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OFFICE OF THE INSPECTOR OF CUSTODIAL SERVICES

Directed Review into an Incident at Rangeview Juvenile Remand Centre and its Implications for Management and Reporting

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Introduction:

INTRODUCTION: CIRCUMSTANCES BEHIND THE DIRECTED REVIEW

1. On 8th January 2007 a detainee at Rangeview Juvenile Remand Centre was restrained by a Juvenile Custodial Officer in such a way that he received facial injuries that necessitated hospitalisation for two days. The Minister's Office was not notified of this matter until 10th January; this eventually occurred by means of a communication between the Department's Public Affairs section and the Minister's Media Advisor. The Minister was concerned both at the incident itself and the issues it raised as to the use and manner of restraints within the Juvenile Estate, and also at the fortuitous manner in which she belatedly came to be informed of the matter. Subsequently, she has issued a direction under Section 17(2) of the *Inspector of Custodial Services Act* that I should look into these matters and associated issues. The terms of the Direction are attached as Appendix 1.

2. It should be emphasised at the outset that the task of the Inspector is not to ascertain the precise rights and wrongs of the particular incident. On 9th January the Department had commenced an internal investigation, and on 10th January this was coordinated with a Police investigation that had commenced after the detainee had made a formal complaint.[1] I have had access to all aspects of the internal investigation and have received full cooperation from the Internal Investigations Branch (IIB) in this regard. The Report is of value in that it contextualises and helps understand the systemic issues that the incident of 8th January raises.

3. Of course, an investigation into a particular incident almost inevitably reinforces a "bad apple" model for explaining such an incident. The question becomes: was the officer's conduct in deliberate contravention of the applicable rules and the training he had received or, conversely, was the detainee confrontational or dangerous? Such questions are important ones and are of the very essence of the IIB and Police investigations; but they must be placed in the broader context of the overall management systems applied across the Juvenile Estate. "Bad apple" behavioural models seldom adequately explain incidents of this type.

4. With regard to the aspect of the Directed Review concerned with communication protocols, the context is that of the ability of the Minister to meet proper standards of accountability and Ministerial responsibility. This has been a particular issue in Western Australia since the time of the W.A. Inc. Royal Commission. More recently in the context of Corrective Services, the Hooker Report has given additional point to this concept. Hooker stated:

> "Ministers are the superiors in departmental affairs. Traditionally they have legislative and political authority to oversee the actions of the officials. This is the area in which the concept of ministerial responsibility was initially developed. Ministers have delegated authority and may be held accountable for its use by Parliament, Parliamentary Committees, application of Administrative Law or the Media....
>
> The actions of Ministers, the extent to which they know about the performance of the departments within their portfolios, and their public justifications therefore all fall for legitimate discussion and commentary as a component of our system of representative democracy. Openness concerning the affairs and performance of Government, through the workings of the Houses of Parliament and the facilitation and informing of public opinion, is an indispensable element of our society....

[1] At the time of completing this Report, no decision had yet been made as to whether criminal charges might follow from the incident.

> The content and limits of the concept of 'Ministerial Responsibility' remain elusive where no personal wrongdoing is at stake. However, the essence of the concept concerns the observance of the supervisory role of Parliament and the free flow of political communication with the electorate."[2]

5. It is self-evident from the above analysis that a Minister must not only be informed of incidents that raise these questions of accountability but must also be informed in a timely manner. An incident apparently involving major violence occurring within a closed institution in relation to a young person to whom the State owes a duty of care is certainly of the kind that potentially would open up Ministerial responsibility for the manner in which a Department is being administered under her authority. She needs to be "on the front foot", therefore, not on the back foot as such matters become public. This was not so in this particular case. The matter was into the media and the public domain at virtually the same time as the Minister's Office, and the Minister herself, were made aware of it.

6. This failure of communication was not an isolated incident. It seems that, since the present Minister was appointed in May 2006, there have been several such occasions. One occasion of which the Inspector is directly aware concerned the death by suicide of Mr Simon Rochford in Albany Prison on 19th May 2006. Mr Rochford was a high profile prisoner in the sense that he had become a prime suspect for a murder for which another man, Mr Andrew Mallard, had served many years of imprisonment. The media allegations were that there may have been some kind of Police maladministration in dealing with the case, and in this context Mr Rochford was in a sense a witness who required protection. The case even at that time was attracting enormous attention and subsequently has been referred to a special hearing of the Corruption and Crime Commission, indicating its importance from the point of view of Ministerial accountability. Mr Rochford's cell had in fact been fitted with a listening device by the Police. Although this action was lawfully carried out, self-evidently it was something that because of its potential political implications the Minister would expect to have been notified about. In the event, although people lower down the Department of Corrective Services organisation knew about this, even the Commissioner himself had not been informed. Accordingly, the Minister herself was not apprised of this fact. This seemed also to epitomise failures of communication within the Department as well as to the Minister.

7. The terms of the Direction also include communication to the Inspector. Whilst at one time communication protocols were relatively clear-cut although not formalised, the arrangements have slipped in recent years and seem to have become far too dependent on chance factors and personal networks. Accordingly, the Minister directed that communication between the Department and the Inspector should also be examined in this Review.

[2] Richard Hooker, *Inquiry into the Escape of Persons held in Custody at the Supreme Court of Western Australia on 10 June 2004*, paragraphs 10.4, 10.7 and 10.11 (State Government, Perth, 2004).

Part 1

THE USE OF FORCE AND RESTRAINTS IN THE JUVENILE ESTATE

INTERNATIONAL AND NATIONAL STANDARDS

8. International Standards discourage the use of restraints against juveniles in detention except in extreme circumstances. The United Nations Rules for the Protection of Juveniles Deprived of their Liberty provide as follows:

   63. "Recourse to instruments of restraint and to force for any purpose should be prohibited, except as set forth in Rule 64.

   64. Instruments of restraint and force can only be used in exceptional cases, where all other control methods have been exhausted and failed, and only as explicitly authorised and specified by Law and Regulation. They should not cause humiliation or degradation, and should be used restrictively and only for the shortest possible period of time. By Order of the Director of the Administration, such instruments might be resorted to in order to prevent the juvenile from inflicting self-injury, injuries to others or serious destruction of property. In such instances, the Director should at once consult medical and other relevant personnel and report to the higher administrative authority."

9. In rather more abstract terms the United Nations Convention on the Rights of the Child picks up the spirit of the above rules. That Convention also contains a cross-reference to the United Nations Standard Minimum Rules for the Treatment of Prisoners, with a provision that likewise limits the lawful use of restraints and force.

10. In Australia the standards for juvenile custodial facilities adopted by the Australasian Juvenile Justice Administrators[3] draws upon the United Nations Rules for the Protection of Juveniles deprived of their liberty, as follows:

    77. "Force or Instruments of Restraint are used on a young person only in response to an unacceptable risk of escape, immediate harm to the young person, or immediate harm to others and are used for the shortest possible period of time and in such a way as to avoid or minimise feelings of humiliation or degradation."

11. Reflecting these Provisions, Section 11C(1) of the *Young Offenders Act 1994* authorises the use of force in general terms. Section 11C(2) goes on to prohibit the use of force except "in the prescribed circumstances". Regulation 72(1) of the *Young Offenders Regulations 1995* defines these circumstances as "an immediate period when a detainee is imminently presenting a risk of physical injury to himself or herself, other detainees or staff". Regulation 72(2) states that when the detainee has been stabilised, then "the prescribed circumstances for the use of force cease to exist".

12. In summary, the overall if rather imprecisely articulated intent of the applicable Western Australian provisions is to minimise the use of force and restraints as far as possible.

[3] Revised edition, March 1999.

