detainees were housed in Unit 5 at Hakea, with 133 detainees remaining at Banksia Hill. While the Department was still assessing the damage at Banksia Hill and formulating a plan to address the ongoing emergency situation, detainees at both sites were subjected to a highly restrictive custodial regime.

7.2 The second time period follows immediately from the first, extending from 4 February through to mid June 2013. At the beginning of this period, the Department transferred the majority of male detainees to Hakea Prison to allow repairs and security upgrades to be undertaken at Banksia Hill. Units 11 and 12 at Hakea were gazetted as a detention centre and referred to as Hakea Juvenile Facility ('Hakea JF'). It was estimated that the works at Banksia Hill would not be complete until the end of June. Hakea JF would therefore be an improvised juvenile detention centre for five months or more. In this context, it was important for the Department to establish a normal regime and a structured program of activities as soon as possible.

7.3 In the aftermath of the riot and in the period up to 4 February 2013, the Department adopted an extremely risk adverse approach to the management of the detainees at both Banksia Hill and Hakea JF. The outcome was the implementation of a restrictive regime of management confinement which was contrary to the legislative framework in the *Young Offenders Act 1994*, as well as the unauthorised routine use of mechanical restraints.

7.4 The custodial regime in place for the detainees at Hakea JF and Banksia Hill, after 4 February 2013, did not reasonably cater for the needs of young persons in detention. The amount of time detainees were spending locked in a cell remained unacceptable, the time available for education of detainees at Hakea JF was less than half of that previously available at Banksia Hill and there was insufficient delivery of programs, including recreation time. In addition, detainees were unreasonably subjected to routine strip searches before and after social visits.

7.5 The Department's inability to establish a normal regime or structured day at Hakea JF has been affected by the ongoing staffing shortages experienced within Youth Custodial Services (YCS), and the limitations of the infrastructure available for services. Nonetheless, since 20 January the Department cannot be said to have met its obligation to provide a positive, busy rehabilitative regime or to have maximised the opportunities at Hakea.

7.6 When the detainees are eventually moved out of Hakea JF and back to Banksia Hill, the infrastructure shortfalls in relation to available classroom and recreation space will be resolved, although the buildings will have been physically hardened. However, as discussed in earlier chapters, stability and security involve far more than physical infrastructure. The longstanding issue of staff shortages will not be fixed by a return to Banksia Hill. Unless the Department can re-invigorate the workforce, this will present continuing threats to security and safety and to the ability to run a decent and constructive regime, with the capacity to rehabilitate detainees.

SUPREME COURT DECISION

7.7 In its response to the Inquiry's draft report in this matter the Department expressed the view that all of the issues mentioned in paragraphs 7.3 to 7.5 above were adequately covered by the Supreme Court judgement in *Wilson v Joseph Michael Francis, Minister for Corrective Services for the State of Western Australia*.[191] A number of sections of the judgement of his Honour Chief Justice Martin were quoted in support of this view, in particular:

> On the evidence available to me, the decisions that have been made with respect to the management of detainees since the riot have been made with the best interests of the detainees strongly in mind, having regard to the risk that detainees might harm themselves or each other, but also taking appropriate account of the need to ensure the safety of staff and the protection of the community. Those decisions have resulted in arrangements for the detention of young offenders which are clearly less than optimal. Units 11 and 12 at Hakea have the physical characteristics of a maximum security prison intended for occupation by adults, and inevitably have a different ambience to the more open and less intimidating environment at Banksia Hill. The current arrangements at Hakea with respect to education, recreation, remedial programmes and visits are acknowledged by all to be less than optimal. Persistent staff shortages result in a daily schedule in which detainees are locked down for longer periods than would be desirable if there were adequate levels of staffing, and in unanticipated lockdowns which disrupt the daily schedule and the capacity to provide education, recreation and remedial programmes, and sometimes have led to the cancellation of visits. However, the limited options for alternative accommodation available following the riot, and the inability to address the shortage of trained staff in the short-term have constrained the department's capacity to provide optimal facilities and services.[192]

7.8 However, it is important to understand that the Supreme Court was considering four specific questions. These related to the legality of the initial decision to transfer the 73 detainees to Hakea Prison and the three subsequent decisions to declare Units 5, 11 and 12, at various times and in different permutations, to be a detention centre. The Chief Justice made it clear that he was not passing a definitive opinion on the appropriateness of the regime which followed the riot and this Inquiry has examined a much longer period of time than was relevant to the evidence before the Supreme Court.

7.9 The Chief Justice held that it was not the task of the Court to assess the appropriateness of the regime following the riot and noted that the findings of this Inquiry might well differ from those set out in his judgement. He said:

> The regime which immediately followed the riot, which included locking down detainees for 23 hours each day, extensive use of physical restraints (flexible handcuffs) and strip searching was maintained for several weeks following the riot. Any assessment of the appropriateness of that regime and its duration must take account of the security risks created by the riot and its aftermath, including in particular the unexpected

191 [2013] WASC 157.
192 Ibid, [10].

> relocation of detainees to a facility which was not designed for their use, and the seriousness of the offences with which the detainees had been charged, or in the case of sentenced detainees, of which they had been convicted. Assessments of that character are best made by the department and the Inspector of Custodial Services, not the court…[193]
>
> As I have noted, the Inspector of Custodial Services has been directed to undertake a broad inquiry into many aspects of the riot at Banksia Hill and its aftermath. Aspects of that inquiry may touch upon or coincide with issues which I will now address. The findings which I make are based only upon the evidence which was adduced in court in the circumstances of expedition to which I have referred. The Inspector's inquiry has a broader range, will take longer, and will provide the Inspector with a broader range of evidence and information than has been available to me notwithstanding the cooperation to which I have referred. In those circumstances, it is to be expected that the Inspector's findings may well differ, in some respects at least, from the findings which I will now set out.[194]

7.10 The Inquiry fully understands the concerns about the security of detainees and staff, the problems with staff shortages and the limitations of the physical infrastructure at Hakea JF. However, for all the reasons given in this chapter the Inquiry considers that the initial three week period of total lockdown of all detainees was, in all the circumstances, unreasonable. It also considers that the custodial regime in place after 4 February 2013, fell short of providing a level of service suitable for the detention of young persons.

IMMEDIATE AFTERMATH – A HIGHLY RESTRICTIVE REGIME (21 JANUARY TO 4 FEBRUARY 2013)

7.11 The 73 detainees transferred to Hakea included 61 detainees who had escaped from their cells. The other 12 detainees had damaged their cells to such an extent that they were uninhabitable. There were a number of other detainees who damaged their cell during the riot and were moved into other cells at Banksia Hill rather than being transferred to Hakea.

7.12 No further attempt was made to identify other detainees involved in the riot and it was apparent that no clear distinction had been made between those who had escaped their cells and were actively involved and those who had damaged, but had been unable to escape, their cells. It was not until May 2013 that 35 detainees were charged by police with offences arising from the riot, mainly criminal damage.

Staff

7.13 The deterioration of staff morale and the high level of staff absenteeism in YCS were not and could not be resolved in the immediate aftermath of the riot. If anything, staff morale worsened as Youth Custodial Officers (YCOs) struggled to cope with the trauma of the riot and the literal upheaval of their working environment. YCO shortages continued and were in fact exacerbated by the need to staff two separate centres. However, unlike before the riot, the Department took steps to supplement the YCO workforce with prison officers

193 [2013] WASC 157, [11].
194 Ibid, [20]

from the adult custodial system as provided for in section 11E of the *Young Offenders Act 1994*. YCOs and prison officers worked alongside each other at both Hakea and Banksia Hill.

7.14 Although the assistance of prison officers addressed the problem of staff shortages, there were significant problems associated with introducing a workforce with no training or experience in dealing with young people in custody. Some prison officers were supportive and eager to work with detainees. However, the Inquiry was told that other prison officers were openly unsympathetic towards the detainees and even the YCOs, who they felt had lost control at Banksia Hill. YCOs invariably expressed feelings of anger and betrayal towards the detainees and the influence of the prison officers did little to lessen a hardening of attitude towards detainees. These attitudes, which were affirmed by Inquiry team observations, were reflected in the highly restrictive regimes applied at both centres.

Restrictive Regime – Lockdowns[195] and Use of Restraints

7.15 During this time detainees in both centres spent virtually no time out of their cells and all meals were served in the cells. Detainees were locked in their cells for 23 to 24 hours per day for 23 continuous days between 20 January and 12 February, and were only allowed out for the time it took to make a telephone call or to meet with a psychologist to undergo a risk assessment.

7.16 Although it appears that the lockdowns were dictated by a combination of factors including staff shortages, suspension of the normal program and the need to assess the security risks, no legal authority or reasonable explanation for the length of the lockdowns over this period has been provided by the Department.

7.17 There was no consideration as to whether the application of such a restrictive regime was reasonable for all detainees. It was particularly inappropriate because the Department did not accurately identify those detainees who were involved in the riot. The lockdowns were applied to all detainees, regardless of their age or circumstances. It included those who had actively refused to take part in the riot and some who had not even been in custody at the time of the riot.

7.18 It is entirely unacceptable, whatever the circumstances, for the detainees to have been confined to their cells for 23 to 24 hours a day for this length of time. This regime of confinement was contrary to the legislative framework in the *Young Offenders Act 1994* and it is difficult to interpret it as anything other than punitive.[196] In fact, the regime was more punitive than the conditions normally applied when a detainee is confined to a cell as punishment for a detention offence. In that circumstance a detainee is required to have two hours of exercise for each 24 hour period of confinement.[197]

195 This report uses the terms 'lockdown' or 'lockdowns' to refer to situations where detainees are locked inside their cells. During non-lockdown times detainees may still be confined within their locked unit, unless allowed outside for recreation or otherwise.

196 Section 7(c) of the *Young Offenders Act 1994* provides that a young person who commits an offence is not to be treated more severely because of the offence than the person would have been treated if an adult and section 7(j) provides that punishment of a young person for an offence should be designed so as to give the offender an opportunity to develop a sense of social responsibility and otherwise to develop in beneficial and socially acceptable ways.

197 *Young Offenders Regulations 1995* (WA) reg 79.

7.19 All detainees in both centres were routinely mechanically restrained (handcuffs or flexi-cuffs to the front of the body or handcuffed to each other in pairs) for any movements within the centres. Handcuffs were even applied when a detainee was simply making a telephone call in their unit.

Photo 19: Detainees at Banksia Hill were required to be handcuffed to each other in order to move around the centre.

7.20 The Department contended that the application of restraints was necessary at Banksia Hill because the broken glass and other debris around the site posed a risk to the safety of detainees and staff. At Hakea, there were suggestions that an unrestrained detainee might access the internal courtyard of Unit 5, climb onto the roof and from there access the rest of the prison and come into contact with adult prisoners. However, there were no individual risk assessments of detainees and little regard seems to have been given to the fact that most of the detainees still held at Banksia Hill had not been involved in the riot. It was not reasonable to assume that every detainee at Banksia Hill presented such a risk that restraints were universally required. Unlike Banksia Hill, Unit 5 at Hakea JF was not affected by broken glass and the risk that detainees might climb onto the roof seemed exaggerated, given the high level of staff supervision in Unit 5.

7.21 Irrespective of the Department's views, the law only authorises the use of mechanical restraints in the circumstances provided by section 11D of the *Young Offenders Act 1994*. Under that Act, the use of restraints is permitted only when an individual detainee is imminently presenting a risk of physical injury to himself or others, where restraints are required on medical grounds, and where detainees are being escorted outside the facility. Accordingly, the routine mechanical restraint of detainees for movements within the centres was in breach of the *Young Offenders Act 1994*.

7.22 This conclusion is supported by the comments of the President of the Children's Court of Western Australia during a recent test case on the relevance of harshness of detention conditions in the sentencing process for young offenders. In *The State of Western Australia v JAB*[198] ('the JAB case'), his Honour Judge Reynolds made reference to the management issues arising from detainees being located at Banksia Hill and Hakea JF and the conditions for the detainees at both facilities. He referred to the use of restraints on detainees and said:

> The material provided by DCS includes a directive given to staff at [Banksia Hill] on 1 February 2013 that 'the escorting of detainees within the centre will continue with restraints except in the circumstances listed above'. One of the circumstances listed above in that directive is that 'detainees within a secure room during interview (psych, legal etc) are not to be restrained unless requested to do so by the interviewer'.
>
> I have already referred to the fact that after the incident at [Banksia Hill] restraints were used on detainees who were not involved in the incident on 20 January 2013.
>
> Section 11D(1) of the YO Act provides as follows:
>
> > 11D. Use of restraints
> >
> > (1) The chief executive officer, or a superintendent, may authorise and direct the restraint of a young offender where in his or her opinion such restraint is necessary—
> >
> > (a) to prevent the young offender injuring himself or herself, or any other person; or
> >
> > (b) upon considering advice from a medical practitioner, on medical grounds; or
> >
> > (c) to prevent the escape of a young offender during his or her movement to or from a facility or detention centre, or during his or her temporary absence from a facility or detention centre.
>
> Section 11D(1) clearly requires the chief executive officer or superintendent to be satisfied that restraint is necessary in the case of the particular individual restrained. A separate consideration is required for each particular individual. In my view the direction to which I have just referred is not authorised by s 11D(1) of the YO Act. The particular circumstance referred to is also unlawful because it purports to give authority to someone who does not have any under the YO Act to decide whether a young detainee is restrained. I do not think that a psychologist would want to interview a detainee when the detainee was restrained but interviews would not necessarily be limited to psychologists.[199]

7.23 In its response to the Inquiry's draft report the Department commented 'With respect, the Department does not agree with His Honour Judge Reynolds that section 11D(1) required an individual assessment of each young person in the circumstances under discussion'.

198 [2013] WACC 3.
199 Ibid, [36–37].

7.24 The Department had an opportunity to provide a more positive regime to youth remaining at Banksia Hill during these early days after the riot. However, detainees were treated as if they were all responsible and posed a high risk to security and safety. A good many of these detainees, might have been trusted with and duly rewarded for their contribution in helping clean up units and grounds with an appropriate level of supervision and risk management. Interested students could have had limited contact with teachers. This may have helped rebuild damaged relations with staff and create a good foundation for cooperation and mutual respect in the coming difficult months.

7.25 Instead, discussions with detainees during the Inquiry confirmed that those who were not involved felt a keen sense of injustice at the way they had been treated in the aftermath of the riot. There had been little recognition and no effort to provide a reward for those who had chosen not to participate. They were essentially treated no differently to those who had participated in the riot. Many said that their treatment since the riot made them wish that they had taken part. This experience was not only disheartening but also potentially damaging to the rehabilitation prospects of a significant cohort of detainees.

HAKEA JF (4 FEBRUARY TO MID-JUNE 2013)

Safety and Security

7.26 Units 11 and 12 are physically separated from any other part of the prison by about 50 metres and are also enclosed by a five metre high cyclone fence. The security and privacy of the Unit 11 and 12 precinct was increased by modifications to the surrounding fence. The section of the fence separating the area from the rest of the prison was covered with a shade cloth screening to a height of about two metres. This eliminated any visual contact with the rest of the prison at ground level. In addition, razor wire was installed on top of every fence in the precinct and on the roofs of the accommodation buildings. Detainees also did not need to move through other parts of the prison except when attending visit sessions or leaving the prison.

Photo 20: Shadecloth added to perimeter fencing of Hakea Units 11 and 12.

Photo 21: Entry to Hakea Units 11 and 12.

7.27 The location of Units 11 and 12 and the measures taken by the Department to make them safer and secure ensured that any potential contact with adult prisoners was minimised. Although it is accepted that most of the measures taken were necessary to meet the requirement that detainees be separated from adults, inevitably, it also made the environment more oppressive and intimidating.

Environment and Facilities

7.28 Units 11 and 12 are the newest accommodation units at Hakea. Both units are clean, modern and spacious, with large common areas. Cells are more spacious than those at Banksia Hill, a fact that was appreciated by detainees. However, it was clearly a more oppressive and confined environment than detainees were accustomed to at Banksia Hill. Security infrastructure is highly visible with razor wire, fences, bars and grilles all in abundance. The Unit 11 and 12 compound is relatively small when compared with the grounds of Banksia Hill and does not have the same sense of openness and space.

Photo 22: Razor wire retrofitted to roof edges to prevent ascents.

7.29 Facilities in each unit included four staff offices and two program rooms which were variously utilised for interviews, counselling, education and health services. The Department dropped three demountable units into the precinct to provide more space for delivery of services on 20 February, but various delays meant that they were not fully operational until 25 March. This lengthy delay deprived detainees of much-needed activities and services. Even with the extra space provided by the demountable units, infrastructure for services was fundamentally inadequate to cater for the size of the detainee population at Hakea JF.

Transferring to Units 11 and 12

7.30 On Monday 4 February 2013, the detainees in Unit 5 at Hakea were transferred to the vacant Unit 12. A few days later, on Thursday 7 February and Friday 8 February, 71 detainees from Banksia Hill were transferred into Unit 11. The inquiry team observed the arrival of some of the detainees at Unit 11. It was an unnecessarily intimidating process for detainees. The transport vehicle parked about 10 metres from the door to Unit 11. Despite this short distance, detainees were handcuffed prior to leaving the vehicle and were escorted into the unit by a YCO with numerous other officers hovering in close proximity. Once inside, handcuffs were removed and detainees were instructed to sit on their hands on a bench in the common area of the unit. Again, there was a heavy presence of YCOs and prison officers surrounding the group of 10 detainees.

Photo 23: Detainees were met with a heavy security presence upon arrival at Hakea JF.

7.31 One of the YCOs spoke to the group of detainees emphasising that the detainees were inside a prison now. They were told in no uncertain terms that they would therefore be treated differently. They were also told, contrary to law, that prison rules would apply to them. In law, because Unit 11 and 12 had been declared as a juvenile detention centre, the same rules applied as at Banksia Hill. This introduction for detainees signalled some worrying changes that did not accord with youth custodial philosophies of rehabilitation. This included the directive to no longer address YCOs by their first names, and instead to address them as 'sir' or 'miss'. Detainees were also told that when in their cells, if an officer opened the viewing hatch in the door, the detainee must stand at the back of the cell with their shirt tucked in and their arms extended downward with palms facing out.

7.32 It is quite understandable that officers felt a need to 'draw a line' with detainees; however, it is quite unacceptable that this was done in ignorance or in flagrant breach of the law.

Staff

7.33 The attitude of YCOs towards working at Hakea JF differed greatly among individuals. Some YCOs were happy at Hakea, welcoming the high security environment as an opportunity to establish stricter routines and standards of behaviour. In contrast, other YCOs were affronted by the secure infrastructure (particularly the bars and razor wire) and were concerned that an increased emphasis on authority and security was being achieved at the expense of good interaction and positive relationships with detainees.

7.34 Poor staff morale and high levels of absenteeism continued to be an issue. The added stress of a new and unfamiliar work environment coupled with the trauma experienced during the riot and its aftermath resulted in even higher levels of staff absence. In Units 11 and 12 at Hakea JF, a full roster required 37 YCOs. In the months following the riot, it was common for 10 YCOs to be absent on any given day and absences were occasionally as high as 18. This naturally had an enormous affect on the operation of the units. More than any other factor, it diminished the Department's ability to provide an appropriate structured daily program of activities for detainees.

Lockdowns

7.35 The extensive lockdowns experienced by detainees in the first two weeks after the riot continued until 12 February. By that time, they had been subjected to this highly restrictive regime for 23 continuous days. There is no reasonable explanation for the continuation of this lockdown regime, particularly in Units 11 and 12, which provided a highly safe and secure environment.

7.36 The Department established a 'structured day' program in Unit 11 and 12 on 12 February 2103. Even if fully implemented this would have involved an average of 15 hours lock down per day over the course of a week at Hakea JF. This is excessive and is not acceptable as a base figure for lockdowns in a detention centre.

7.37 In practice, however, detainees continued to experience more extensive periods of lockdown. In addition to scheduled lockdowns, ongoing staff shortages and resourcing issues meant that detainees were also subject to a significant number of unscheduled lockdowns. Actual lockdown hours frequently exceeded the times set by the Department in its structured day program. Unfortunately, the Inquiry team has been unable to establish the precise number and duration of the unscheduled lockdowns because Department has not kept adequate records.[200]

7.38 The President of the Children's Court has expressed his concern about the Department's lack of record keeping and its inability to answer specific questions both in correspondence to the Department and to this Inquiry. Judge Reynolds requested information from the Department in the form of detention management reports (DMRs) to assist the court in determining what weight should be given to the harshness of conditions for young offenders

200 Poor documentation and record keeping was also one of the findings of the Inspection of Banksia Hill in 2011. See OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 76 (March 2012) iv, 48.

and has commented that the reports continue to be generic rather than individualised particularly as to the structured-day program, lockdowns and rehabilitation programs.[201] In a letter to the Inquiry dated 22 May 2013, Judge Reynolds commented, in part:

> The DMRs show that record keeping by DCS of relevant information on detainees is poor. DCS has been unable to provide information for individual detainees in relation to schooling, recreational activities, lock-downs and the use of restraints. Given the importance of those activities, it is highly likely that DCS also does not record other relevant information. This raises the question, how can YJD case manage the rehabilitation of individual detainees without such information?

7.39 The President of the Children's Court has also criticised the continuing and restrictive nature of the lockdown regime. When dealing with the three young offenders involved in the JAB case, Judge Reynolds concluded that the ongoing lockdowns equated to a 'daily average per week of 17 and two-third hours per week'. He said, in part:

> That figure, it seems to me, would be dependent on there being no staff shortages…
>
> Then in addition to this 17 and two-thirds hours per day per week on average, there will be periods of time when people have been locked in their cell or within the unit but outside the cell, but at the same time secure in a limited space having meals. So it can be seen from all of that that the extent of the lockdowns is extremely extensive, harsh and onerous and not what one should expect at a juvenile detention centre.
>
> So my comment on all of that is that this extremely high level of lockdown time is completely contrary to the legislative framework in the *Young Offenders Act 1994*. While the Act makes it clear that one of the purposes of detention is punishment, the Act also makes it clear that another one of the purposes of detention is rehabilitation. Lockdowns of this magnitude are not only contrary to the purpose of rehabilitation but, even worse, they will likely result in already-damaged children becoming even more so.[202]

7.40 Overall, the amount of time that detainees were spending locked in cell at Hakea JF was entirely unacceptable.

201 Judge Reynolds D J, Children's Court of Western Australia to the Department, letter (19 April 2013).
202 Transcript of Proceedings, *State of Western Australia v BAJG* (Unreported, the Children's Court of Western Australia, KT35/12, Reynolds J, 27 March 2013) 50.

Recreation

7.41 The time and space available for detainees to participate in outdoor recreation at Hakea JF was insufficient. The structured day program did not even guarantee one hour of outdoor recreation per day for all detainees. Some detainees had as little as four hours per week of scheduled outdoor recreation. As with all other services, detainee access to recreation was heavily dependent on staff availability. Ongoing staffing shortages meant that actual outdoor recreation time was frequently far less than scheduled.

7.42 Facilities for outdoor recreation in Units 11 and 12 included a grassed area and a basketball court between the units. Adjacent to the units but separated by fences is an oval. When Unit 11 and 12 were first selected as temporary accommodation for the detainees, the oval was seen as a significant asset that would allow detainees access to outdoor recreation. Unfortunately, the oval was found to be in poor condition. The surface was uneven and scattered with building rubble left over from the construction of Unit 11 and 12. Remedial works were required and the oval was not considered to be fit for any sort of use until April 2013. Even then, it was not considered safe to play competitive sport. Detainees were permitted onto the oval in groups of up to 40, but they were restricted to walking laps or kicking a ball to each other.

7.43 Even during very recent visits, it was observed that detainees were not even provided with a usable ball on the oval (though many balls were trapped in the razor wire). Far from being a positive opportunity, outdoor 'recreation' for these detainees involved nothing more than aimless and frustrating meandering.

Education and Programs

7.44 The education program had been completely suspended in the aftermath of the riot and it was not until detainees were transferred to Hakea JF that the first attempts were made to re-engage detainees with education. Education classes did not commence at Hakea JF until 18 February 2013, a full month after the riot. The structured day schedule provided for a maximum of nine hours per week of education for each detainee. This was clearly inadequate, and less than half of the 20 hours of education that detainees received under the normal regime at Banksia Hill before the riot.

7.45 The main factor in this diminished service delivery was the lack of available classroom space. Three program rooms were used, with 16 detainees attending each room. A fourth classroom became available when the demountable units were opened, but this was not until 25 March. Even then, maximum classroom capacity was 64 detainees at any one time, and Hakea JF typically held twice that number of detainees.

7.46 Teachers also noted that they were working with limited resources. There were no computers available for education at Hakea JF and any other educational resources were limited to what could be carried into the prison by education staff. Teachers reported that it was more difficult to keep detainees engaged and stimulated, particularly the older detainees and those at higher education levels.

7.47 Program delivery was even more severely restricted by space. There were no rooms available for offender, health or personal development programs until demountable buildings were provided. As noted above, three demountable units were installed on 20 February, but were not fully operational until 25 March. In March, only the Department's 'Emotional Management' program and Mission Australia's 'Motivation to Change' programs were delivered at Hakea JF, both commencing in the second week of March.

7.48 Thereafter, delivery of programs continued to be limited. A further offender rehabilitation program focussed on sentenced detainees commenced in April, as did two key programs available to detainees on remand. However, it was not until May that other key health and personal development programs were added to the service provision.

7.49 A failure to provide programs is likely to enhance community risk and reduce the prospects of successful reintegration. The Department is also legislatively required to provide a rehabilitative regime. The Chairman of the Supervised Release Review Board, the Hon Michael Murray QC, wrote to the Department in February and March 2013 expressing the firm view that functions of the Review Board were being made more difficult by the lack of availability for detainees of necessary assessment, treatment, remedial and educational programs.

7.50 That position has continued. In a letter to the Department in early July 2013 the Chairman said, in part:

> As you know, the Board has been struggling with its decision-making process since at least the beginning of March against the background of the general unavailability of remedial and training programs while the inmates are in Hakea (particularly psychological counselling and treatment programs). We have had to take greater risks in our decisions to make Supervised Release Orders than we would ordinarily regard as acceptable, and I think it is true to say that there has been a noticeable boost in the failure rate when orders have been made before the young offenders have been ready to take advantage of supervised early release. That difficulty will no doubt continue for some months after normal service is resumed.[203]

Food, Clothing and Bedding

7.51 During the Inquiry, complaints were made about the poor quality of the food and particularly about the inadequate quantity of food provided, with allegations that this had resulted in significant weight loss for some detainees. After some weeks at Hakea JF, it was discovered that the pre-packaged meals provided for detainees' lunch and dinner by the Hakea kitchen contained considerably smaller portions than those being distributed to adult prisoners.

7.52 Compounding this issue was the failure to provide morning tea to detainees during these first few weeks. In the youth custodial system, in recognition of the increased appetites of growing adolescents, it was established practice to provide morning tea for detainees. This was not instituted at Hakea JF until 18 February.

203 The Hon M J Murray QC, Chairman, Supervised Release to the Department, letter (10 July 2013).

7.53 The Department installed a significant amount of additional equipment in the Hakea kitchen and a staff member from the Banksia Hill kitchen was placed at Hakea permanently to oversee preparation of detainee food. From this point, the issues such as portion size and provision of morning and afternoon tea began to be addressed. However, complaints about food quality continued and breakfast portion sizes had still not been increased by the end of May.

7.54 During the Inquiry respondents to the detainee survey noted problems with access to clean clothing and bedding. Detainees claimed that they were forced to wear clothing and underwear for days on end and that sheets and towels were sometimes not changed for weeks. Some detainees reported that they washed their own clothes in the shower or sink in their cell. Many had only one set of clothing in their cell and so could only wear a towel while they waited for their clothes to dry.

Social Visits

7.55 In order to accommodate the detainees having social visits, prisoners were locked down during the visiting times allocated to juveniles. The detainees were transferred to the Hakea visits centre in a vehicle, strip searched prior to their visit and seated at tables in the visits hall before their visitors were allowed in. Visitors were required to submit to a higher level of security than they were used to at Banksia Hill, including a walk-through metal detector, an iris biometric recognition scanner and more frequent presence of drug detection dogs. Information about these visit arrangements was sent to parents and placed on the Department's website.

7.56 While the resumption of regular visits was welcomed, there were some teething problems and in particular some considerable distress for detainees and families over the exclusion of relatives (other than immediate family) and friends from social visits. These restrictions were lifted only gradually through protracted negotiations between managers from Banksia Hill and Hakea, starting after a couple of weeks with a restoration of visit rights by partners and children of detainees and an increase in the size of visit parties to five, from 16 March. Ultimately, by 5 April, a second visit session was allowed each day at 5.10 pm. Nonetheless, it took over 10 weeks before visit services for detainees held at Hakea were restored to a normal level.

7.57 Sadly, for regional detainees held at Hakea JF, family video visits have not been available since the riot. While detainees are transported to Banksia Hill for court video links the afternoon prior to their scheduled appearance, no such arrangement is in place to facilitate family video visits. Indeed, the Inquiry was informed that family video visits had already fallen away after the transfer of detainees from Rangeview to Banksia Hill in October 2012, as the amalgamated centre was left with a single video-link facility which was overwhelmingly needed for court video-link purposes. This is most concerning for a system that was originally installed to facilitate family participation in case conferences and family visits for detainees.

Official Visits

7.58 Official visits arrangements for detainees at Hakea have been particularly problematic and a major source of complaint by legal practitioners and others. Units 11 and 12 as originally occupied, as well as Unit 5 before, did not have enough interview rooms to accommodate consultations by psychologists and other medical practitioners, or to facilitate case planning reviews. At first, many of these interviews had to take place on picnic tables outside, in a corner of the unit, or in a programs room which also acted as a staff lunch room. Eventually, by late March, access to an interview room in one of the demountables was made available.