UK EXPERIENCE AND IMPLICATIONS: THE DEATH OF A YOUNG PERSON

13. In the U.K. the vulnerability of young people to the use of force and restraints was graphically illustrated in 2004 by the death of a young person, Gareth Myatt, at Rainsbrook Secure Training Centre. Gareth died as a consequence of the application of what was known as the "double-seated embrace" which asphyxiated him. This method of restraint involves two officers sitting on either side of the person locking the arms and legs and leaning the body forward, with a third officer possibly pushing the head downwards into the chest. As a consequence of this death several legal proceedings and inquiries took place. The Howard League for Penal Reform commissioned Lord Carlile of Berriew QC to lead an Inquiry.[4] One of the matters to which his report draws attention is that there is a paucity of research into deaths in custody of juveniles following or during restraint. However, what was relatively clear from the discussion and expert evidence presented to the Inquiry was that young people are particularly vulnerable to forceful restraints techniques generally.

14. The double-seated embrace has not been used in Western Australian juvenile detention centres. The case that has led to this Directed Review involved dropping the young person to the prone position (i.e., so as to have him lying face downwards). As mentioned, the force with which this apparently was done left him with serious facial injuries including a fractured cheekbone.[5] It is not fanciful to surmise that in slightly different circumstances this incident could have resulted in brain damage or even the death of the young person.

15. The U.K. Chief Inspector of Prisons, Anne Owers, commented in her 2005 Inspection Report on Wetherby Young Offenders Institution as follows:

> "For the second time in recent inspections, Inspectors found evidence of the damage that can be done to young bones in the course of control and restraint. Although there was no evidence that staff had acted inappropriately, Inspectors remain concerned about the appropriateness of the nationally authorised holds and inconsistent recording, compounded across the Juvenile Estate, of what does or does not constitute use of force."

The "double-seated embrace" has subsequently been banned in the U.K. and "dropping" or "decking" have also been prohibited except in the most extreme circumstances.[6]

[4] The Lord Carlile of Berriew QC, *An independent inquiry into the use of physical restraint, solitary confinement and forcible strip searching of children in prisons, secure training centres and local authority secure children's homes* (The Howard League for Penal Reform, London, 2006).

[5] Evidence given to the IIB inquiry by the Clinical Nurse Manager was that in eleven years working in the juvenile justice system she had never seen the level of injuries caused in this case.

[6] However, other forms of restraint and application of force are still being used in various centres. A House of Lords debate on 19th February 2007 describes the range of practices and documents some continuing Governmental ambivalence about fully implementing the Report.

THE INSPECTOR'S PREVIOUS OBSERVATIONS ABOUT WESTERN AUSTRALIA

16. The Office of the Inspector has also had concerns about this matter in Western Australia for several years, though they have not been as acute or active as the concerns of the U.K. Chief Inspector. Jurisdiction to inspect juvenile detention centres was conferred upon this Office by the *Inspector of Custodial Services Act 2003*. Shortly after that time senior departmental personnel brought it to our attention that there seemed to be a developing culture amongst Group Workers (now known as Juvenile Custodial Officers) to use force and restraints; senior management were under pressure to provide additional training in regard to these matters. At that time this trend was apparently more noticeable at Banksia Hill, which is the centre for sentenced juvenile detainees, than at Rangeview. The explanation for this was complex, but the sense that there was a subtle shift in culture was apparently tangible enough for this to be drawn specifically to our notice.[7]

17. We inspected Rangeview, however, before Banksia Hill; this occurred in June 2004. At that time several matters concerned us, including the use of mechanical restraints for many external escorts – a practice which, we believe, pushed to the very boundaries the applicable AJJA Standard relating to the use of force. We were also concerned about issues of strip searching. These matters were referred to in the Exit Debrief presented to management and other staff at the institution at the end of the inspection. The Department partially responded to our concern about external escorts by modifying its procedures in relation to pregnant female detainees and has assured us that strip-searching is a highly exceptional process "only carried out where there is significant suspicion in relation to issues of security."[8]

18. In the Inspection Report[9] itself, we addressed the question of the use of force more directly, as follows:

> 9.22 "Discussions with detainees during this Inspection indicated their unhappiness about the use of force by Group Workers when enforcing an order on a young person. Described by detainees as "being dropped", this practice appears to involve having a Group Worker twist a detainee's arm behind their back, and make the detainee either bend down to the ground or walk. Young people spoke of this practice causing them pain, especially pain to the breasts of the female detainees when their bodies reached the floor. Discussions with Group Workers suggested that, while this practice does occur, it involves a detainee being "put on the ground rather than being dropped". While the descriptions of this practice may differ, it seems clear that a form of physical restraint is regularly occurring at Rangeview to control the behaviour of detainees."

[7] The data in the Table set out in paragraph 21 indicate that a distinct shift in the use of restraints was occurring at about that time.

[8] Letter of 27th March 2007.

[9] Office of the Inspector of Custodial Services, *Report of an Announced Inspection of Rangeview Juvenile Remand Centre* (Report No. 29, August 2005).

19. Despite expressing our concern, we did not take the matter to the point of a formal recommendation, for the evidence at that time seemed mixed and beyond the reach of objective verification. However, in the light of subsequent events, these observations certainly resonate so as to suggest that the incident of 8th January possibly fits within a pattern of systemic responses to detainee conduct.

20. In that regard, it is appropriate to acknowledge the very considerable pressures that Juvenile Custodial Officers and other staff face in carrying out their duties. Anecdotally, it seems clear that the demeanour of young detainees, particularly those coming in on remand, has become more challenging. This is an observation that we made in relation to adults in our recent inspection of Hakea, the main metropolitan remand prison, and for much the same reasons which include greater pre-admission use of amphetamines and alcohol. It seems clear that the juvenile population has become more difficult to manage.[10] Whilst putting this point on the record, it should also be said that the very essence of working in this occupation is to be trained to deal with these challenges and to exercise self-restraint before applying restraints to others.

THE USE OF RESTRAINTS AT RANGEVIEW IN RECENT TIMES

21. The Review has looked at the pattern of restraints applied at Rangeview over the last 12 months or so. A preliminary point is that what amounts to a "restraint" is often confused, and this point will be discussed later. However, taking the data at face value the following pattern emerges. First, there seems to be no doubt that the trend in the use of restraints, as defined, over the last seven years has been sharply upwards. Since the introduction of the TOMS system in 2000, a restraint that has to be notified includes not merely the application of force or mechanical restraints but also "any physical escort in guiding or forcing a person from one place to another". Counting processes seem to be a little inconsistent, however, so that the 2006 figures submitted to the Review varied from 177 incidents on one count to 215 on another count. Possibly, this is attributable to the definition problem. Be that as it may, the Table below indicates an upwards trend in the use of restraints at Rangeview[11]:

Year	Restraints
2000	44
2001	69
2002	86
2003	153
2004	135
2005	220
2006	177

[10] Overcrowding in the adult estate is now being mirrored in the juvenile estate, and this factor exacerbates the stress for everyone involved.

[11] Precise population figures are not available for the period. However, it is clear that the increase in the use of restraints runs substantially ahead of population increase.

22. In January 2007 there were 20 restraint incidents at Rangeview in relation to a daily average population of less than 50. The relevant Regulation 72(5) requires a report to be made in each of these cases, and this was properly done in each case. However, there does not appear to be a culture of analysing such incidents to identify patterns or trends that they may indicate. In other words, no attempt has been made to aggregate and then analyse these events so as to identify not only how and when they occur but how they might possibly be prevented or minimised in their impact. Whilst there is compliance with the reporting requirement, there does not appear to be any established mechanism by which to learn from these incidents as a whole.

23. Yet even the most superficial examination seems to offer some useful information. For example, eight of the 20 incidents involved separating detainees who were fighting each other or threatening to do so. Another eight involved one-to-one, officer to detainee situations, several of which were nothing more than a threat or a gesture or an aggressive demeanour of the detainee. A further two cases could be seen as amounting to a mere verbal threat rather than an actual attempt to assault the officer. One case involved disobedience to an order, and the final case involved property damage.

24. It is probable that factor analysis of all incidents that occur over the course of a year would reveal not only risk situations and times and places but also opportunities for prevention or de-escalation. De-escalation is a key concept that will be discussed later, but seems to be under-identified and under-emphasised in the present practices of the Juvenile Custodial Service.

25. At my request the Rangeview management attempted to carry out a retrospective analysis of the 2006 restraints incidents, and although this was useful it necessarily fell short of the cross-referencing of the dependent variables that would be more informative. For example, whilst it emerged that the Education Centre was the single most frequent location for the use of restraints, this information was not able to be cross-referred with the age of the detainee, the time of day, whether both sexes were present in the Centre at the time, whether primarily these incidents involved detainee to detainee conflict or direct one-on-one conflict with a Juvenile Custodial or an Education Officer, and so on. One of the recommendations of this Review will be that much better record-keeping and ongoing factor analysis of restraints events should become standard within the Juvenile Estate. As the Carlile Report stated:

> "The use of physical restraint for children and young people in secure custodial settings has very little evidence base."[12]

26. The value of such an evidence base can hardly be doubted. Guideline 10.17 of the Code of Practice of the UK Youth Justice Board picks up on this point in the context of the inquiries and procedural re-assessment following the death of Gareth Myatt, as follows:

> "A monitoring system must be in place to record individual incidents in a way that allows them to be aggregated over time to give a total picture of the use of restrictive physical intervention in each establishment."[13]

[12] The Carlile Report as cited at note 4, chapter 7, paragraph 116.

[13] Youth Justice Board, *Code of Practice: Managing the Behaviour of Children and Young People in the Secure Estate* (Youth Justice Board, London, 2005).

27. Indeed, in a rough and ready way the Rangeview management was able to confirm the value of aggregated data by showing that the number of restraints incidents fell when the Senior Officer (Training) was taken off-line to give further informal training on the ground and to supervise these situations, but rose again as soon as he was posted back to his normal duties. In this way, an important variable emerged – reinforcement of training by workplace observation and direction.[14]

28. In summary, in relative and absolute terms the number of restraints incidents has steadily increased over the last seven years. A reporting process is applied to each such incident, but very little trend or factor analysis of aggregated incidents has occurred in the past. The available evidence suggests that trend and factor analysis would provide valuable information that could be translated into operational changes and training focal points.

THE VULNERABILITY OF JUVENILE CUSTODIAL OFFICERS

29. It was mentioned earlier (paragraph 20, above) that the volatility of the detainee population appears, anecdotally, to have increased over the last few years. The Rangeview management provided the Review with Occupational Health and Safety data for the 12 month period commencing February 2006. There were ten occasions during that period when employees were injured in the course of applying restraints and two further occasions when they were assaulted by detainees before a restraint situation arose.[15] The Review was informed that in those two cases the injuries involved were quite severe and that it is quite likely that this has had an indirect impact on the attitude of staff towards the use of restraints. Without making a judgement about this, quite clearly it would be naïve to disregard or attempt to discount staff fears and anxieties. Such matters feed into the overall culture of any work environment and must be dealt with as a fact of life. In this regard, training is essential, as well as the clarity of the expectations and the supportive supervision of both local management and the Department in terms of appropriate behaviour.

PRACTICE, TRAINING AND THE IMPORTANCE OF DE-ESCALATION

30. The question of de-escalation is crucially important. The Carlile Report commented with regard to use of restraints in Secure Training Centres (the institutions which mostly cater for 14 to 17 year olds in the U.K.) that:

> "Staff development in some establishments currently focuses on physical management of aggression and violence rather than developing skills to avert conflict."[16]

[14] In this regard, note the Victoria best practice, described in paragraphs 45-46 below. What has been done in an *ad hoc* manner in Western Australia was carried out as a committed and comprehensive project in Victoria.

[15] In the letter of 27th March 2007 the Department stated that there had been 11 staff injuries in such circumstances in the last 6 months of 2003, 9 in 2004 and 18 in 2005. Those figures clearly indicate something about the risk to staff and reinforce the view expressed in the text that it would be wrong to discount staff fears or anxieties.

[16] The Carlile Report, cited at note 4, Chapter 6, paragraph 61.

31. Evidence to that Inquiry also stated that:

> "Information from psychiatric and other health care settings indicates that strategies to promote reduced use of physical restraint can be successful."

Evidently in the UK the emphasis in the Centres had been primarily on the physical management of aggression rather than strategies to reduce the use of restraints through prevention or de-escalation.

32. The Review received evidence and documentation relating to the Department's current training packages. The Entry Level Program for newly-recruited Juvenile Custodial Officers lasts eight weeks. In that time, it naturally covers a wide range of essential material. The section relating to "Managing Difficult Behaviours" occurs in the second and third week and lasts for seven days. The first two days focus on "Principles and Practice." The next five days relate to "Self Defence" and "Recovery Training."

33. Our Recommendation 64 in the Rangeview Inspection Report was that the "Managing Difficult Behaviours" program should be continuously evaluated to ensure that it remained responsive to Departmental needs. Subsequently, a new two-day section entitled "Dealing with Conflict and Non-Compliance" has been added; that section seeks to bring alive the principles of managing difficult behaviours in a non-conflictual manner. That is certainly a welcome development. However, the observations of this Office in the course of its liaison visits to the two Centres have been that follow-up or in-service training has been sketchy in these areas.[17]

34. A Review team member also attended some of the E-DaRT (Essential Defence and Restraint Training) sessions available to Juvenile Custodial Officers. The Review also has taken note of the Juvenile Custodial Rules applicable as at 8th January 2007 and the Draft Juvenile Custodial Rules February 2007, which are expected to be proclaimed shortly.

35. Whilst the notion of de-escalation is certainly present in the induction training package, the Review considers that it is somewhat under-emphasised. Certainly, the Department has now given it more prominence than previously, and that is a matter that deserves to be acknowledged. However, our discussions and observations suggested that the physical and the non-physical elements of training officers in "Managing Difficult Behaviours" were not well integrated, with those responsible for the longest section on physical interventions not really being aware of the substance of the non-physical component. This situation was exacerbated by the fact that the "Dealing with Conflict and Non-Compliance" segment is delivered by an external contracted provider.

36. Accordingly, it is not all that surprising that the formal documentation that sets the context of daily routines takes the notions of prevention and de-escalation for granted, rather than spelling them out. For example, the old Juvenile Custodial Rule 207 (see Appendix 2) implicitly

[17] The Mahoney Inquiry Report recommended that additional funding should be provided for the training of Juvenile Custodial Officers. An additional amount of $632,000 has been allocated for 2006/07, so it may now be hoped that the follow-up or in-service training deficits can now be addressed.

acknowledges the question of de-escalation but without offering any guidance as to how exactly this might be achieved:

> 1. "Wherever possible, the Superintendent should endeavour to identify alternatives to the use of physical force in maintaining the good order and security of the Juvenile Detention Centre."

The applicable Standing Order (No. 14, November 2001) for Rangeview states that force should only be used "when all other alternatives have been exhausted", but makes no mention of what those alternatives might be. The reference to "alternatives" thus seems in this context to be somewhat tokenistic.[18]

37. In this regard the Standing Order reflects the tone of Rule 207 itself, which likewise proceeds on the basis that force and restraint are more normal than abnormal. Thus, the questions that seem primarily to be addressed relate to the manner and extent of the force. The proposed new Rule 207 is identical to the old Rule in the essential elements.

38. There seems to be an unspoken assumption that all officers will somehow or other, on the basis of this Rule and their previous induction training, understand and subscribe to the value and necessity of de-escalation. Yet the lack of explanation or descriptions of what constitutes de-escalation, how it might subtly or optimally be achieved, and in what kinds of situation are not spelt out sufficiently in the workplace setting. The balance tips towards the use of restraints as being normal rather than exceptional.

DE-ESCALATION; THE 'BEST PRACTICE' APPROACH IN VICTORIA

39. The situation in Victoria appears to be more advanced than that in Western Australia. It seems likely that something could be learned from it as the Department reviews its practices. The principal standards document – "Standards to Guide the Delivery of Services in Juvenile Justice Custodial Centres 2005" – states the basic rule as to the use of force in a manner that is consistent with the AJJA principles and is very similar to the broad statement of principle found in this State:

> "Reasonable force will only be used as a last resort and staff will only use the minimum amount of force for the minimum amount of time necessary."