7.59 A permanent reservation was made in the Hakea Official Visits centre for non-departmental official visitors such as lawyers. The main difficulty, however, was moving the youth to and from Units 11 and 12 in a way that prevented any contact with adult prisoners. As only one vehicle was available to service this and other requirements, there were often considerable delays in producing the young person required for the visit.

Transport Hub

7.60 Following the transfer, it was realised that morning escorts of detainees from Hakea JF through Hakea Reception to court at the same time as outgoing prisoner escorts, medical escorts and returns from court, was unsustainable. It was too difficult to maintain adequate separation between detainees and adult prisoners at these busy times.

7.61 It was therefore determined that Banksia Hill would remain as the hub for all external transports of detainees. Detainees at Hakea JF required in court the next day (whether in person or via a video-link) or due to appear before the Supervised Release Review Board were therefore transferred to Banksia Hill. The daily transfer also included detainees who had misbehaved and required separation from other detainees and detainees who required medical treatment or needed to be kept under observation for mental health or other reasons.

Strip-searches

7.62 The DMRs provided by the Department to the Children's Court in March and April 2013 confirmed that from 20 January 2013 detainees were strip searched when transferring from one detention centre to another (Hakea JF to Banksia Hill and vice versa) and on leaving or returning to the detention centre (for example, for court appearances). Detainees were also strip searched before and after every social visit up until 5 March 2013 when the search prior to the visit was discontinued.

7.63 As Banksia Hill had become the transfer hub for all external transport of detainees from both facilities the amount of times that some detainees have been strip searched increased markedly. Two recent examples obtained from DMRs are illustrative. In one case, a detainee was strip searched once (on admission) between 13 October 2012 and 21 January 2013. From 21 January to 28 June 2013 he spent approximately four months in detention and was strip searched 62 times (15 times per month) relating to transfers to and from Hakea JF and in relation to court appearances. In another case, between 2 March and 18 June 2013 (three and a half months) a detainee was strip searched 42 times relating to transfers to and from Hakea JF.

7.64 The use of strip-searching at Banksia Hill was examined in a June 2008 inspection of Banksia Hill and although the Department agreed to review the practices and procedures relating to the strip searching of detainees, it appears that there has been little change. At the time of the inspection in 2008, detainees at Banksia Hill were routinely strip-searched on every entry into and exit from the centre. Strip-searches were conducted on detainees arriving from Rangeview, despite having been strip-searched there prior to travelling in a secure vehicle (staffed by juvenile custodial officers) and disembarking in the secure sally port at Banksia Hill. This double search process was said to be unnecessary, as there should have been no opportunity after strip-searching at Rangeview for a detainee to access any contraband, weapon or self-harm implement prior to arriving at Banksia Hill. There was no clear risk to be mitigated by a second strip-search.[204]

7.65 The Acting Inspector commented that:

> In the majority of cases, strip-searches were undertaken as part of routine procedure rather than in response to suspicion or information received. The use of strip-searching as a routine practice at Banksia Hill cannot be justified from a risk management perspective – it should be targeted based on reasonable suspicion. The extensive use of routine strip-searches is a breach of human rights and dignity, at odds with the otherwise individual-focused care of detainees maintained by the centre.[205]

7.66 Regulation 86(2) of the *Young Offenders Regulations 1995* provides that a detainee should be strip-searched if there are circumstances giving rise to a reasonable suspicion that the detainee may be in possession of an item that could jeopardise the safety, good order or security of the detention centre or could be used for self-harm.

7.67 Notwithstanding the provisions of regulation 86(2), the Department's standing orders made strip-search mandatory for detainees on admission and discharge,[206] transfer between detention centres and departure or return to a detention centre.

7.68 Strip-searches are invasive and even if conducted appropriately, they can be embarrassing and raise considerable feelings of anguish or inferiority, particularly for more vulnerable young detainees. It is clear that the conduct of a strip-search, upon the reasonable suspicion set out in regulation 86(2), could not be regarded as unlawful or unreasonable. There is a need to for some security measures to prevent contraband from entering detention centres. However, to subject detainees to routine strip-searches, particularly before and after social visits, without a proper evaluation of whether it was needed in a particular individual case or situation was unreasonable and contrary to the intent of regulation 86(2).

204 OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 58 (December 2008) [2.32].
205 Ibid, [2.38].
206 Standing Order 17

7.69 The President of the Children's Court, Reynolds J, has also expressed the view the practice of strip-searching is overused:

> In relation to strip-searching, I have already expressed the point that I think it is highly embarrassing, degrading. It is also very humiliating. Strip-searching seems to be overly used. There does not seem to be any discretion to decide whether or not it is needed in a particular case, in a particular situation. There is just this broad brush approach which I do not think is appropriate. It seems to be happening in relation to attendances at court, which is highly undesirable. Accepting that it has happened when Mr Hawkins has visited JAB – that is in my view totally unacceptable, and without good reason.[207]

7.70 Reference was also made in the above case to the affect of strip-searches on detainees at the time of social visits. Information provided by counsel for one of the detainees was that the detainee had asked his family to stop visiting him because he did not want to be subjected to the humiliation of a strip-search before and after the visit.[208]

BANKSIA HILL (4 FEBRUARY TO MID-JUNE 2013)

Who Was at Banksia Hill?

7.71 After most of the male detainees were transferred to Hakea JF on 7 and 8 February 2013, 33 young people were left at Banksia Hill. These included 10 young women and girls, residing in Yeeda Unit. There were also four male remandees under fourteen years of age as management had decided that detainees in that age group would not be sent to Hakea.

7.72 There were another 19 older male detainees, most of whom were eligible for bail and imminently due back in court or who had been sentenced but were due for release. A few were kept at Banksia Hill for welfare or management reasons. The male detainees (including the four under 14 years of age) were accommodated in the Harding Unit which has 28 standard cells, five with double bunks, and eight management and observations beds.

Transport Hub

7.73 Following the transfer, it was realised that morning escorts of detainees from Hakea JF through Hakea Reception to court at the same time as outgoing prisoner escorts, medical escorts and returns from court, was unsustainable. It was too difficult to maintain adequate separation between detainees and adult prisoners at these busy times.

7.74 It was therefore determined that Banksia Hill would remain as the hub for all external transports of detainees. Detainees at Hakea JF required in court the next day (whether in person or via a video-link) or due to appear before the Supervised Release Review Board were therefore transferred to Banksia Hill. The daily transfer also included detainees who had misbehaved and required separation from other detainees and detainees who required medical treatment or needed to be kept under observation for mental health or other reasons.

207 Transcript of Proceedings, *State of Western Australia v BAJG* (Unreported, the Children's Court of Western Australia, KT35/12, Reynolds J, 27 March 2013) 53.
208 Ibid, 34.

The Harding Unit

7.75 Banksia Hill also continued to be the reception centre for all arrested detainees brought in by police, detainees newly remanded from metropolitan children's courts and for detainees transported by the regional youth transport service from remote and regional areas. Together with its role as the transport hub and releasing facility, Banksia Hill reception, located in the Harding Unit, was exceedingly busy.

7.76 Staff in the Harding Unit therefore had to cope most days with multiple movements and diverse detainee needs. The operation of the unit was often affected by short staffing caused by high levels of staff absences of various kinds and at times extra resources were needed to cover other operational requirements. On such days, time out of cell for detainees in the Harding Unit was extremely limited.

7.77 On the other hand, the Harding Unit often benefited from the presence of recovery staff, regional transport staff and admissions staff which made it possible to start to allow detainees to stay up for meals, undertake more cleaning and laundry duties and have more phone calls. Eventually, in March, detainees were also allowed to have recreation time in the yard adjacent to one of the wings and to play table tennis in the wings.

Female Detainees[209]

7.78 The selective staff roster in the girls' precinct (Yeeda Unit) had largely survived the crisis,[210] so there was a greater consistency in detainee care and management practices than in other areas. The girls had intermittent access to recreation in the gym and were able to make a canteen order on 27 January, just a week after the riot. One young woman was allowed to continue to reside in the self-care unit.

7.79 Classes recommenced in the Yeeda Unit on 12 February, three weeks after the riot. These were well resourced, with two education staff in each of the two classrooms. By that time there were only 10 remanded or sentenced girls in residence. Numbers of sentenced and remanded female detainees continued in the 9–13 range in the following few months.

7.80 The girls were progressively allowed to leave their cells to make their own breakfasts, help distribute lunches and evening meals, clean, do laundry and perform the Saturday morning wing clean-up. Even so, for the following three months they continued to be confined to their cells, typically for 15 to 19 hours per day on weekdays and for 15 to 22 hours per day on weekends.

209 As the primary focus of this Inquiry is male detainees, and it is three years since OICS last examined the detention of females, there was a discrete inspection of their circumstances during May 2013. The report of this inspection will be separately published in the last quarter of 2013.

210 In Yeeda Unit the staff roster was made up of officers who were specifically selected or recruited to work with the female detainees.

The Youngest Detainees

7.81 The under 14 year old boys who remained at Banksia Hill after most of their older peers had been transferred to Hakea JF, had no designated residential area of their own. They were simply scattered between the wings in the Harding Unit along with the other male detainees.

7.82 An effort was made to get detainees from these wings to the gymnasium for an hour each day, with others having exercise time in the caged yard in the Harding Unit. However, the ever-changing cycle of detainee movements, detainees on management regimes, and detainees with special needs, in combination with staffing shortages meant that it was a struggle to maintain any kind of consistency in the regime including access to recreation. The first real change in their program was in the week beginning 18 February when up to 16 of the youngest detainees were allowed to attend school in the junior school area adjacent to the Harding Unit.

7.83 Between 8 and 28 February 2013, there were numerous occasions on which Harding Unit had to manage over 28 young males overnight (being the number of standard cells), due mainly to the number of detainees transferred from Hakea JF for court or board appearances the next day, in concert with incoming detainees from police or regional courts.[211] When such an influx was anticipated, some of the detainees resident in Harding had to be doubled up, either in double-bunked cells or using a mattress on the floor. This included the youngest detainees, who were certainly at-risk of being doubled with older detainees returning from Hakea JF or newly admitted to Banksia Hill.

7.84 Accordingly, in early March a decision was taken to place seven male detainees, under the age of 15 years, in the girls' unit. In principle, the placement of young males in the same unit as young females and the compromise to privacy for young women and girls is exactly the situation that the separate girls' precinct was designed to prevent. However, in practice, strict separation was maintained between male and female detainees in the Yeeda Unit and the arrangement provided a greater degree of stability for the youngest boys in custody including more regular access to time out of cell, recreation and schooling than could be achieved for them in the Harding Unit.

Education and Programs

7.85 As noted above, female detainees were able to attend school from 12 February 2013 and young males from 18 February. After a time, selected older detainees nominated by education were added to the class lists in the junior school. Older detainees resident at the Harding Unit for special needs were the first to benefit from this. In May, as numbers of female detainees began to climb, a second classroom was also reopened making six classes in all, catering for up to 32 male students and 16 females.

7.86 With almost all detainees in the Harding and Yeeda Units attending school, supervision was able to be reduced and YCOs were able to attend to other chores. This in turn made it possible to offer more out of cell time before and after school either in their wings, or in the gym. Increasingly in late March, April and May, the main yard at the back of the Harding Unit was being used for all of the detainees for recreation and socialisation, before and after school and at lunch time. Staff were often seen speaking to detainees about their issues, playing chess or cards with detainees or otherwise supervising their recreation.

211 This happened on 12 occasions in February 2013.

7.87 Although there was a significant setback in provision of personal development and rehabilitation group programs for four to six weeks after the riot, by March 2013 an essentially normal level of group programs was provided to all of the detainees still resident at Banksia Hill.

SUMMARY: HAVE HAKEA JF AND BANKSIA HILL BEEN MEETING THE REQUIREMENTS OF THE YOUNG OFFENDERS ACT?

7.88 One of the principles to be observed in the performance of functions under the *Young Offenders Act 1994* is that the detention of a young person in custody is to be in a facility that is suitable for a young person and at which the young person is not exposed to contact with any adult in the facility.[212] In keeping with this principle the Department's own standards for the management of its youth custodial facilities provide that:

- 5.1 The objectives of youth custodial facilities should be to provide a humane, safe and secure environment, which assist young people to address their offending behaviour and to make positive choices about their offending behaviour, both during custody and upon their return to the community.
- 5.2 Youth Custodial facilities should aim to maximise young people's chances of rehabilitation and integration into society.
- 5.3 The fundamental principles of this philosophy are to provide young people in youth custodial facilities with:
    - 5.3.1 a safe and secure environment
    - 5.3.2 living conditions that meet duty-of-care requirements
    - 5.3.3 privacy and dignity
    - 5.3.4 programs and services that meet their educational, vocational and gender and age-related needs
    - 5.3.5 adequate health services
    - 5.3.6 adequate recreation facilities
    - 5.3.7 an acknowledgement of the complexities of cultural diversity of the population and the wider community.[213]

7.89 Since 20 January 2013, however, the Department cannot be said to have met its own standards in providing a suitable facility for the detainees at Banksia Hill and Hakea JF.

7.90 The immediate aftermath of the riot saw the implementation of an oppressive regime of lockdown of all detainees (whether they were involved in the riot or not) for which there is no reasonable explanation and which was contrary to the legislative framework in the *Young Offenders Act 1994*. In addition, detainees were subject to a practice of the routine mechanical restraint which was in breach of the provisions of the *Young Offenders Act 1994*. Early steps should have been taken to prevent the continuation of these conditions.

212 *Young Offenders Act 1994*, section 7(i).
213 DCS, Youth Custodial Rule 1.2 [5].

7.91 What followed by way of the 'structured day' program for the detainees at Hakea JF and Banksia Hill, after 4 February 2013, fell short of providing the positive, busy rehabilitative regime necessary for the detention of young persons. The amount of time detainees were spending locked in a cell remained unacceptable, the time available for education at Hakea JF was less than half of that previously available at Banksia Hill, the time and space available for recreation was insufficient and the delivery of programs was severely restricted. In addition to these deficiencies, detainees suffered the indignity of routine strip-searches before and after social visits.

RECOMMENDATIONS

Recommendation 24

The Department should ensure that:

(a) The number of scheduled and unscheduled lockdowns of detainees is substantially reduced and that accurate records are kept of the reasons for any lockdowns and their duration;

(b) Detainee participation in education, rehabilitative and recreational programs is substantially increased in keeping with the Department's standards for the management of youth custodial facilities; and

(c) Accurate records are kept with respect to each and every detainee of all of these matters.

Recommendation 25

Mechanical restraints must not be used as a routine measure to control the movement of detainees within detention centres. They should only be used following a proper assessment of the risk posed for and by the particular individual to be restrained in accordance with section 11D of the *Young Offenders Act 1994*.

Recommendation 26

The Department should review and alter its practices relating to the strip-searching of detainees:

(a) To cease the practice of routinely strip-searching detainees on every entry and exit to detention centres, particularly when they have been transported in a secure vehicle; and

(b) To ensure that strip-searches in relation to social visits are not routine but are undertaken only on reasonable suspicion of contraband, assessed on a case by case basis.