40. However, the Victoria Juvenile Justice Custodial Operational Manual brings this general statement alive in ways that markedly contrast to the Juvenile Custodial Rules of Western Australia. In particular there is a very detailed section on "Reactive strategies – de-escalation". This section of the Operational Manual is attached in full as Appendix 3. The key factor is that instead of stopping at the general exhortation that force should only be used as a last resort (or as in Western Australia that the Superintendent should endeavour to identify alternatives

[18] The equivalent Standing Order (No. 18) for Banksia Hill likewise makes no specific mention of de-escalation.

to the use of physical force), the Manual sets out in considerable detail the sorts of matter that may be available to staff when dealing with "clients"[19] as a means of heading off or at any rate minimising the incident that might otherwise result in an application of force and the use of restraints.

41. The main headings give something of the feel of the Victorian approach. For example, there is a section on "Increasing or Decreasing the Situations related to Behaviours" – a concept that includes both increasing situations that produce appropriate behaviour and decreasing situations that produce inappropriate behaviour. In that regard, considerable emphasis is placed on the staff member's own behaviour in terms of interactions and reactions.

42. It is also emphasised that responses within the de-escalation model should if possible be related to individual behaviour management plans – in other words, the working assumption is that the staff know the clients well enough to take their particular idiosyncrasies into account in their handling of incidents. There is a cross-reference to another part of the Operational Manual – Proactive Strategies – that reinforces this approach. More generally, the Victoria documentation recognises that violence is in part a function of the overarching atmosphere in an institution and that staff have a crucial role in creating this atmosphere. For example, there is a specific reference to the undesirability of swearing either at clients/detainees or in their presence.

43. The de-escalation part of the Operational Manual also contains a section headed Supplementary Information – also attached as part of Appendix 3 – which sets out in detail various intervention strategies proceeding from the management philosophy that "by intervening early, staff could prevent a full blown incident from occurring". It is only at the end of these various guidelines that the question of the logistics or mechanics of restraint is addressed. This contrasts with the Western Australian approach that appears to focus primarily on the physical management of aggression and violence and only refers to the issue of developing skills to avert conflict in a subsidiary way.

44. Although the Review has not had an opportunity to observe directly the training of Juvenile Custodial Officers in Victoria, we are confident from our inquiries and discussions that the training package very much reflects the tone of the Operational Manual and that, moreover, as much is done as is reasonably possible to reinforce this approach in the workplace.[20]

45. An outstanding example of this occurred in May-August 2006. A psychologist was stationed in each Unit within the three Victoria Centres for a period of three days, with the remit of observing staff behaviour particularly with regard to their approach to de-escalation in the course of their daily duties. The psychologist was then able to provide immediate feedback to individual staff to talk through situations that had occurred and to analyse how they could

[19] The WA documentation adopts the nomenclature of "detainees" rather than "clients".

[20] In its letter of 27th March, the Department was inclined to doubt whether it could learn anything from the Victoria approach. The Review acknowledges that the most cogent study should combine observation of training with data analysis as to the frequency and typology of incidents, but this simply could not be done within the available time and resources. Nevertheless, the tangible evidence of good documentation and process that is set out in this Report would seem more than enough to suggest that Victoria may have something to teach Western Australia in its approach to this crucial aspect of dealing with juveniles in detention.

have handled them differently or better. She was also able to work with Unit Managers to develop an action plan to maintain and improve de-escalation strategies and techniques within their Units. This whole exercise involved 45 observation days in all across the three juvenile detention centres.

46. This was followed up by staff surveys six months after the observation period had finished. The results confirmed the informal feedback that had been received at the time, namely that staff really appreciated this form of practical training where they were being observed and coached in practical on-the-job situations rather than in just the staged situation of training.

POSSIBLE RELEVANCE OF THE FACT THAT BOTH BOYS AND GIRLS ARE HELD AT RANGEVIEW AND THE DESIRABILITY OF REVIEWING CURRENT DEPARTMENTAL PLANS TO CONSTRUCT NEW ACCOMMODATION FOR GIRLS AT RANGEVIEW RATHER THAN AT BANKSIA HILL.

47. A peripheral matter that should be addressed about the Rangeview situation is the fact that it accommodates both boys and girls. It was suggested to the Review that this may cause greater volatility and cultural dissonance, leading to a greater number of incidents triggering the use of restraints. In the absence of incident data collected and aggregated in such a way that a factor analysis could be carried out, the hypothesis that a gender-mixed environment begets violence could not be validated. It would not be prudent to proceed on this basis, therefore.

48. The question of how girls should be managed within the juvenile estate is not, strictly speaking, within the terms of reference of this Review. However, it is one which the Inspector has previously investigated. The notion of accommodating remand class girls in the same place as sentenced girls does not per se contravene international standards. The UN Rules for the Protection of Juveniles Deprived of their Liberty provide as follows:

> 28 ... "The principal criterion for the separation of different categories of juveniles deprived of their liberty should be the provision of the type of care best suited to the particular needs of the individuals concerned and the protection of their physical, mental and moral integrity and well-being."

49. At inspections of both Banksia Hill and Rangeview, we have been concerned at the restrictions on the regime for girls arising partly out of the fact that they do not constitute a critical mass for girl-centred services when they are spread between two institutions. We had recommended, therefore, and the Department had accepted, that all female detainees should be held at the same centre. This seemed in terms of the UN standard to be the optimum arrangement from the point of view of their "physical, mental and moral integrity and well-being."

50. Our own firm recommendation had been that Banksia Hill best lent itself to this, there being a natural precinct that could readily be adapted so as to achieve separation without disadvantaging girls. The operational culture is also preferable in that Banksia Hill accommodates a more settled population with better-focussed and more purposeful activities. However, the Department has decided to go ahead with this project in the rather cramped conditions of Rangeview, and a

building program is scheduled to commence soon. What this Review has confirmed is that Rangeview is a more volatile institution than Banksia Hill and thus, we would argue, a less desirable location for detaining girls. If it is not too late, our own Banksia Hill proposal should be re-examined and the viability of both sites re-assessed.[21]

APPLICABILITY OF THIS REVIEW TO THE WHOLE JUVENILE ESTATE WHETHER MANAGED BY DCS OR BY ANY OTHER STATE GOVERNMENT DEPARTMENT, PARTICULARLY THE DEPARTMENT FOR COMMUNITY DEVELOPMENT

51. The recommendations that will be made as a consequence of this Review arise out of an examination of the particular situation at Rangeview. Over the last year (the period for which figures were available) the use of restraints at Banksia Hill has been markedly less than at Rangeview in relation to a larger daily average population. Nevertheless, the recommendations are equally applicable to Banksia Hill and indeed to any future additions to the juvenile estate such as those that have been mooted for the Geraldton and Kalgoorlie regions.

52. Juvenile detention centres managed by the Department of Corrective Services are not the only places in Western Australia where juveniles are involuntarily detained. The Department for Community Development manages five residential care hostels, the daily average population of which is normally about 35 to 40. In August 2006 the Ombudsman published her "Report on Allegations concerning the Treatment of Children and Young People in Residential Care". The trigger for her Inquiry had been allegations by an informant to the Department for Community Development that punitive measures had been used against juvenile residents by staff at these hostels, including the use of excessive force in restraints. Specifically, one of the allegations was that hostel staff had resorted to the technique of "dropping" young people, as referred to in paragraph 18 above, in relation to Rangeview.

53. The Ombudsman's jurisdiction hinged on the fact that the Department had failed to investigate properly the allegations of the informant, so that a "matter of administration" arose under the *Parliamentary Commissioner Act 1971*. However, the substantive matters underlying the matter of administration were the subject of some recommendations relevant to this Directed Review. The first of these arose out of the fact that "direct care workers" (i.e., staff working in residential care hostels) had recently been authorised under the *Children and Community Services Act 2004* to apply restraints to children and young people. (Previously, there had been some legal ambiguity about this.) Accordingly, the Ombudsman recommended:

    16. "Given the recent authorisation of DCWs under the C&CS Act to apply restraints to children and young people, the Department should undertake regular physical restraint training of all its DCWs to ensure that they are familiar with authorised techniques, restrictions relating to the use of physical restraints against abused young people, and contemporary notions of best practice in these matters."