Chapter 8

A BETTER FUTURE FOR YOUTH JUSTICE IN WESTERN AUSTRALIA

OVERVIEW

8.1 This report has revealed a youth custodial system struggling for identity and direction, and suffering from inconsistent leadership and poor management. Over time, Banksia Hill's performance has fluctuated but the past two years have seen declining performance, increasing risk, poor governance and growing staff disillusion. The riot of 20 January 2013 was a reflection of these problems rather than a cause.

8.2 Although the focus of this Inquiry is on custodial services for juveniles, it has also become increasingly obvious that addressing the problems will require a holistic response. Rational improvements to Youth Custodial Services cannot be considered in isolation from broader questions of prevention, diversion and alternatives to custody. The focus must be on ensuring that resources are efficiently targeted to key areas, including Aboriginal youth, mental health and mental impairment and that there is a more nuanced approach to issues of age, gender and regional diversity.

8.3 This Inquiry has concluded that a fresh approach is required in order to revitalise youth justice, to better embed a genuine whole of government approach, and to ensure vigorous and innovative engagement with non-government agencies. It has also concluded that responsibility for youth justice should no longer reside with the Department of Corrective Services but, as in other Australian jurisdictions, should be placed with an agency whose primary remit is youth justice.

8.4 During the course of this Inquiry it has also become very clear that some fundamental issues are at stake in terms of the future. In particular, the Department has frequently asserted that detainees are now different, and more difficult to manage, and that a fundamental change of direction is required with respect to their management. However, it has produced no evidence to support this view. In reality, most of the issues are depressingly constant.

8.5 Some parts of this chapter reflect whole of government challenges. Others involve systemic matters that need to be addressed by the Department itself, subject to appropriate external support and scrutiny. The chapter contains a series of system-based recommendations that must be addressed if Western Australia is to move forward from the current crisis with a more viable and effective youth justice system. The recommendations in this chapter are to be read along with the rest of the report, including those relating to leadership, management, security and culture.

LEARNING FROM OTHERS

8.6 Western Australia is not alone in having faced major problems in its youth custodial system during the past decade. Victoria, the Australian Capital Territory (ACT) and New Zealand have faced some similar issues to Western Australia and their experiences offer compelling lessons. In all three cases there appears to have been significant improvement within two years. Three of the keys to success are: a sense of immediate urgency; the injection of 'new blood'; and the implementation of a holistic approach which recognises that security and safety are underpinned by an active rehabilitative regime and positive relationships between staff and the youth.

8.7 In Victoria, two major reviews of youth custodial facilities were produced in 2010. A report by the Ombudsman was prompted by serious allegations relating to staff culture.[214] These included breaches of security, rorting and mistreatment of clients,[215] combined with a lack of direction. A report by Neil Comrie (former Chief Commissioner of Victoria Police) examined a range of security issues following escape and some serious assaults on staff.[216] This report revealed numerous security failings. These two reports produced a total of more than 150 recommendations, all bar one of which were accepted by the Victorian government. Although youth justice managers in Victoria acknowledge that they are still addressing some of the issues, there is evidence of improved security, a better staff culture and a more positive rehabilitative regime.

8.8 The Bimberi Youth Justice Centre in the ACT opened in 2008, replacing the Quamby Centre. By 2010, Bimberi was experiencing a range of problems, including high levels of staff absenteeism, an escape attempt, assaults on staff and a complacent security culture. In January 2011 the ACT Human Rights Commission was directed to undertake a review of Bimberi and released its report in July 2011.[217] The Commission and other external stakeholders told the Inquiry that there have been marked improvements in terms of relationships and safety in the past two years.

8.9 In 2004 there was a major riot at the Te Au rere a te Tonga Youth Residential Facility in New Zealand. A judicial inquiry into the riot was undertaken by Judge Harwood. The (unpublished) report of the inquiry prompted a fundamental reassessment of the approach to youth custodial services and risk management. It led to a sharper strategic focus on three core areas: strengthening engagement, a positive structured day, and training staff in techniques for non-violent crisis intervention.[218] The Inquiry was told that the results have been positive and that serious incidents and security challenges have declined.

8.10 The fundamental lessons from Victoria, the ACT and New Zealand mirror the findings of this report: improvement will not come simply from target hardening Banksia Hill or 'toughening' staff responses. A far more holistic approach is required. Common features of successful institutional and systemic reform have been as follows:

- Reducing or pegging the number of youth in detention;
- Having a range of detention options, including regional and lower security facilities;
- Strong central leadership and a clear sense of direction and values;
- Ensuring staff act in accordance with operating philosophies, policies and standards;
- Active engagement by detainees in healthy, positive rehabilitative activities and reduced lockdowns;

214 Ombudsman Victoria, *Whistleblowers Protection Act 2001 Investigation into Conditions at the Melbourne Youth Justice Precinct* (October 2010). See: http://www.ombudsman.vic.gov.au/resources/documents/investigation_into_conditions_at_the_melbourne_youth_justice_precinct_oct_20101.pdf

215 It is significant that in Victoria youth in detention are called clients rather than detainees.

216 Comrie N, *Review of Escape Incident at the Melbourne Youth Justice Centre on 19 May 2010* (unpublished).

217 ACT Human Rights Commission, *The ACT Youth Justice System 2011: A Report to the ACT Legislative Assembly (July 2011).*

218 Advice to the Inquiry from relevant managers in New Zealand. The Inspector gratefully acknowledges their engagement.

- Clear and real incentives for good behaviour and a strong but fair response to poor behaviour;
- A more proactive and less reactive model of staff/detainee engagement;
- Better case management;
- Improved programs and services;
- Intelligent improvements to procedural security;
- Firm and consistent management of staffing issues including welfare concerns and absenteeism.

8.11 In summary, there is every reason to believe that holistic strategies, adopted with a sufficient sense of urgency, can lead to tangible improvements within a relatively short timeframe. There is equal reason to believe that target hardening will create more problems.

NUMBERS, COSTS AND BALANCE

Numbers

8.12 The following table shows that number of youth in detention in Western Australia has generally fluctuated between 160 and 200 since the start of 2011 and that from 2008 to 2010 numbers were generally 140 to 160. From 2002 to 2007, numbers had generally been in the range 110 to 120.

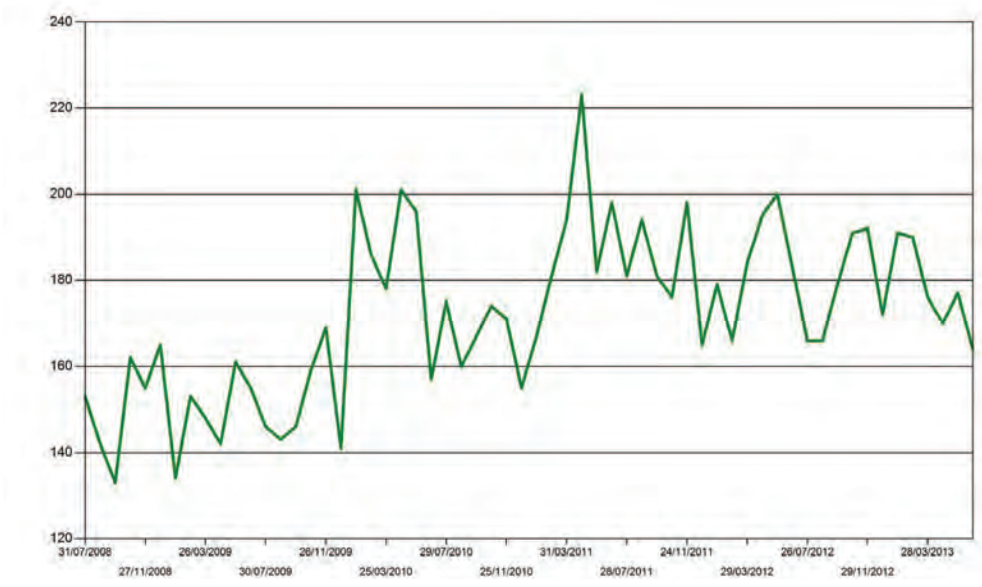


Figure 4. Number of juveniles in detention in Western Australia 2008–2013.[219]

219 http://www.correctiveservices.wa.gov.au/_files/about-us/statistics-publications/statistics/mg-report-1307.pdf

8.13 The following chart shows that Western Australia has a higher rate of juvenile detention than any other Australian jurisdiction except the Northern Territory, and sits at close to twice the national average.

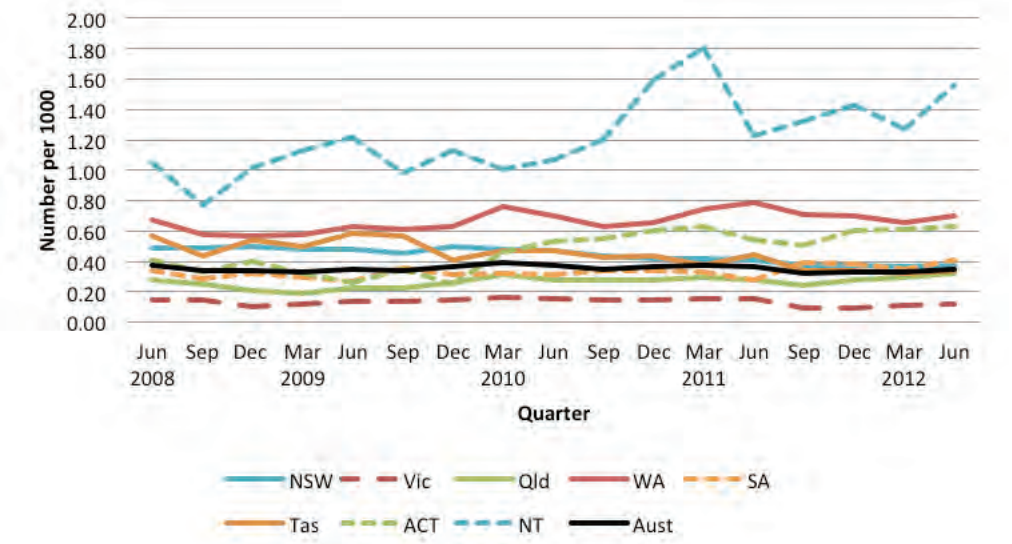


Figure 5. Young people aged 10–17 in detention on an average night, states and territories, June quarter 2008 to June quarter 2012 (rate).[220]

8.14 On a per capita basis, Western Australia has the highest rate of Aboriginal youth incarceration in the country (over 800 per 100,000). This is three times the rate in Queensland and Victoria, more than double the national average and the rate in the Northern Territory, and well ahead of any other jurisdiction.[221] Typically, somewhere between two-thirds and three-quarters of detainees are Aboriginal and the vast majority of detainees aged 14 and under are invariably Aboriginal youth from regional areas.[222]

8.15 Generally, around 50 per cent of detainees are on remand.[223] In the aftermath of the 20 January riot, the President of the Children's Court examined the files of all remandees to consider whether any could be considered for release on bail. His Honour concluded that with only a couple of exceptions, this was not legally or practically possible. In submissions to this Inquiry he emphasised that this pointed to the need for better forms of prevention and diversion at an earlier stage in offenders' lives and also better options for monitoring and supporting young people on bail, especially in regional areas.[224]

220 http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129542551 See also Productivity Commission, *Report on Government Services 2013*, http://www.pc.gov.au/gsp/reports/rogs/2013
221 Productivity Commission, ibid [15.66].
222 See Appendix 4 and Chapter 2.
223 Although patterns vary across the country, this is not unusual: ibid.
224 The Law Reform Commission of Western Australia, *Court Intervention Programs: Final Report, Project No. 96* (June 2009).

Understanding Expenditure and Appraising the Balance

8.16 Youth justice is an expensive business, especially detention. In 2011–2012 the average cost of holding a juvenile in detention in Western Australia was $624 per day or $228,000 per annum.[225] The average daily cost of managing a juvenile through community supervision was $77 per day or $28,000 per annum.[226]

8.17 Broadly speaking, expenditure on youth justice services provided by the Department in 2011–2012 was $100 million out of a total departmental budget of more than $700 million.[227] In 2008–2009 and 2009–2010, expenditure on community based youth justice services was approximately the same as expenditure on juvenile detention but that is no longer the case: figures provided to the Inquiry show that the Department's expenditure on custody now significantly outstrips its expenditure on community justice services.[228]

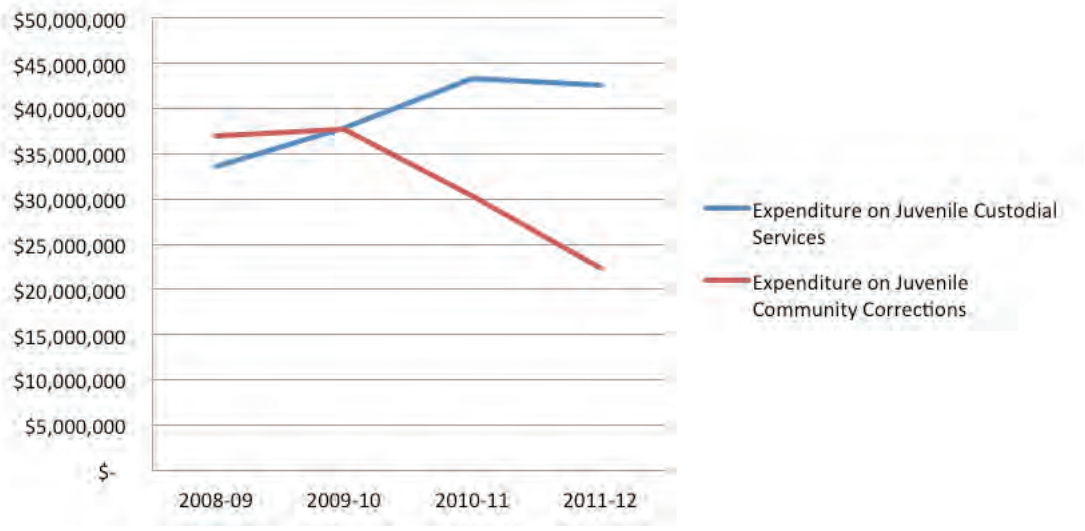


Figure 6. DCS, expenditure on youth justice services in the community and custody 2008–09 to 2011–12

8.18 The Productivity Commission's annual *Report on Government Services* raises some related questions. Nationally, over 86 per cent of 'youth justice clients' are supervised in the community, and fewer than 14 per cent are in detention. In Queensland and Victoria, over 90 per cent are in the community and fewer than 10 per cent in custody. In Western Australia, 20 per cent are in detention, the highest proportion in the country.[229]

225 DCS, *Annual Report 2011–2012*, 113.

226 The cost of managing juveniles, whether in custody or the community, is around double the cost of managing adult offenders: ibid 114. National comparisons are not readily available; however, other jurisdictions have more favourable staff to detainee ratios and consequentially higher staff costs. See Productivity Commission, *Report on Government Services 2013*, http://www.pc.gov.au/gsp/reports/rogs/2013

227 DCS, Budget Estimates 2011–2012.

228 Hon JM Francis, Response to Question on Notice, Legislative Assembly 7 May 2013: http://www.parliament.wa.gov.au/parliament/pquest.nsf/Parliament/pquest.nsf/SrchQON/909E3CC9FED074BD48257B5F002AB9FC?opendocument It is outside the scope of this report to examine the reasons for this change but it supports the argument that further work needs to be undertaken on understanding total costs and priorities for youth justice services.

229 Productivity Commission, *Report on Government Services 2013*, http://www.pc.gov.au/gsp/reports/rogs/2013 [15.64].

8.19 Over recent years, the Department has pursued some important initiatives in terms of youth justice services in the community, including the Metropolitan Youth Bail Service (MYBS) and Regional Youth Justice Services (RYJS). These initiatives formed part of a concerted effort to give the youth justice function a sharper focus within the Department and to make it a business in its own right. Neither MYBS nor RYJS have been adequately evaluated but the available data and anecdotal evidence would suggest that they have achieved some promising results and that there is an opportunity to explore further opportunities.[230]

8.20 Given that Banksia Hill has been full and fragile, and given this comparative data, it is timely for a rigorous review of expenditure on youth justice across the whole of government and of options for the future. Although the Department has primary responsibility for youth justice, such a review will need to embrace other specialist programs which can broadly be classified as involving 'youth justice', but which fall under the auspices of other departments, such as Attorney General, Health and Education. It is not easy to define the exact boundaries and scope of such services or to estimate their costs: for example, programs to counteract truancy have preventive, educational and welfare dimensions.

8.21 Discussions with government agencies would suggest that if you added up all expenditure targeted at youth at-risk across government, it would total more than $200 million outside of the Department of Corrective Services. This includes a broad range of programs such as school psychology services, support to students for whom English is a second language, Aboriginal school attendance grants, recreation camps, drug and alcohol services, mental health services, and services for young people with a disability. Thus, the State's total outlay on youth justice and related youth services is likely to be at least $300 million a year.

8.22 It is clear that a review of total system costs is needed. This should then help to inform decisions at a whole of government level about the best model for delivering youth justice services into the future.

WHICH GOVERNMENT DEPARTMENT?

Transfer from Corrective Services

8.23 Meeting the needs of young offenders requires skills that reside in a range of agencies and services that straddle both the government and non-government sectors. For example, the majority of young offenders have issues requiring specific interventions such as intellectual disability, mental illness, homelessness and trauma. The challenge is to develop a government structure which enables the adage of a whole of government approach to be something more than a platitude. Under current arrangements it has not been easy to achieve multi-agency working as different departments have different mandates and priorities.

230 The Department advised the Inquiry that there have been no evaluations of the metropolitan youth bail service. The Department conducted a preliminary evaluation of RYJS services in the Goldfields and the Midwest Gascoyne from 2009 to 2011: DCS, *Regional Youth Justice Services: Early Impacts Goldfields and Midwest Gascoyne Region*, unpublished and undated. It also advised that there has been no subsequent evaluation of RYJS in these regions or in the Kimberley and Pilbara where they were introduced in 2011.

8.24 Western Australia is the only state where a department responsible for adult offenders also carries responsibility for youth justice. In other jurisdictions, responsibility lies with agencies whose focus is human services, families and children or the administration of justice.[231] As evidenced above, the vast bulk of the Department's budget relates to adult offenders, and adult imprisonment in particular. This inevitably means that adult custodial concerns tend to attract the highest attention. Tellingly, attempts by some senior departmental personnel to articulate the philosophical and operational differences between a 'prison' and a 'detention centre' to this Inquiry and to the Supreme Court lacked clarity and confidence.

8.25 The President of the Children's Court, the Commissioner for Children and Young People and a number of other stakeholders have argued that the Department of Corrective Services should no longer have primary responsibility for driving youth justice and that this responsibility should lie with an agency whose primary remit is children. This Inquiry has reached the same conclusion.

8.26 The main option that has been suggested to date is to transfer the youth justice responsibilities and budget currently allocated to the Department to either a new stand-alone department or to the Department of Child Protection (DCP).[232] DCP has legislative responsibilities with respect to children but little current experience in running places of detention. The main relevant example is a small facility for at-risk children in Parkerville called the Kath French Centre. DCP already has a central role to play in the lives of many children in contact with the justice system and would undoubtedly provide a stronger child-centred focus than the Department of Corrective Services. However, there is no guarantee that changing departments alone will improve service delivery and correctional outcomes and DCP already has myriad roles and responsibilities.[233]

8.27 Rather than layering a new division onto an existing department, it would therefore be preferable to establish a model where one agency has youth justice as its raison d'etre and sole focus. One option is to establish a new Department for Youth Justice which would take over the current budget and functions allocated to the Department of Corrective Services along with any other programs and services identified as appropriate by government. The other is to establish a Youth Justice Commission, building on experience both local and international experience.

231 Productivity Commission, *Report on Government Services 2013*, http://www.pc.gov.au/gsp/reports/rogs/2013 [15.63].

232 Commissioner for Children and Young People, *Youth Justice*, Issues Paper 13 (May 2013) http://www.ccyp.wa.gov.au/files/IssuesPapers/Youth%20Justice%20Issues%20Paper%20May%202013.pdf

233 Similar problems arise with the suggestion that the Department of the Attorney General (DoTAG) might take over responsibility: DoTAG does not have relevant custodial experience and also has numerous other responsibilities and roles.

A Youth Justice Commission?

8.28 As previously noted, one of the major challenges is to coordinate aims, resources, services and practices across the whole of youth justice services and across different agencies. Over 10 years ago, similar problems were recognised in England and Wales. The result was the establishment, in 2000, of the Youth Justice Board (YJB). The geography, context and challenges faced in Western Australia are very different but the model should be actively examined.

8.29 It is not for this report to discuss the workings of the YJB in detail or to examine how a Western Australian version might differ. However, it is important to outline the key features of the YJB. It has a comprehensive remit:

- Monitoring the operation of the whole of the youth justice system, including both secure and community-based services;
- Setting performance standards for youth justice services;
- Identifying and increasing awareness of good practices;
- Commissioning research into prevention, rehabilitation and all other matters relevant to youth offending patterns;
- Commissioning secure accommodation including, but not limited to, Her Majesty's Prison Service; and
- Advising the Minister in relation to each of these matters.

8.30 The Board itself consists of 10–12 members appointed by the Minister. The members are able to bring a wide range of expertise to the task. The YJB administers a budget in excess of £300 million for secure accommodation and has purchased youth residential facilities from three sources: the prison service, the private sector, and local government authorities.

8.31 The YJB drives community-based as well as custodial services. Again it is not a direct service provider but commissions, coordinates and evaluates the services of providers across both the government and non-government sectors. For example, referring to issues relating to the resettlement of youth released from custody, the Board has stated:

> The YJB has already led on the development of seven resettlement consortia across England and Wales. Each consortium … works by facilitating closer working relationships between local authorities, youth justice services and housing and education providers, as well as private and voluntary organisations. The consortia way of working is showing promising early results in terms of resettlement outcomes for young people and a reduction in re-offending.[234]

234 Youth Justice Board (YJB), *Developing the Secure Estate for Children and Young People in England and Wales: Plans until 2015*, 2011, [108]–[109].

8.32 In a later paper, the YJB developed its model for overseeing and supporting community youth justice. The detailed recommendations are not relevant to Western Australia but the broad principles are highly pertinent, namely, devolving services to those best placed in terms of skills and geography to deliver them, and oversighting delivery to ensure that applicable standards are met.[235] Again, services may be provided by government agencies, the private sector and not for profit organisations. This has obvious resonance in this state, not least in the context of services to Aboriginal youth.

8.33 In essence, under the Youth Justice Commission model, the Department of Corrective Services would become, like Her Majesty's Prison Service in the UK, a potential service provider, as would non-government entities and departments responsible for areas such as child protection, education, health and recreation.

8.34 The upfront costs of establishing another agency appear likely to be outweighed by benefits flowing from innovation, transparency and accountability, coordination and efficiency. And while the model may initially seem 'radical', there is a direct parallel in the state already, namely, the Mental Health Commission.[236]

8.35 A corollary of this proposal is that departments and agencies supplying youth services would need to identify those costs so that they could be re-deployed to the Youth Justice Commission. For the first time the State would then have a ready tool for ascertaining exactly how much is being spent on such services and a basis for evaluating whether those moneys are being spent to best effect. At present, their fragmented nature makes it nigh on impossible to understand where the funds are going, whether the services and programs are coordinated across service providers and whether the outcomes are the best that can be achieved.

8.36 The Youth Justice Commission model should also allow the problem of inter-agency collaboration to be better tackled as the oversight role of the Commission would allow it to identify gaps and drive change.

8.37 In summary, responsibility for youth justice should no longer reside with the Department of Corrective Services and should be placed with an agency with a sharp and specific youth justice focus. If this decision is taken, rigorous transition arrangements will need to be put in place.

IMPROVING DEPARTMENTAL ACCOUNTABILITY AND STANDARDS

8.38 Irrespective of decisions regarding future responsibility for juvenile justice, the Department of Corrective Services will be running youth custodial services for some time to come. It is critically important for systems and processes to be put in place to improve accountability and to ensure that performance is measured, monitored and evaluated.

235 YJB, *Improving Outcomes in Community Youth Justice Services: Blueprint 2012*. The Board also emphasised the importance of formal independent inspection services that report to Parliament to examine service delivery and performance.

236 http://www.mentalhealth.wa.gov.au

Record Keeping

8.39 This report has identified a litany of serious deficiencies with respect to record keeping. Examples of poor record keeping can be found in all areas and include some very basic matters such as the following:

- The frequency and duration of lockdowns and the reasons for those lockdowns;
- The use of regression and other responses to detainee misbehaviour;
- The use of restraints on detainees;
- The regime for detainees after the incident, including access to education, programs and recreational opportunities.
- Major decisions made at the time of the riot including the transfer of detainees to Hakea and police involvement on site;
- The extent of detainee involvement in the riot; and
- The extent, causes and management of workers compensation and absenteeism.

8.40 The Children's Court has experienced considerable frustrations with the inability of the Department to provide detailed, accurate information regarding the situation of detainees at both Banksia Hill and Hakea. The President of the Children's Court is requesting the Department to prepare Detainee Management Reports (DMRs). He has requested information on matters such as time out of cell, time out of the unit, hours and details of participation in education, programs and recreation and the use of restraints. Recording of the use of restraints was non-existent prior to mid-February but improved after interventions by the Inspector.

8.41 Even six months after the riot, information on the other issues remains inadequate for the purposes of the court. The DMRs provide some generalised figures and commentary but they do not provide the level of information that could reasonably be expected or that the court has requested. DMRs invariably state:

> The Department cannot provide a running daily account setting out details of the kind of subjects, the number of sessions per day and the length of time .. that the school education program has been provided … [or such details]… for other rehabilitation programs… [or] … the kind, the number of sessions and the length of each session of recreation programs … [or] actual hours of lockdown ….[237]

8.42 The President of the Children's Court has made his concerns very clear to the Department.

8.43 Another telling example relates to staffing. In response to a request for copies of exit interviews conducted with staff who had left Youth Custodial Services between 1 February 2012 and 31 January 2013, the Department simply wrote:

> [The Department] does coordinate an Exit Survey for staff who leave the department. However, we are unable to identify the business area from where the responses have originated. Therefore we are not able to provide any records of any separation surveys and/or interviews for staff.[238]

237 Copies of DMRs provided to the Inquiry by His Honour Judge Reynolds. The DMRs use the same template and generally the same or very similar wording.

238 DCS, Response to OICS request for information (18 February 2013).

8.44 The failure to keep good records hinders accountability and stymies reflection and learning. It also means that the Department has been poorly placed to build evidence-based cases for some fundamental contentions,[239] and has been unable to meet reasonable requests for detailed information by the courts and by OICS.[240] There must be improvements.

Improving Performance

8.45 This Inquiry has concluded that it is essential that clear service and performance requirements are set for Youth Custodial Services and that these are externally monitored, assessed and reported on. These requirements should not be expressed in the form of general Key Performance Indicators (KPIs) because there is a tendency for KPIs to become desirable or optional rather than essential. The service and performance indicators set for the Department should take the form of quasi-contractual obligations, with relevant managers given responsibility for meeting these requirements.

8.46 The contract management division of the Department itself has considerable relevant expertise. It is already involved in the development and management of multi-million dollar contracts for prison services and the contracts for both Acacia Prison and the Wandoo Reintegration Facility contain detailed performance requirements. Contractors who fail to meet these requirements will lose performance linked fees and may also face other remedial requirements. Failure to meet the performance standards can lead to further penalties or even to loss of the contract.

8.47 The Department carefully monitors the private service providers' compliance with a wide range of issues such as prisoners' access to employment, education and programs, lockdowns and staff shortages. These tasks are performed by a combination of onsite monitors and head office personnel. Naturally, most of the measures relate to performance within the facility but the Wandoo contract also contains outcome-linked measures, such as the number of prisoners entering employment immediately on release. Both the Acacia and Wandoo contracts are publicly available, as are the Department's annual reports on contract performance. To date, the Department has never applied the same tangible measures, strict monitoring and public reporting systems to its own prisons or detention centres.

8.48 The existing contracts for custodial services and the expertise of the contract management division of the Department therefore provide a valuable resource on which the government can draw in order to set service and performance requirements for Youth Custodial Services. However, it is critical that the requirements are independently set and that the tasks of monitoring and reporting are undertaken externally.

8.49 OICS will be conducting a full inspection of Banksia Hill at an appropriate time in 2014. Inspection cannot replace the need for ongoing measurement and reporting, as they are qualitatively different processes. However, the timing and structure of the 2014 inspection will complement and cross-validate any initiatives taken by government with respect to tighter monitoring.

239 See [1.53]–[1.64].

240 The Minister for Corrective Services has also expressed dissatisfaction at the quality and timeliness of advice to him: http://www.abc.net.au/news/2013-07-12/prisons-minister-vows-to-change-culture/4818016

SERVICE DELIVERY OPTIONS

8.50 Provided the previous recommendations are adopted, it should be possible for the Department to lift performance within 12 months and for government to have independent sources to validate this. Combined with the proposed establishment of a Youth Justice Commission or Department and the need to consider additional forms of youth custodial placement,[241] this will allow well-informed decisions to be taken about future options.

8.51 The private sector currently operates two adult prisons in Western Australia, Acacia and Wandoo, as well as providing adult prisoner transport and court custody services. Given the issues at Banksia Hill, including staff shortages, it seems inevitable that consideration will turn to the future role of private and non-government sector bodies in providing specific services at youth justice facilities or even in operating such facilities.

8.52 Privatisation of custodial services is always controversial. However, experience in Western Australia is that both the public and private sectors are capable of good performance or of less than good performance. It also needs to be recognised that private sector involvement is not an 'all or nothing' proposition. No Australian jurisdiction has privatised the operations of a juvenile detention centre but both Victoria and the ACT use private security companies for 'front of house' services at the entrance to juvenile facilities. Both jurisdictions indicated to the Inquiry that one driver for this change was staff shortages, that they had confidence in the division of labour which had resulted, and that it had freed up youth justice officers for other activities involving interaction with detainees.

8.53 Hitherto, when Western Australian governments have decided to 'test the market' for the private sector to operate prisons, they have announced that the private sector will run the facility and then invited private sector bids. The Department has not been allowed to bid but has played a central role in evaluating the bids. The alternative approach is one of true 'contestability' under which the capacity of the public sector is tested against the capacity of the private sector. By way of example, the UK system has now matured to the stage that the public sector is successful in competition with the private sector.