[21] It is understood that the funds for creating a separate female precinct have been allocated by Government on the basis that this development would take place at Rangeview. It is not within the Department's own discretion to alter this. However, the decision is a wrong one. The Government should now review the matter in the light of the changed circumstances.

54. The Ombudsman was also, as with this Review, somewhat frustrated by the lack of aggregated information about the use of restraints. She accordingly recommended:

    20. "The Department should maintain statistical data on the use of restraints in its residential care facilities...."

55. The Ombudsman's recommendations are currently being reviewed by a Working Party.[22] In this Review's opinion, the whole question of the use of restraints against children and young people should be subject to a single code. This is a straightforward human rights principle that needs to be reflected in good governance practices. It would be anomalous for the lawfulness and acceptability of when and how young people may be subject to restraint to depend on the fortuitous factor of which Government department happens to be the employer of the person using the force.

56. The UK Youth Justice Board has picked up this point, recommending in the preamble discussion to its Code of Practice that:

    > "The Department for Education and Skills, the Department for Health, the Youth Justice Board and the National Offender Management Service should issue one agreed set of principles for the use of control methods in all settings where children are cared for, including secure settings. This should take account of children's views and the need to place physical control within an overall behaviour management strategy, and in a wider context of prevention."[23]

    This should also be the case in Western Australia; there should be a single set of principles. This is particularly the case since the Working Party into the Ombudsman's Report is considering whether to introduce into child residential care a notion of "secure welfare".

57. It would also follow from this that there should be a unified training regime covering the defined principles and procedures of behaviour management in juvenile managed residential settings.

THE DEPARTMENT'S INTERNAL INVESTIGATION REPORT

58. Several other matters that arise from the Rangeview incident will not be addressed by this Review as they are more appropriately and thoroughly dealt with by the Department's internal investigation procedures. These matters include: recruitment practices; referee checks and clearance routines relating to applicants for positions as Juvenile Custodial Officers; rostering policy so as to avoid situations where inexperienced officers are teamed together for Unit duties; evidence gathering protocols following incidents, including how and when photographic

[22] The Steering Committee regarding the Whole of Government Recommendations of the Ombudsman's Report concerning the Treatment of Children and Young People in Residential Care (WA Department of Premier and Cabinet).

[23] Youth Justice Board cited at note 11, above. The recommendation picked up and endorsed a recommendation made by the Joint Inspectorates (i.e. the Chief Inspector of Prisons and the Commission for Social Care Inspection) as part of their July 2005 report, *Safeguarding Children – the Second Joint Chief Inspectors Report on Arrangements to Safeguard Children*. The recommendation referred to the fact that the four listed agencies had discrete and overlapping roles in relation to the detention of children and young people.

evidence should be obtained; and the obligations of witnesses and possible sanctions for non-cooperation. This last point is particularly important; the apparent reluctance of some officers to cooperate fully with the investigative process may, as the IIB Report surmised, be indicative of an evolving culture that focuses more on protecting fellow workers from criticism than on assisting with an objective analysis of the event. These matters are covered by the report of the Internal Investigation Branch,[24] and their validity should be assessed within the evidence put forward in that Report.

RECOMMENDATIONS RELATING TO THE USE OF RESTRAINTS

59. In the light of the above discussion, the Review recommends as follows:

i. The Department of Corrective Services should re-cast the Juvenile Custodial Rules, Local Orders and the training and re-training packages so as to emphasise more strongly strategies and techniques of prevention and de-escalation of confrontational situations that might otherwise require the use of restraints.

ii. Particular attention should be given to the Victoria model for reinforcing prevention and de-escalation strategies and techniques through on-the-job observation and coaching.

iii. Where the point is reached that restraints need to be used, the Department should continue to emphasise the requirement that the intervention should be the least forceful that is consistent with achieving the objective of stabilising the situation and ensuring the safety of the persons involved.

iv. The methods of restraint that are used should be further reviewed, taking into account the profiles of the detained population, in particular as to age and sex, and the potential risk posed to the restrained person by the particular method, and the training and re-training packages should reflect these matters.

v. Each incident involving the use of restraints should be promptly reviewed by the management of the Centre and a report prepared addressing and analysing the circumstances from the point of view of their compliance with the applicable standards.

vi. In addition to reviewing each incident, the Department should collect data relating to all such incidents in such a way as to enable factor and trend analyses to be carried out so as to enable the ongoing evaluation of risk situations, opportunities for prevention and de-escalation, and effectiveness of training.

vii. As an aspect of data collection, the various modes of restraint and use of force must be differentiated.

viii. The standards derived as a result of the above recommendations should be applicable not only across the juvenile estate but also in relation to any other situation where children and young people are held in State institutions in circumstances where restraints may lawfully be applied to them – in particular institutions administered by, or managed on behalf of, the Department for Community Development.[25]

[24] Critical Incident Review IN100107 (March 2007).

[25] This recommendation should be drawn to the attention of the appropriate Minister.

Part 2

COMMUNICATION STRATEGIES INVOLVING THE MINISTER, THE DEPARTMENT AND THE INSPECTOR.

In addition, the question of whether young female detainees should be accommodated at Rangeview or at Banksia Hill should be reviewed. From the point of view of the safe, equitable and constructive management of girls, Banksia Hill has marked advantages over the proposed Rangeview development.

THE LEGAL FRAMEWORK CONCERNING THE MINISTER AND THE DEPARTMENT

60. As the deficiencies in communicating with the Minister are at the core of this aspect of the Review, that matter will be dealt with first. The implications for communication within the Department to the Commissioner and from the Department to the Inspector will flow naturally from this matter.

61. The natural starting point is what is required by statute. Section 7 of the *Prisons Act 1981* provides as follows:

Powers and Duties of Chief Executive Officer

(1) "Subject to this *Act* and the control of the Minister, the Chief Executive Officer is responsible for the management, control, and security of all prisons and the welfare of all prisoners.

(2) The Chief Executive Officer is responsible to the Minister for the proper operation of every prison and shall notify the Minister as soon as practicable of -

(a) Any escape by a prisoner from lawful custody; and

(b) Any accident, serious irregularity, or any other unusual event which affects the good order or security of the prison."

Thus, it is absolutely clear that the Commissioner for Corrective Services himself is at the central point of the communication process upwards to the Minister.

62. The *Prisons Act 1981* also authorises delegation by the Chief Executive Officer of a wide range of his powers under the *Act*. Although there are some exceptions to this (i.e., powers that he is required by statute to exercise directly and personally), the functions under section 7 are not excluded from delegation. However, even if delegated they remain the responsibility of the Commissioner. Section 8(2) is quite explicit:

> "For the purposes of this *Act*, the exercise of a power or the performance of a duty by a delegate under this section shall be deemed to be the exercise of the power or the performance of the duty by the Chief Executive Officer."

63. By the same token the non-exercise or deficient exercise of a delegated power or duty remains the responsibility of the Commissioner. Accordingly, the initial discussion of this matter will proceed upon the basis that the Commissioner himself is, and should be, accountable for the notification system and its practical application. In summary, notifications to the Minister should be carried out by, or in the name of, the Commissioner, and decisions not to notify should likewise be made by, or in the name of, the Commissioner.

64. In the particular case of juvenile detainees, Section 9 of the *Young Offenders Act 1994* provides that "it is the duty of the chief executive officer, under the direction of the Minister, to carry into operation the provisions of this Act."[26] Thus the Minister requires to be fully informed, and clearly this obligation upon the Commissioner covers the use of force within Section 11C of the Act. Provisions parallel to those found in the *Prisons Act* as to the power to delegate are expressed in Sections 10 and 11 of the *Young Offenders Act*.