8.54 It is important to emphasise that if contestability is pursued simply to reduce costs it will fail. The aim of contestability is value for money in the sense of improving the quality of services delivered in return for expenditure on those services. To date, this point has been recognised and embedded in Western Australia and has been fundamental to the success of Acacia.[242]

241 See [1.70]–[1.76].

242 OICS, *Report of an Announced Inspection of Acacia Prison, Report No 71 (May 2011);* OICS, *Report of an Announced Inspection of Acacia Prison, Report No 53* (July 2008).

8.55 If the government decides to test the option of the private sector undertaking the management of an existing or future juvenile detention centre,[243] it is recommended that a contestability model be adopted. In other words, in addition to seeking bids from the private sector, it directs or invites the public sector to bid. Depending on timing, the proposed Youth Justice Commission would be well-placed to assess future need, to develop requests for tender and to assess the bids.

8.56 A contestability model, allied with a Youth Justice Commission, is also likely to open up more opportunities for innovative engagement with the non-government sector. Organisations such as Halo, Outcare and Ruah already provide credible and efficient support services. There are also many Aboriginal organisations across all parts of the state who are keen to provide a service and well-equipped to do so. To date, however, many of the initiatives have been somewhat ad hoc, and responsibility has been spread across different government departments. A Youth Justice Commission model would help to provide direction, support, evaluation and efficiencies. It may also be able to assist organisations in building capacity.

DETAINEES AT BANKSIA HILL: 'NOT THE SAME' AS THEY WERE?

8.57 There are two incontrovertible truisms: some detainees have committed very serious offences and some present very difficult management challenges.[244] This has always been the case and will always be the case. However, departmental advice to the then Minister on 23 January 2013 went much further, asserting that:

> The current operating philosophy within the centre has to change. [Banksia Hill] was originally opened in 1997 and the young person incarcerated now is not the same one that was housed in the centre when it first opened in 1997.[245]

8.58 The advice did not explain what was meant by the phrase 'not the same' but forceful assertions also emerged in evidence by senior departmental representatives to the Supreme Court that detainees are now fundamentally different.

8.59 Given that Banksia Hill was performing well six years ago, and that the operating philosophy of Youth Custodial Services was subject to fundamental review by the Department itself from 2009 to 2012, the Inquiry examined two questions:

- What is the evidence that detainees have become harder to manage and what are the specific causes of these changes?
- How should the philosophy change and how did the Department factor these changes into its own planning for the redevelopment of Youth Custodial Services over the past three years?

243 See [1.72]–[1.80].

244 The two groups are not necessarily the same. Sometimes people who have committed very serious offences are relatively compliant in custody and people who have committed lesser offences present serious management problems.

245 DCS, *Briefing to Minister for Corrective Services: Critical Incident at Banksia Hill Detention Centre on 20 January 2013 – Supplementary Briefing* (23 January 2013).

8.60 The Department was asked whether it had commissioned or carried out any research or analysis into changes in the behaviour, offending profile or other management challenges in the juvenile detainee population that would indicate whether they are becoming harder to manage. It said that it had not commissioned or undertaken any such work. Nor did it volunteer any other evidence to explain or support the claim.[246]

8.61 The Inquiry did locate a Youth Custodial Services business case to increase staffing levels from September 2010.[247] The arguments on which the case was based included comparisons with other jurisdictions and 'the general increase in the number of offenders entering Youth Custodial Services for serious offences'. However, while the statistics did show an increase in the number of detainees (a fact that was already known) the ratios entering custody for different types of crime had in fact remained constant. In any event, the Commissioner's Executive Team (CET) did not consider this to be a priority to be pursued any further.

8.62 Another potential measure of detainee difficulty might be to examine records relating to charges under the general law or the *Young Offenders Act 1994* for offences committed while in detention. However, as previous OICS reports have pointed out, responses to detainee misbehaviour have been problematic and record keeping poor, so this would not be a viable or valid indicator.[248]

8.63 In response to questions during the Inquiry, a number of other suggestions were also made. One was the problem of 'FASD' (fetal alcohol spectrum disorder). However, as recent Parliamentary inquiries have noted, whilst use of this label is relatively new in Australia, the issue and associated behavioural consequences are all too chronic and entrenched.[249] Another suggestion was that methamphetamine use is leading to more volatile and violent behaviour. However, while substance abuse is clearly a major issue among young offenders, the President of the Children's Court, lawyers and others told the Inquiry that methamphetamine use is far from the biggest problem.

8.64 It is also important to compare Banksia Hill with Rangeview. If detainees are getting more difficult to manage, Rangeview should have felt this at least as much as Banksia Hill. As the state's remand centre, Rangeview was housing children at a time when they were more likely to have been affected by recent substance abuse. However, from 2010 to 2012 Rangeview experienced nothing like the problems of Banksia Hill.

246 DCS, response to OICS request for information 94 (30 April 2013).
247 As noted at [6.57], the primary catalyst for this business case was the August 2010 escape.
248 OICS, *Report of an Announced Inspection of Banksia Hill Juvenile Detention Centre*, Report No. 76 (March 2012).
249 This view was put during briefings to the Department by the Inquiry team on its findings with respect to security and emergency management. A recent Commonwealth Parliamentary Inquiry commented that the issue is that Australia has lagged behind when it comes to standardised FASD diagnostic criteria and prevalence data: Senate Standing Committee on Social Policy and Legal Affairs, *Inquiry into Foetal Alcohol Spectrum Disorders: Summary of Report* (November 2012) 2: http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=spla/fasd/report.htm

8.65 The point is simple: detainees' behaviour will reflect how they are treated as well as their inherent problems. The issues are well-illustrated by the case of R.P.[250] The Department had applied for R.P to be transferred to an adult prison because of his behaviour at Banksia Hill but the Children's Court refused the application. The President was extremely critical of R.P's management at Banksia Hill but emphasised how well he had progressed after he had been transferred to Rangeview.

8.66 The views of staff respondents to the Inquiry survey were also telling. Although they held concerns for their safety, very few attributed blame for the riot to the detainees. Almost without exception they said the riot was a consequence of poor management, staff shortages and lockdowns.

8.67 National comparisons are interesting too. Members of the Inquiry team sought to test the thesis that detainees are getting harder to manage during visits to youth justice facilities interstate. Such arguments were rarely raised by staff or management except in the specific context of youth gang tensions of a nature and scale that are unknown in Western Australia. It may also be noted that the number of juveniles in custody in New South Wales has dropped markedly over the last three years, hardly an indicator of a hardening youth culture.

8.68 Finally, the thesis that detainees are getting more difficult to manage was not factored in any clear or sustained way into the key policy documents underpinning the redevelopment of Youth Custodial Services, including its impact on design, operational philosophy, security processes and staffing.

8.69 In summary, there is no doubt that most detainees have complex needs, that some have committed very serious offences, and that some present significant management problems. It has always been this way. But changes in direction must be based on evidence, not on anecdote, assertion and generalisation. The Department has not produced any valid evidence to support its thesis that the young person of 2013 is fundamentally different to the young person that Banksia Hill was originally designed to accommodate. Nor can this thesis explain how performance at Banksia Hill could have declined over a relatively short period while Rangeview remained essentially stable. In truth, most of the fundamental problems faced by young people are depressingly similar to what they were 10 or 20 years ago and the challenges are essentially unchanged. And if profound changes of the degree stated by the Department in 2013 had occurred, it should have factored these explicitly into its planning and budget submissions from 2009 to 2012.

LEGISLATIVE FRAMEWORK AND PRINCIPLES

8.70 The *Legal and Administrative Context Review Paper* which accompanies this report examines the legislative framework for youth justice in Western Australia and the intersection between legislation, national and international standards, and the Department's rules, standing orders and other governing documents. For present purposes it is only necessary to make a few brief comments.

250 *Department of Corrective Services v R P* [2012] WACC 5. See [2.21]–[2.22].

8.71 The *Young Offenders Act 1994* is the governing legislation and all subsidiary legislation, rules and orders must be compliant with that Act. To the extent that they are inconsistent, the rules and orders will not be legally valid. As recommended in Chapter 4, it is essential that all governance documents are brought up to date and that they fully comply with the requirements of the *Young Offenders Act 1994*.

8.72 The *Young Offenders Act 1994* is underpinned by a set of 'objectives' (section 6) and by 'general principles for juvenile justice' (section 7). These principles are not only matters of state law but directly reflect the language of international conventions to which Australia is a signatory. The objectives and principles in the *Young Offenders Act 1994* are therefore, in a sense, 'non-negotiable'. They require a balance to be struck between the rights of young people involved in the justice system and the protection of the community. They also specifically require a focus on rehabilitating young people who are in contact with the law, on their reintegration to the community, on punishing them in a way that encourages a sense of responsibility and allows them to develop in beneficial and socially acceptable ways.

8.73 The Inquiry has concluded that these objectives and principles strike an appropriate balance. They should not be altered but need to be more fully implemented.

DEVELOPING CAPACITY AND OPTIONS

What is Needed?

8.74 Banksia Hill is now the state's only youth detention option. This means that it must accommodate males and females, children of all ages, sentenced detainees and remandees, and children from across the whole state. It is a maximum-security facility and there are no lower security placements for those detainees who could be safely managed under less secure conditions.[251] As there is only one facility, there are no regional custodial options and no opportunities for dispersal if the management of individuals or groups becomes problematic.

8.75 In considering future development and investment, it must be understood that Banksia Hill is already full and there is no reasonable scope for any further expansion at the site.[252] It is also the largest juvenile detention centre in Australia. Other roughly comparable jurisdictions have opted to establish a range of smaller facilities, offering a more nuanced approach and the more separation/dispersal options. For example, New South Wales has eight Juvenile Justice Centres to cater for around 350 young people. Queensland has two main detention centres in Brisbane (capacity 120) and Townsville (design capacity 48 with an expansion of 48 underway), supplemented by some bush camp options.

8.76 It is not for this report to attempt to provide a blueprint for the future shape of the youth custodial system but it is time for a fundamental appraisal of supply and demand and for more varied options to house juvenile detainees. Submissions and comments to the Inquiry from the President of the Children's Court, the Commissioner for Children and Young People and others have reached the same conclusion.

251 See Chapter 4.

252 The Inspector has been informed that some preliminary thought has already been given to constructing another unit could be built on the oval. This is simply untenable.

8.77 These submissions and comments have generally argued that males should be separate from females and sentenced children separate from those on remand. There is no doubt that legal status and gender are important variables. However, other variables must also be factored in, including age and geography. In Western Australia, the detainees under 14 are almost all Aboriginal children from remote and regional areas. The vast majority are being held on remand but some are already sentenced. The arguments in favour of developing regional placements that would allow these children to stay 'in country' – whatever their gender or legal status – may have a higher priority, in terms of the use of scarce resources, than the case for separating sentenced detainees from remandees or males from females. Age should also be factored into future planning for metropolitan facilities.

Future Options and Current Facilities

8.78 In the aftermath of the riot, there have been some calls for Wandoo to revert to its former role as a juvenile detention centre in order to allow more options and separation of different cohorts of juveniles. However, this would be highly problematic: quite apart from the fact that Wandoo is now a privately operated facility, it is in the community's interests for positive rehabilitative initiatives to be provided for young prisoners aged 18 to 24. At present, Wandoo is the only prison that does this. However, the *Young Offenders Act 1994* does allow juveniles to be transferred to adult prisons by order of the Children's Court under certain circumstances and there may be opportunities for some selected older detainees to be placed at Wandoo.[253]

8.79 In terms of future planning and expenditure, it is also vital not to lose sight of the pressing needs of female prisoners. Bandyup Women's Prison is too small and much of it is severely run down or unfit for purpose. For some years, OICS has been calling for more investment in female prisons and the Standing Committee on Public Administration has echoed this.[254]

8.80 Women's prisons and juvenile custodial services are the two highest priorities and intelligent planning and investment is required in both areas. This planning should include some lateral thinking. This report has shown that whilst Banksia Hill was designed as a juvenile detention centre, its current size, configuration and structure have become problematic. If, as recommended here, government decides to explore the development of a more nuanced juvenile system, based on smaller metropolitan and regional options, it will be necessary to consider the best use for Banksia Hill.

8.81 If it is decided that Banksia Hill is no longer best used as a juvenile facility, consideration should be given to its possible use as a female prison. Some aspects of the site, such as the relatively small units and the general physical environment, lend themselves to use as a female prison. If this was done, much of the harsh recent target hardening could also be removed. In addition, consideration could be given to co-locating juvenile females on the same site in the existing girls' unit (Yeeda) and allowing some intelligent mixing of juvenile and young adult females in programs relating to issues such as parenting, health and family violence.

253 See [1.78]–[1.80].

254 OICS, *Report of an Announced Inspection of Bandyup Women's Prison*, Report No. 73 (August 2011): Standing Committee on Public Administration, *Omnibus Report – Activity during 38th Parliament*, Report 15 (November 2012).

8.82 It must be emphasised that this is not being put forward as a specific proposal for women's imprisonment: the point is that there needs to be a stocktake of existing custodial assets and an intelligent reflection on future options, especially at times of financial constraint.

BETTER MEETING THE NEEDS OF YOUNG ADULTS

8.83 One of the problems facing Banksia Hill is the need to accommodate such a variety of young people of different ages and backgrounds in the same facility. Overall, the population is heavily skewed to the older ages (17 plus) and between 10 and 15 fifteen per cent of the population are generally over 18. This older cohort is no longer of compulsory schooling age and has very different needs from the younger group.

8.84 As previously discussed, the vast majority of juvenile detainees are Aboriginal. And the younger they are, the more likely they are to be Aboriginal. This is also true in the adult prison system where young Aboriginal people constitute a depressingly high proportion of young prisoners. Unfortunately, the evidence is that too many of the young Aboriginal prisoners are disengaged and disheartened.[255] To date, the Department has not developed any specific strategies within mainstream prisons to better engage and target the needs of young adults.

8.85 It is important for the Department to develop a sharper focus on regimes and programs for young adult prisoners. This will also enhance the prospects of the Department being able to argue successfully in the Children's Court for the placement of detainees aged 18 or above in an adult prison when their needs, circumstances and behaviour may justify this.

RECOMMENDATIONS

Recommendation 27

The Department must improve the scope, detail, accuracy and availability of records across all aspects of Youth Custodial Services.

Recommendation 28

It is recommended that the government conduct a high level review of expenditure on youth justice services across all agencies with a view to (i) gaining a more complete understanding of the full range and cost of services; (ii) appraising the balance between the budgets for custodial services, prevention and diversion schemes, and community-based supervision; and (iii) assessing future options.

255 This point has been made many times: see OICS, *Report of an Announced Inspection of Albany Regional Prison*, Report No. 78 (August 2012); OICS, *Report of an Announced Inspection of Hakea Prison*, Report No. 81 (January 2013); OICS, *The Diminishing Quality of Prison Life: Deaths at Hakea Prison 2001 - 2003*, Report No. 22 (March 2004); *OICS, Annual Report 2011-2012.*

Recommendation 29

It is recommended that the government:

(a) Develop plans and processes to transition youth justice services out of the Department of Corrective Services to an agency whose sole focus is youth justice; and

(b) To that end, establish either a Youth Justice Commission (modelled on the Youth Justice Board of England and Wales and the WA Mental Health Commission) or a stand-alone Youth Justice Department.