65. Overlaying the provisions of the *Prisons Act* and the *Young Offenders Act* are the arrangements made under section 74 of the *Public Sector Management Act 1994* – "Agreement for Communications between the Minister for Corrective Services and the Department of Corrective Services". This provides that "for all communications of a strategic policy nature, a covering memo will specify that the Commissioner has noted and endorsed the response before it was sent." Views may differ as to what constitutes a "strategic policy" issue, but it does not seem to be stretching the point to include within that notion matters going to the question of Ministerial responsibility for the administration of the Department.

"NOTIFIABLE INCIDENTS"

66. The question therefore arises: What sorts of matter should be notified to the Minister? In terms of section 7 of the *Prisons Act*, an "escape from lawful custody" is a self defining event, but the reference to any "accident, serious irregularity, or any other unusual event which affects the good order or security of a prison" requires further definition, which is not found in the *Act* itself. What should a notifiable event be, therefore?

67. The touchstone has been discussed in paragraphs 4 and 5, above. It revolves around the notion of matters that may call into question the accountability of the Minister under the principles of Ministerial responsibility that have evolved in our society. Political risk is the handmaiden of Ministerial responsibility. An aspect of Ministerial responsibility, therefore, is the increasing media scrutiny that all forms of Governments seem to attract, as identified by the discussion contained in the Hooker Report and quoted at paragraph 4. Media scrutiny is no less important a tool for creating political risk than Parliamentary scrutiny. Comparable criteria should be applicable to incidents occurring within the juvenile estate or in relation to community justice services.

68. This concept is increasingly found in other jurisdictions. For example, the Incident Reporting protocols in the Victoria Department of Human Services, which is responsible for the management of Juvenile Detention Centres in that State, acknowledge that:

> "There is intense public and media interest in the operations of Victoria's Human Services, and it is essential that the Department and the Minister's Office are able to respond quickly to issues and events that arise."

[26] See also Section 181 of the *Young Offenders Act*, which empowers the Commissioner, with the approval of the Minister, to make rules for the management, control and security of detention, and for the management, control and security of detainees, and for the management of officers.

These protocols sometimes do not work as they are intended, as an incident involving the escape of three men from the State-wide Forensic Services Centre in January 2007 demonstrated. The responsible Minister complained that she was not informed about the incident until 9.00a.m. the next day, and was then given inaccurate details about their escape as well as ambiguous information regarding suppression orders surrounding the three men. She stated:

> "I am also concerned about the communication of information to myself so that I can fully understand and appreciate what had happened."

It can be seen from this example that even jurisdictions that bring to the surface the criteria of Ministerial accountability in the media do not always get the communications right. However, at least the criteria for notification were in place – an essential starting point.

69. Accordingly, how can one reliably define what is or should be a notifiable incident? On the one hand, the Minister must be in a position to demonstrate both within Cabinet structures, to the media and within the Department the fact that she accepts and can effectively meet the requirements of Ministerial responsibility for the conduct of Departmental affairs; on the other hand, no Minister's Office can afford to be swamped by trivia. Thus, if one simply defines notifiable incidents in terms that leave too much filtering discretion to the notifying agency, she may be left exposed through ignorance; but if one lists events in an all-inclusive and prescriptive manner, one runs the risk of not covering the unpredictable contingencies of a Department such as Corrective Services as well as swamping the Minister's office with too much information.

70. A starting point, however, may be to look at matters included in a list that seems to be working reasonably satisfactorily. This relates to notifiable incidents for the purposes of the *Acacia Prison Services Agreement* - i.e., incidents that have to be notified to the Department by the Operators of Acacia Prison so that the Department in its turn may meet its accountability duties. The Department must then decide which of these incidents should be notified onwards to the Minister, paralleling what should be done in relation to incidents occurring within the public sector side of its activities.

71. The *Agreement* provides that a notifiable incident means:

a. an escape;
b. the death of a Prisoner who is in the custody of the Contractor or the death of any other person at the prison;
c. an emergency;
d. loss of control;
e. the charging of a Contract Worker [prison officer] with an offence;
f. the Serious Assault of a Prisoner or any other person at the Prison;
g. attempted suicide of a Prisoner at the Prison;
h. a fire at the Prison;
i. any incident compromising the security of the Prison;
j. any medical emergency in relation to a Prisoner or any other person at the Prison;
k. any incident of Serious Self-harm by a Prisoner at the Prison;
l. any incident that may result in media attention or the need for written notification to the Minister;
m. any accident, serious irregularity or other unusual event which affects the good order or security of the Prison;
n. any incident which might escalate into any of the above incidents;
o. any incident which is required to be notified under the Prison Operating Manuals;
p. any incident involving the use of force or an instrument of restraint that must be notified to the State under Policy Directive 5; and
q. voluntary starvation by a Prisoner.

72. This list covers quite well the range of matters that should be notified upwards within the Department to the Commissioner or, at the very least, to the relevant Deputy Commissioner. A strong point is that at least three categories leave something to the judgment of the reporting officer. These are: (l) incidents that may result in media attention; (m) serious irregularities or other unusual events; and (n) any incident that may escalate into any of the above incidents. The Victoria Incident Reporting protocols also pick up the need for the exercise of judgment, stating that "it is not feasible to list every type of [notifiable] incident. Staff should use their judgement in considering the sensitivity ... of individual incidents."

REPORTING TO THE COMMISSIONER OR A DELEGATED DEPUTY COMMISSIONER

73. A way forward, therefore, may be to build around the above list as the basis of what should be reported to the Commissioner[27] or his delegate to enable a decision to be made as to further notification onwards to the Minister. Note the logical corollary of this – notifications to the Minister would not emanate from lower levels within the organisation.

[27] All references to "the Commissioner" or to the "Deputy Commissioners" must be taken as referring to anyone acting from time to time in any of these positions.

COMMUNICATION STRATEGIES INVOLVING THE MINISTER, THE DEPARTMENT AND THE INSPECTOR.

74. There are several flow-charts circulating in the Department at present, as it struggles with this issue, and they are in some ways confused and confusing as to who is responsible for what. Indeed, in the case giving rise to this Directed Review, it was unclear whether the responsibility for notification lay with the Commissioner, the Deputy Commissioner Community and Juvenile Justice or the Director Juvenile Custodial Services. It seems essential to bring clarity and consistency to this issue, therefore.

75. As discussed, if the Commissioner prefers to delegate the notification process and decision-making to a lower point and allow his judgment to be exercised by way of delegation, he can do so – but in the context of his own accountability. In other words, if a matter is not passed to him on the basis that he has instructed that he does not need to know this from the point of view of his own functions and also from the point of view of his possible reporting onwards to the Minister, and that judgment call is wrong, that is the Commissioner's responsibility. In other words, the *Commissioner cannot escape his own accountability responsibilities by means of delegation*. The appropriate cut-off point for delegation should be that of the operational Deputy Commissioners, in relation to events occurring within their own portfolio responsibilities.

76. In the context of the currently evolving management structures of the Department, it is important to emphasise that the delegation route should not lead towards the Assistant Commissioner Professional Standards. The role of that Division is not to deal with operational exigencies but with retrospective evaluation and prospective rectification of system shortcomings or failures. From the point of view of Ministerial notifications, that Directorate is something of a *cul-de-sac*. Moreover, it is not the right place at which judgment calls should be made about current and ongoing operational exigencies and the political/strategic risk they pose.

77. Many of the judgment calls that might have to be made would be relatively straightforward. Would the Commissioner or the delegated Deputy Commissioner need to be informed about a medical emergency of a kind that might occur to a free citizen – for example, a heart attack not resulting in death? Obviously not. Such a matter is not of a kind that would need to be notified to the Minister. However, if the medical emergency involved acute food poisoning apparently attributable to prison-supplied food, or if it were caused by alcohol or drug abuse in the prison setting (the Inspector has previously come across a case where a prisoner had a blood alcohol level of 0.32 from a home brew), then quite obviously it would need to be notified to the Commissioner or Deputy Commissioner as falling within the terms of paragraph 72, above. That person would then in turn make a decision – almost certainly in the affirmative - as to whether to notify onwards to the Minister.