Recommendation 30

It is recommended that the government sets clear service and performance requirements for Youth Custodial Services and ensures that these requirements are subject to external monitoring, assessment and reporting. These service and performance requirements should cover all relevant areas, including security and safety, detainees' access to employment, education programs and recreation, lockdowns, and staffing levels, absenteeism and management.

Recommendation 31

It is recommended that government consider whether there are benefits in outsourcing some aspects of youth custodial operations, such as gatehouse security, allowing existing staff to be deployed to other areas.

Recommendation 32

Subject to its evaluation of performance by the Department of Corrective Services and to decisions regarding investment in new detention facilities, it is recommended that government consider whether a contestability model for Youth Custodial Services delivery will lead to improved outcomes.

Recommendation 33

It is recommended that government develop a master plan regarding the best use of existing adult and juvenile custodial facilities. The key outcomes of this should include:

(a) Provision of a wider range of options for youth, in order to allow for the better separation of different cohorts of detainees and to provide improved services to target issues of age, gender, legal status, the needs of Aboriginal youth and youth from regional areas, and specific problems such as mental health;

(b) Improvements to the conditions and services provided to adult female prisoners; and

(c) Better targeting of the needs of adult prisoners in areas such as mental health/mental impairment.

Recommendation 34

It is recommended that the Department, drawing on experience with the Wandoo Reintegration Facility, develops new initiatives and injects the necessary resources into developing a sharper focus on the needs of young adult men and women held at prisons other than Wandoo.

Recommendation 35

Reforms and initiatives undertaken with respect to youth justice services should be underpinned by a focus on the needs of Aboriginal youth across the state, including innovative forms of engagement with Aboriginal organisations and service providers.

Appendix 1

CHRONOLOGY OF EVENTS BEGINNING 20 JANUARY 2013

Time	Events, actions and decisions
1745	Staff contacted the Shift Manager suspicious about detainees absconding the unit to ascend the roof.
1755	A population count was called for the facility. Three detainees absconded from a unit and the whole centre was alerted via radio transmission. An instruction was issued to secure all detainees in cell. The absconding detainees entered the female precinct and scaled the roof. They remained on the roof for a few minutes, descended and ran into officers demanding the staff get out of their way. The detainees continued towards a group of visitors being escorted from the centre. They were deterred by an officer and turned around ascending another roof. Whilst on this roof, one of the detainees threw a rock at an officer but missed.
1810	A radio transmission was issued advising that the population count was correct with three detainees recorded as unsecure.
1812	The detainees, having descended the roof again, were observed outside the centre's management wing. Staff witnessed the detainees throwing rocks at a cell's external window. The cell window was breached in less than two minutes and a special profile offender was freed.
1818	The four detainees moved to another unit and freed a fifth detainee. A call was made to the Department's Emergency Support Group (ESG) requesting their assistance. The five detainees were observed moving towards another unit. The officer supervising detainees in this unit secured herself in the office bathroom.
1822	A sixth detainee was observed breaching his cell from this unit. The group of detainees moved to the gatehouse. One detainee was observed throwing a rock at the glass entry door. The group of detainees continued moving unchecked throughout the centre.
1834	The Shift Manager requested the assistance of Western Australia Police (WAPOL) to man the perimeter wall.
1844	The detainees entered an unfinished and unsecured unit. They were observed re-emerging from the unit with bedframes, table legs and a fire extinguisher.
1850	Eight detainees were confirmed out of cell. The Director of Youth Custodial Services and the Assistant Superintendent arrived onsite and assumed control of the incident
1900	All staff were accounted for in the staff amenities room after being escorted from various units throughout the centre by Banksia Hill's Primary Response Team (PRT).

Time	Events, actions and decisions
1901	The detainees breached two unit offices and a detainee was overheard on the public address system encouraging other detainees to damage centre property.
1904	The ESG arrived onsite.
1910	WAPOL begin manning the centre's external perimeter road in the event of a detainee attempting to escape.
1930	PRT and WAPOL response planning was conducted.
1936	Sixteen detainees were confirmed out of cell.
1937	Approval was given by the Corrective Services Commissioner for the use of Tasers.
1948	Some detainees were observed accessing the centre's administration building. The ESG checked their weapons and WAPOL firearms were secured outside the centre.
2000	ESG and WAPOL move into the facility
2005	Approximately 25 detainees were apprehended and held on the basketball court near Turner unit.
2009	A perimeter breach was called as one detainee was observed nearing the perimeter wall.
2010	Approximately 10 detainees surrendered in the girl's precinct.
2015	The Incident Control Facility (ICF) at the Department's Head Office was opened.
2030	A second perimeter breach was called as three detainees were observed nearing the perimeter wall. The Director of Youth Custodial Services and WAPOL requested authorisation from the ICF to have the detainees removed from Banksia Hill. The Hakea Superintendent was contacted regarding the availability of space in Hakea for the detainees
2110	A list of the detainees was compiled and organisation for detainee transfers to Hakea began.
2125	Hakea Prison's Superintendent arrived at Hakea with Senior Youth Justice staff.
2126	The Banksia Hill Security Manager arrived onsite.
2130	The ESG Superintendent advised the ICF that 37 detainees were apprehended and plans were in place for a population count and cell integrity checks. The ESG Superintendent stated that no use of force was deployed and there were no injuries to detainees or staff. The ICF instructed the ESG Superintendent to ensure all detainees were medically assessed.
2150	The Hakea Command Post was opened.
2200	Welfare checks began in some units within the centre for detainees who remained in cell.

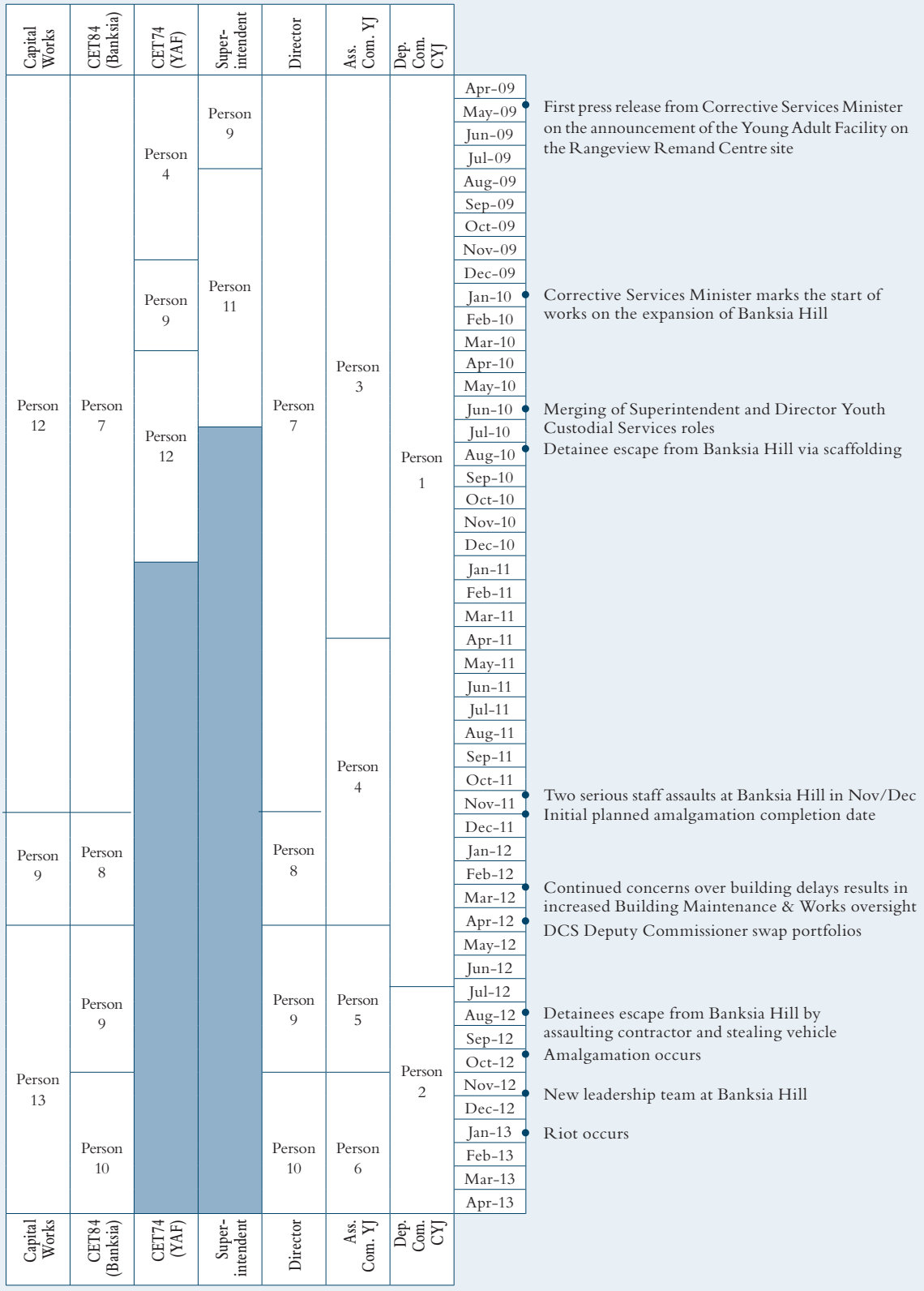
Time	Events, actions and decisions
2220	Hakea staff were given a copy of Juvenile Custodial Rule 208 (use of restraints) and two YCOs were posted at Hakea for the night.
2222	A female detainee was identified as suffering an asthma attack.
2225	The ICF advised the prison officers' union (WAPOU) that Banksia Hill detainees would be relocated to Hakea.
2229	The detainee suffering an asthma attack was administered medication by medical staff. The detainee was then moved to another cell having caused damage to own her cell when she was allegedly attempting to gain staff attention.
2308	Another population count was called.
2322	Banksia Hill medical staff assessed the apprehended detainees. One detainee was assessed as requiring hospitalisation.
2324	The population count continued as more detainees are apprehended and secured.
2230	Hakea staff were deployed to the unit awaiting the relocated detainees. The number of detainees to be accommodated at Hakea continues to change throughout the night.
0021	21 JANUARY 2013 The Director of Youth Custodial Services queried the population count and subsequently another count was undertaken.
0025	All apprehended detainees had their shoes removed after a detainee attempted to abscond from the basketball courts where he was being held. Cell integrity checks commenced throughout the centre.
0031	Another special profile offender allegedly assaulted a senior ESG officer. He was restrained with mechanical restraints on both wrists and ankles.
0038	The Director of Youth Custodial Services provided an update to the ICF noting his uncertainty regarding Taser use. A direction was issued by the ICF Incident Controller that the detainee who allegedly assaulted the senior ESG officer, was not to be transferred to Hakea with the other detainees.
0115	The first WAPOL transport van departed Banksia Hill for Hakea Prison with 12 detainees on board.
0122	The Shift Manager called the population count correct.
0220	The detainee involved in the alleged assault of the senior ESG officer was moved to the centre's multi-purpose unit. Six additional transfers were conducted by WAPOL to Hakea Prison.

Time	Events, actions and decisions
0415	The Director of Youth Custodial Services provided another update to the ICF reporting that 144 male cells were assessed for cell damage. Damage was recorded in 92 cells.
0421	The transfer was completed with 73 detainees removed to Hakea Prison.
0432	A Banksia Hill staff debrief was conducted.
0509	The Director of Youth Custodial Services advised the ICF that the staff debrief was concluded and that staff were disgruntled. The Director confirmed no detainees were Tasered.
0740	The Corrective Services Commissioner declared the situation an 'emergency' and the incident a 'riot'.
0753	The Corrective Services Commissioner verbally briefed the Inspector of Custodial Services.
0828	The ICF were advised that some staff property was allegedly stolen during the riot. These belongings included medication.
0859	There were discussions held at the ICF regarding whether some detainees at Hakea were to be transferred to Casuarina Prison.

Appendix 2

TIMELINE OF KEY STAFFING AND AMALGATION EVENTS

This timeline depicts changes to key personnel responsible for the amalgamation, in addition to significant staffing and amalgamation related events between April 2009 and April 2013.



Appendix 3

SELECTED KEY INCIDENTS AT BANKSIA HILL JANUARY 2010 TO JANUARY 2013

	Date & Short Description	Further Details
1.	**19 January 2010:** roof ascent	DM, RB and others went onto roof of Turner Unit. They admitted doing the same thing with others undetected the night before.
2.	**25 February 2010:** roof ascent, threats, damage	Six youth, including DM, IG and JM, went on the roof of Turner Unit, damaged roof fittings and held staff at bay with makeshift weapons.
3.	**21 March 2010:** roof ascent	DD, LH and SM ran off from Jasper, with DD ascending Harding Unit roof, and others the Lenard Unit roof. The incident lasted one and a half hours.
4.	**9 April 2010:** absconded from cell, attempt to break out of cell	A youth absconded from his cell which had not been properly locked and attempted to break out a friend from another cell causing damage to the glass.
5.	**4 June 2010:** roof ascent	LM and HW went on Ed/Voc roof for an hour and half.
6.	**22 June 2010:** officer assaulted	TL head butted an officer.
7.	**12 July 2010:** out of bounds	DM and TT absconded to the hill.
8.	**12 July 2010**: roof ascent	HH accessed the roof of Lenard Unit for a short time.
9.	**27 July 2010:** roof ascent, attempted assault	CJ accessed the Harding Unit roof, then gathered materials to use as weapons from the reception building site to throw at staff. He caused damage to roof fittings and attempted to break his friends out of Harding Unit by breaking windows.
10.	**29 July 2010:** roof ascent	PF, LP, JR and TL went onto the Ed/Voc roof for a brief period.
11.	**25 August 2010:** detainee in visits	During an argument in visits ZL threw furniture, a TV and video across the room and hit his head against the glass door and wall.
12.	**29 August 2010:** escape, attempted escape	AF, DM, PF and SI absconded and entered the reception building site where they used bricks and other materials as weapons. They held staff at bay while they moved scaffolding material to the perimeter and scaled the fence. AF jumped down on the other side and escaped.
13.	**27 September 2010:** roof ascent	CJ accessed Harding Unit roof for a brief period.
14.	**14 October 2010:** officer assaulted	SI assaulted an officer after being regressed.