78. Similarly, a workshop fire quickly extinguished without injury or major damage would not normally need to be reported all the way to the Commissioner. But a cell fire requiring the rescue of a prisoner or a bush-fire causing an evacuation clearly would.

79. Likewise, the use of mechanical restraints (handcuffs or shackles) to facilitate moving a prisoner to a discipline area is a relatively normal prison event and would not require notification all the way up to the Commissioner or his delegate. But if the restraints use was extreme (causing substantial injury as ion this case) or the prisoner against whom the force was applied was a person of great public interest, the case would be different.

80. Examples like these could be multiplied *ad infinitum*. What they demonstrate is that a category of listed notifiable incidents can only take one a certain distance; the more workable approach must be one that superimposes good judgment exercised at an accountable level – ultimately that of the Commissioner.

REPORTING ONWARDS TO THE MINISTER

81. This approach means that the Commissioner would not report onwards matters that his Deputy Commissioners do not consider should be reported upwards to him. Doubtless, internal criteria would be developed to guide these decisions, as well as further delegations down to the Director level and below. Possibly, at least in the short-term until such time as all the parties understand each other's needs, there would be a degree of over-reporting to the Commissioner/Deputy Commissioners. This in turn may set the scene for a degree of over-reporting onwards to the Minister.

82. To forestall swamping (the Minister's small staff could readily be swamped by the vast bureaucratic resources of the Department), a system of "preliminary notifications" might be developed. This could take the form of notifying in two categories: first, matters that the Commissioner is clear in his own mind the Minister should know about, and second matters that merit a preliminary alert which will either be upgraded into a full notification in the light of subsequent events or will be subject to a "no follow-up" or cancellation notice. Within the Minister's office, preliminary notifications could be quickly scanned by an appropriate officer.

83. The objectives sought to be achieved by this system would be: to encourage quality control within the Department whilst at the same time neither inhibiting the notification process nor allowing the Minister's office to be swamped. The system should provide a framework within which mutual confidence can grow, and as this happens the "hit rate" of appropriate notifications (i.e., those that the Minister believes she requires) should increase.

84. The corollary is that, as changes occur in the personnel of the Minister and/or the Commissioner, the system would have to be re-calibrated, within the suggested framework.

85. The summary points are as follows:

- The Commissioner must be at the central point of decision-making as to what is notified to the Minister;
- Within the Department, the Commissioner may delegate decision-making as to what is passed upwards to him and what is, or is not, notified to the Minister;
- In the context of the kinds of incident that may fall into the categories that potentially may require notification to the Minister, delegation should be at the level of the operational Deputy Commissioners;
- Unless a matter is notified to the Commissioner or a delegated Deputy Commissioner, it will not be notified to the Minister;

- The categories of notifiable incidents will be clarified within the Department, along the lines of the *Acacia Prison Services Agreement* and will include flexible categories of the kind identified in paragraph 72, above;
- A system of "preliminary notification" should be developed to cover borderline, developing or ambiguous situations that may develop into full-scale notifiable incidents, so as to avoid swamping the Minister's office whilst simultaneously ensuring that the Commissioner can pass on these matters.

FORM OF NOTIFICATION

86. The Department has been developing a *pro forma* for internal use. That seems *par excellence* to be a matter for its own decision-making. However, the form does not appear to require or encourage the kind of strategic analysis in terms of risk that the Minister would require. A new or additional *pro forma* should be developed, including a narrative section for assessing the strategic importance of the matter.

THE ROLE OF THE DEPARTMENT'S MEDIA AND PUBLIC AFFAIRS UNIT

87. The Department's Media Release relating to the Rangeview incident was transmitted to the Minister's Media Advisor before the Minister had been notified by the Department that such an incident had occurred. The Department's Media Coordinator has assured the Review that this occurred *despite* the arrangements that have been made as to the protocols.

88. The Mahoney Report had addressed in Recommendation 147 the question of the potential for harm and strategic risk if media responses to critical incidents were not sensibly modulated and coordinated:

> "To avoid inadvisable political responses to media pressure, the Department should develop a protocol ... to ensure that information provided to the media about offenders or incidents involving offenders:
>
> (a) is complete and accurate;
>
> (b) is provided in a timely manner; and
>
> (c) preserves the right to privacy of those involved including victims, offenders and Departmental officers."

89. The Office of the Minister and the Department of Corrective Services have subsequently (late 2006) developed a "Protocol for the Provision of Information to the Media regarding High-profile Offenders or Serious Incidents." This Protocol seems to cover most situations reasonably well, and is calculated to ensure that the left hand normally knows what the right hand is doing. However, it would need amendment if the proposals for notification set out above are accepted. Some of its reference points are to the existing (confused and confusing) flow charts as to who does what according to what timescale.

90. A system that puts the Commissioner at the fulcrum of decision-making as to what is passed upwards to the Minister requires that, whilst work on fact-gathering and media releases can continue as the incident is being evaluated, there should be an internal embargo on any release until such time as the Commissioner has decided whether or not to send the matter on. That in turn requires key people in the organisation to recognise that, by its very nature, the incident in question is of a type that is likely to require a Commissioner's decision. Thus the incident notification criteria must be understood at all managerial levels, above all within the Media and Public Affairs Unit.

91. In summary, the new Protocol seems fairly robust but would require modification to meet the proposed system whereby a decision as to whether to notify the Minister of an incident is made at Commissioner level. One such modification would be an internal embargo system to ensure that a Media Release did not occur prematurely, before that decision was made and implemented.

NOTIFICATION TO THE INSPECTOR

92. The information needs of the Inspector are different from those of the Minister. It is well understood that he has no operational responsibility for the failures (or successes) of the corrective services system, so no question of responsibility for its day-to-day problems can arise. That being so, the need to notify him promptly about such matters is less pressing than in the case of the Minister. If the Minister herself decides to seek advice on such a matter from the Inspector in terms of Section 23 of the *Inspector of Custodial Services Act 2003*, there can in effect be a notification downwards from her Office to put the Inspector's office in the picture.

93. However, there are matters that are so central to the Inspector's statutory scope to review "the management, control or security" of a prison or juvenile detention centre or "the security, control, safety, care or welfare" of prisoners or detainees that their occurrence may properly trigger a "watching brief" or even an immediate visit. For example, a custodial officer strike at Hakea, involving also a possibility that nurses might not have crossed the picket line, or a custodial officers' strike at Casuarina, with its attendant risks both to prisoner welfare and control, are matters about which, having been promptly notified by telephone, the Inspector and staff members have responded to by immediate inspection.

94. Similarly, having received notification of the death of a prisoner in circumstances where the Inspector's previous knowledge of the situation raised some concerns as to the appropriateness of the health care he had received, the Inspector requisitioned the patient files the following day.

95. The Inspector's response to these three incidents is clearly anchored in his statutory remit. Prompt observation of the aftermath of a major fire or a loss of control and immediate if hands-off involvement in the investigation of a suicide are likewise related to statutory responsibilities.[28]

[28] The Inspector visited Acacia Prison a few days after a major bushfire around and partly within the site to ascertain whether the processes had been in place for the safety, care and welfare of prisoners during that event, and kept a watching brief on the development of revised procedures to cover any future such event.

96. Each of these matters is an actual example of an occasion where prompt notification has been received. In the 2000/01 Annual Report it was stated:

> Critical incidents
>
> The Office has developed a role in relation to critical incidents in two ways. The most straightforward is to visit a prison where a critical incident is in progress so as to evaluate the impact upon prisoner services. This was done for the first time during the Hakea strike in July 2001. The benefit for the Department and the Minister is that an independent view of the prison situation is thus created; this also is in the public interest. If allegations and accusations are made as to occurrences during the critical incident, the Inspector should be in a position to provide a third view.
>
> The second aspect of this evolving role is to prod the Department into making its own proper inquiries into critical incidents and, in turn, making the results of those inquiries available to the Office for evaluation. The prime example of this related to a fire at Hakea Prison on 9th January 2001...."