	Date & Short Description	Further Details
15.	**31 October 2010:** escape through roof of secure cell, roof ascent, damage and attempted staff assault.	SI broke through the roof of his cell in Harding Unit and onto the roof. He broke off roof material which he threw at a staff member. He threatened to assault staff and release another detainee.
16.	**2 January 2011:** escape through roof of secure cell.	JR broke out of his cell in Lenard Unit through the roof and was eventually talked down by staff. A cell roof in Jasper Unit was also damaged by anther unidentified detainee.
17.	**17 March 2011:** roof ascent and fire.	TO accessed the Lenard Unit roof after SI started a fire in an oven. Detainees were affected by the smoke and one was taken to hospital due to the effects of the fire suppressant used. SI and another detainee smashed cell lights in Harding Unit that night.
18.	**20 March 2011:** escape from secure unit, roof ascent and massive damage property.	SI and AF broke out of Harding Unit, accessed the roof and caused extensive damage. AF further incited SI to harm staff.
19.	**26 March 2011:** roof ascent and damage.	Five youths from Karakin accessed and damaged the roof of Ed/Voc after rolling lockdowns.
20.	**26 March 2011:** cell extraction.	SI and GY made threats to self-harm by making cords from mattress lining. A cell extraction was required for SI.
21.	**5 April 2011:** suicide attempt.	SI attempted suicide by hanging in his cell.
22.	**14 April 2011:** escape planning.	TO and HW attempted to recruit a third detainee to join them in an escape attempt involving scaffolding from a building site and loose materials as weapons.
23.	**19 June 2011:** roof ascent.	BG and CJ absconded from Harding Unit and went on the roof.
24.	**18 June 2012:** damage and serious self-harm requiring a cell extraction.	CJ destroyed his TV and the observation window in his Harding Unit cell, and cut himself severely with glass.
25.	**28 June 2011:** simultaneous roof ascent.	Four detainees from Lenard Unit absconded. Two accessed the roof of Harding Unit, and two accessed the roof of the Yeeda Unit building site.
26.	**2 July 2011:** roof ascent.	CJ accessed the roofs of Harding Unit and adjacent buildings. The disruption lasted five hours.
27.	**31 July 2011:** roof ascent, damage and attempted assault.	CJ and BG absconded from Harding Unit and accessed the roof, causing extensive damage a number of buildings, using parts as missiles to keep staff at bay.

	Date & Short Description	Further Details
28.	**23 August 2011:** escape planning.	BG incited other detainees to join him an escape attempt involving access to a building site and using loose materials as weapons.
29.	**12 September 2011:** roof ascent and damage.	CJ, JC and MN accessed the Harding Unit and Medical Centre roofs where they caused minor damage to fittings.
30.	**30 September 2011:** prescription drugs stolen and misused.	A Webster pack containing doses of anti-psychotic medication were discovered to have disappeared. A number of detainees were identified as having taken the medication, and were transferred to Harding Unit in restraints for observation. One was obstructive and was moved in full restraints. Another detainee was transferred to Rangeview for observation, and then to Fremantle Hospital.
31.	**10 October 2011:** roof ascent, damage and attempted assault.	During a period of rolling lockdowns RP and another detainee accessed the Staff Room and Ed/Voc roofs. They caused considerable damage and threw loose materials at staff.
32.	**12 October 2011:** roof ascent.	JC and three others accessed the Harding Unit roof shortly before they were evening lock up. The last came down almost four hours later, after the ESG were called and a PRT were in place.
33.	**31 October 2011:** roof ascent.	CJ and ZL accessed the Ed/Voc roof.
34.	**21 November 2011:** assault occasioning bodily harm of staff, out of bounds, roof ascent and attempted staff assault.	RP seriously assaulted an officer and scaled a barbed wire fence into a building site. He accessed the roof and threw bricks at staff, holding them at bay for a considerable period.
35.	**14 December 2011:** assault occasioning grievous bodily harm on staff.	RP seriously assaulted a staff member while under escort in Harding Unit. This resulted in him being placed onto a management regime described by Judge Reynolds as 'psychological subjugation' and 'cruel and inhumane,' until his transfer to Rangeview in late February.
36.	**26 December 2011:** planning roof ascent.	CJ attempted to recruit other detainees for a roof ascent.
37.	**6 January 2012:** roof ascent.	CJ absconded from Karakin Unit and accessed the staffroom roof, then the Ed/Voc roof.

	Date & Short Description	Further Details
38.	3 February 2012: out of bounds, roof ascent, damage and attempted assault staff.	BG, BS and four other detainees absconded from Lenard Unit, scaled the barbed wire fence around the Urquhart Unit building site, and accessed the roof. They armed themselves with loose materials to keep staff at bay.
39.	**4 March 2012:** suicide attempt.	DM made a serious suicide attempt using a sheet and was found on the floor of his cell. It appears to have been triggered by failure to make a phone call in relation to his sick child. The Hoffman knife produced to cut the sheets was too blunt.
40.	**21 April 2012:** out of bounds, roof ascent attempted assault.	MH and JJ absconded, accessed the Yeeda Unit building site and staff at bay with rocks.
41.	**24 April 2012:** out of bounds.	JL and DW absconded and accessed the Case Planning building site. They quickly left the site and were apprehended.
42.	**16 June 2012:** roof ascent and damage.	BS and DL from Turner Unit accessed the Ed/Voc roof. They did some minor damage and came down after one hour.
43.	**2 July 2012:** roof ascent and attempted assault on staff by throwing missiles at staff.	PM, LP and HW went on the roof the Case Planning building site, and used bricks and rocks as missiles to keep staff at bay. They entered the Yeeda Unit building site, then ran to another part of the centre and accessed the roofs of Harding Unit and Ed/Voc.
44.	**8 July 2012:** out of bounds, roof ascent, manufacture of weapons and attempted assault on staff by throwing missiles at staff.	JR, TC and four other youths the Yeeda Unit building site and threw missiles at staff. JR and TC then ran to and accessed the roof of Jasper Unit, after which the other four surrendered. After another hour, TC surrendered and was found to be in possession of a glass shiv made from a plate microwave plate and a shiv made from a toothbrush.
45.	**2 August 2012:** escape from centre and assault occasioning bodily harm.	CM and PG absconded from the gymnasium and scaled a fence into the Yeeda Unit building site. They used rubble to assault a contractor, break into and steal a utility vehicle, and then drove through two roller doors and a mesh gate to escape the centre.
46.	**2 October 2012:** detainees out of bounds	IG, RL, CM, CU and HW accessed the Ed/Voc roof, holding staff at bay with bricks and rubble for almost two hours.
47.	**15 October 2012:** attempt to escape escort vehicle	During an escort DJ managed to partly kick open the door of the escort vehicle.

	Date & Short Description	Further Details
48.	**7 November 2012:** escape planning	DD and HW were reported by other detainees to be making serious plans to escape by using rocks to hold staff at bay and attacking the glass in the gatehouse.
49.	**6 December 2012:** out of bounds, roof ascent	MU recruited four other youth and accessed a roof. Three were caught in Yeeda Unit. Two accessed the Case Planning roof but came down after being spoken to, 15 minutes after the incident began.
50.	**8 January 2013:** out of bounds, roof ascent	DM, CP and BS ran from Urquhart Unit armed with sporting equipment, scaled the Yeeda Unit fence, and accessed the roof of the Yeeda Education facility. They armed themselves with rocks and used them to damage windows in the adjacent wing. The incident ended after two hours.
51.	**11 January 2013:** assault on officer	DM assaulted an officer in Harding Unit.
52.	**20 January 2013:** the riot	See Report
53.	**20-21 January 2013:** self-harm, damage	Three female detainees in Yeeda Unit self-harmed during the riot and its aftermath. While there is no separate incident report on TOMS, OICS has been informed that some of the female detainees also destroyed their cells causing considerable damage.

Please note:

- This date range was chosen to encompass the period in which construction was taking place in the centre, through to the amalgamation and up to the major incident of 20 January. The first incident that involved a detainee entering a construction site was on 27 July 2010.
- The designation of what constitutes a 'critical incident' is not at all stable in Youth Custodial Services, and many of these events were not classified as such. The above list includes all identified instances of roof ascent, including a number where the impact was actually quite minor.
- These incidents are only a very small portion of incidents recorded on TOMS. There are many other instances of staff abuse, attempted staff assaults, fights and assaults between detainees and other forms of serious misbehaviour which are not included in the above list. Only a couple of instances of self-harm are included which are linked to other major incidents; again there are very many more on record.
- Only a single particularly serious incidence of escape planning is included above. There were many other instances of planning for roof ascents, escapes or similar, recorded. These were especially prevalent in the last six months of 2012.

Appendix 4

DETAINEE PROFILE

WHO WAS AT BANKSIA HILL ON 20 JANUARY 2013?

Table 3: Age, Gender and Aboriginality

	FEMALE	MALE	Grand Total
Aboriginal	**17**	**119**	**136**
13 yrs		7	7
14 yrs	3	12	15
15 yrs	4	26	30
16 yrs	3	22	25
17 yrs	6	44	50
18 yrs	1	7	8
19 yrs		1	1
Non-Aboriginal	**4**	**67**	**71**
14 yrs		2	2
15 yrs	3	8	11
16 yrs		19	19
17 yrs	1	23	24
18 yrs		14	14
19 yrs		1	1
Grand Total	**21**	**186**	**207**

Table 4: Legal Status, Age and Aboriginality

	ARREST	REMAND	SENTENCED	Grand Total
Aboriginal	**1**	**69**	**66**	**136**
13 yrs		7		7
14 yrs		12	3	15
15 yrs		17	13	30
16 yrs		13	12	25
17 yrs	1	19	30	50
18 yrs		1	7	8
19 yrs			1	1
Non-Aboriginal	**1**	**30**	**40**	**71**
14 yrs		1	1	2
15 yrs		5	6	11
16 yrs		6	13	19
17 yrs	1	14	9	24
18 yrs		4	10	14
19 yrs			1	1
Grand Total	**2**	**99**	**106**	**207**

Table 5: Age, Home Location and Aboriginality

	GOLDFIELDS and EAST	METRO	MID WEST	NORTH WEST	SOUTH WEST	SOUTH AUST	Grand Total
Aboriginal	**12**	**71**	**10**	**33**	**9**	**1**	**136**
13 yrs	2	1	1	2	1		7
14 yrs	2	7	2	3	1		15
15 yrs		17	3	7	3		30
16 yrs	2	12	1	8	2		25
17 yrs	6	28	3	11	1	1	50
18 yrs		5		2	1		8
19 yrs		1					1
Non-Aboriginal	**3**	**63**	**1**	**1**	**2**	**1**	**71**
14 yrs		2					2
15 yrs		11					11
16 yrs	1	16		1	1		19
17 yrs	1	22	1				24
18 yrs	1	11			1	1	14
19 yrs		1					1
Grand Total	**15**	**134**	**11**	**34**	**11**	**2**	**207**

Table 6: Security Ratings by Age and Aboriginality

	MAXIMUM	MEDIUM	MINIMUM	Grand Total
Aboriginal	**117**	**19**		**136**
13 yrs	7			7
14 yrs	15			15
15 yrs	28	2		30
16 yrs	21	4		25
17 yrs	42	8		50
18 yrs	3	5		8
19 yrs	1			1
Non-Aboriginal	**59**	**11**	**1**	**71**
14 yrs	2			2
15 yrs	10	1		11
16 yrs	16	3		19
17 yrs	23	1		24
18 yrs	8	6		14
19 yrs			1	1
Grand Total	**176**	**30**	**1**	**207**

Who was Involved in the Riot?

The Department has not kept clear records of the number of detainees involved in the riot or the extent of their involvement. Those assessed to be 'involved' in the following graphs are the 73 detainees who were transferred on the night to Hakea Prison because their cells were unusable.[256]

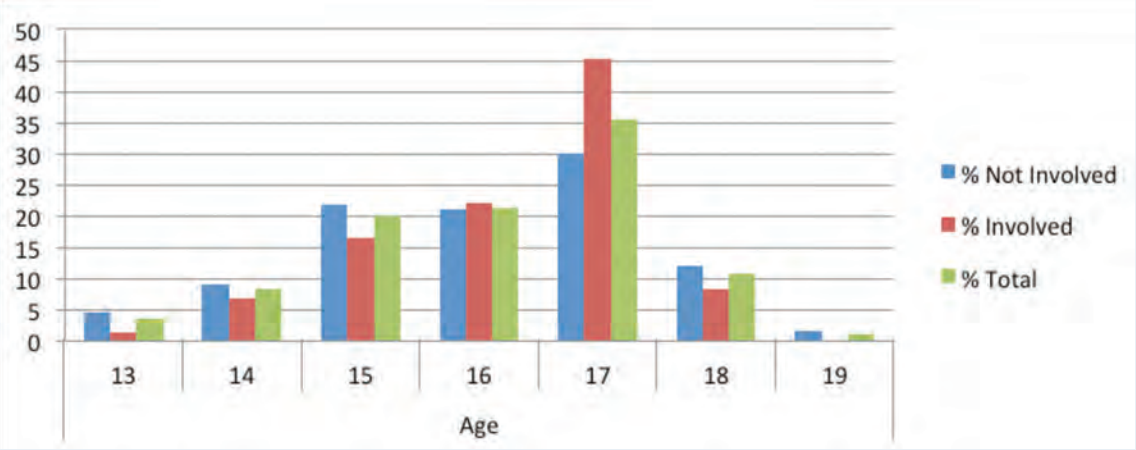


Figure 7.

Figure 8.

256 This is not a completely accurate figure but is the best available.

Appendix 5

INDEPENDENT EXPERTS

Name	Current position	Agency	Area of expertise for inspection
Mr Jonathon Ford	CEO	Moorditj Koort	Group facilitation
Mr Bob Jennings		Former Superintendent, Casuarina Prison	Custodial management
Mr Lin Kilpatrick	Architect (specialising in safe and secure environments)		The physical design of secure facilities
Ms Fiona Macleod	Senior Consultant	Price Consulting	Staff culture, organisational change and change management
Dr John Paget	Consultant and Lecturer at Charles Sturt University	Formerly: CEO, Department for Correctional Services (SA); Assistant Commissioner, Department of Corrective Services (NSW); Director, Alexander Maconochie Centre Project (ACT); Corrections Adviser to NSW Attorney General and Minister for Justice	Procedural security and behaviour management

Appendix 6

SUBMISSIONS AND CONTRIBUTIONS

Public Submissions were received and are available on our website (http://www.oics.wa.gov.au/go/banksia-hill-inquiry).

Submissions were made by:

- The Alliance for Future Health
- Amnesty International
- Western Australian Council of Social Service Inc
- Scales Community Legal Centre
- CPSU/CSA
- Youth Affairs Council of Western Australia
- Legal Aid
- Commissioner for Children and Young People
- Western Australian Aboriginal Advisory Council
- Royal Australasian College of Physicians

Private submissions were received from the Aboriginal Legal Service and two individuals.

The Inspector wishes to acknowledge and express appreciation for the assistance of the following persons and organisations:

- His Honour Judge Denis J Reynolds, President of the Children's Court of Western Australia.
- The Honourable Michael J Murray QC, Chairman of the Supervised Release Review Board, Western Australia.
- The Office of the Ombudsman, Western Australia, in arranging the secondment to the Office of the Inspector of Custodial Services, for the duration of the Inquiry, of their Principal Legal and Investigating Officer, Mr Darryl Goodman.
- The Department of Justice and Attorney General (Qld), Ethical Standards Unit, for the assistance of their Principal Inspector, Youth Detention Inspectorate, Mr Graham Morrison.

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Inspection of prisons, court custody centres, prescribed lock-ups, juvenile detention centres and review of custodial services in Western Australia.

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