97. In the past two or three years, there has been slippage in the Department's practice of notifying the Inspector about critical incidents. Indeed, no formal process for doing so exists; notification is only received if at all through informal personal networks. For example, the notorious hostage-taking incident at Bunbury prison in March 2005 only came to the Inspector's notice when a person from a separate Department phoned him at home. Similarly, in August 2004 there was a serious disturbance at Hakea Prison about which the Inspector was never properly informed. The incident has not to this day been fully investigated or adequately analysed.

98. The time would now seem ripe, therefore, for restoring and refreshing these protocols. Notification to the Inspector would readily hang off the new procedures suggested for notification to the Minister. In relation to a narrower category of critical incidents – deaths in custody, escapes from secure prisons, riots or temporary loss of control, industrial action, fires, and hostage situations – the Inspector's office should be notified in the same terms as, and shortly after, the Minister's Office. This should be achieved by way of a new Memorandum of Understanding. The critical incident coverage could be amended from time to time in the light of experience.

99. This would not only provide the tools to enable the Inspector to decide how best to meet his statutory responsibilities but would also ensure that he would be in a position to offer advice to the Minister upon request, as specifically covered in the statutory remit.

100. The Department should also as a matter of course send the Inspector's Office copies of all its Media Releases – just as the Inspector sends the Department copies of his own.

101. With regard to general information flow, the *Inspector of Custodial Services Act 2003* provides that "the Inspector or any person authorised by the Inspector ... may have free and unfettered access to ... a person whose work is concerned with a prison, and ...all documents in the possession of the Department in relation to a prison or to a custodial service in relation to a prison." This ensures that there is a regular flow of run-of-the-mill information to the Inspector's office.

102. However, there continues to be a misapprehension within the Department that information requests must be channelled through a single point. Whilst that is understandably more convenient for the Department, it can often work so as to cause an unnecessary delay. The statute clearly contemplates a model where any authorised person is entitled to seek relevant documentation from any Departmental employee, and of course as a matter of practice that usually means the person who can most readily supply it. The Department can meet its own needs of keeping a tab on what documentation has left the Department for the Inspector's office by establishing an internal system of notification to a central point within the Department.

103. Effective and unfettered information flow to the Inspector's office is a key aspect in his being able to advise the Minister if requested in terms of the *Act*.

RECOMMENDATIONS

104. In the light of the discussion in paragraphs 58-96, the Review recommends as follows:

ix. That the Department's system for informing the Minister of critical incidents should be simplified and streamlined;

x. That the Commissioner should be directly responsible for managing the process, with power to delegate to Deputy Commissioners in relation to their own operational responsibilities;

xi. That the categories of "notifiable incidents" should be refined and clarified along the lines indicated above;

xii. That a system of "preliminary notification" to the Minister's Office should be developed, as discussed above;

xiii. That the "Protocol for the Provision of Information to the Media regarding High-profile Offenders or Serious Incidents" should be adapted to take account of the proposed new procedures;

xiv. That an embargo system should be created in relation to any Media Release relating to a matter that is under consideration for notification to the Minister; and

xv. That the Department should notify the Inspector of "critical incidents" as defined above immediately after notifying the Minister of such incidents, and that a Memorandum of Understanding covering this matter and related matters of information flow should be made and reviewed in the light of experience from time to time.

105. The above recommendations and those set out in Part 1 of this Directed Review should be implemented promptly. The Rangeview incident has revealed that there are systemic problems both as to the substance of the use of force against detained juveniles and as to communication protocols from the Department to the Minister and to the Inspector. These matters should now be addressed and resolved.

Appendix 1

TERMS OF REFERENCE OF THE DIRECTED REVIEW

DIRECTION TO THE INSPECTOR OF CUSTODIAL SERVICES PURSUANT TO SECTION 17(2)(B) OF THE *INSPECTOR OF CUSTODIAL SERVICES ACT 2003* (WA) TO REVIEW A PARTICULAR CUSTODIAL SERVICE IN RELATION TO A DETENTION CENTRE AND OTHER GENERIC CUSTODIAL SERVICES IN RELATION TO PRISONS, DETENTION CENTRES AND COURT SECURITY CUSTODIAL SERVICES.

1. The Inspector is directed to report on the use of restrictive physical intervention techniques in detention centres and the frequency of such incidents, the criteria according to which such interventions are deemed appropriate, the methods used, the training of the relevant staff, the internal accountability and monitoring of such incidents including compliance with section 11C(2) of the *Young Offenders Act 1994* and regulation 72 of the *Young Offenders Regulations 1995*, the involvement of external agencies in assessing or finalising such incidents, and the notification criteria and protocols for informing the Minister, the Commissioner and the Inspector about such incidents.

2. The Inspector should make recommendations with regard to any of the matters set out in paragraph 1.

3. The Inspector is directed to report on the criteria by which the Department defines an incident involving the management, control or security of a prison, a detention centre or a court security custodial service or an incident involving the security, control, safety, care or welfare of a prisoner or a detainee or a person in custody as notifiable, and the criteria and protocols for informing the Minister, the Commissioner and the Inspector about such incidents.

4. The Inspector should make recommendations with regard to any of the matters set out in paragraph 3.

Appendix 2

WESTERN AUSTRALIAN JUVENILE CUSTODIAL RULE 207

RULE NUMBER:	207
TITLE:	PHYSICAL FORCE
DISTRIBUTION:	STAFF ONLY

The principal guidelines for the use of physical force (non-mechanical restraint) are outlined in this Juvenile Custodial Rule and shall be observed as shown. The provision of Juvenile Custodial Rules 208 and 703 shall also apply.

1. Wherever possible, the Superintendent should endeavour to identify alternatives to the use of physical force in maintaining the good order and security of the Juvenile Detention Centre.

2. All endeavours to have the detainee walk to a cell, or comply with instructions, without the use of physical force must have been exhausted. The detainee must be presenting a risk of physical injury to himself, other detainees or staff and it must be a time of active danger to justify the use of any form of physical force.

3. All Officers shall be made aware of the necessity to limit the application of physical force to that immediate period when the detainee is imminently presenting a risk of physical injury to himself, herself, other detainees or staff. As soon as the imminent risk has passed, and the detainee has stabilised, then the use of physical force shall cease.

   3.1. In the event of physical force being required then only that degree of physical force which is deemed to be the minimum required to control a detainee's behaviour shall be applied.

4. At all times the Superintendent shall take care to ensure that the method of physical force, and the continuation of such restraint, does not cause physical injury to a detainee. Restraint by use of neck holds and head locks is potentially lethal and shall never be used on a detainee.

5. Officers should not put themselves at risk of injury for the sake of preventing damage to property.

6. PROHIBITED STAFF CONDUCT

In the discipline or control of behaviour of detainees the following conduct is prohibited in a Juvenile Detention Centre:

6.1. The administering of corporal punishment;

6.2. Physical contact involving undue physical force;

6.3. Physical restraint holds such as the wrist locks, "chicken hold", neck holds, head locks and the use of pressure points and thumb pressure;

   6.3.1. Only those restraint holds that are currently authorised and taught by qualified restraint training personnel shall be used in the restraint of detainees;

   6.4. Exertion of undue psychological pressure; verbal abuse or denigration;

6.5. Sparring, the use of threats or being involved in physical interplay with detainees; and

6.6. Any practice prohibited by the rules of the Juvenile Detention Centre.

7. REASONABLE PHYSICAL FORCE PERMITTED

7.1. *Section 6* above, does not prevent physical force being used where, for the protection of a detainee, other detainees, or other persons, it is necessary to physically restrain a detainee, provided that the physical force does not exceed that which is reasonable, having regard to all the surrounding circumstances.

7.2. In all cases where physical force or other restraint has been used against a detainee, the detainee shall be examined by the medical staff as soon as is practicable after the incident.

7.3. The Nurse or Medical Officer shall ensure photographs are immediately taken of any injury sustained either by the detainee or staff, and such photographs, along with a copy of the medical report shall be forwarded to the Superintendent.

8. PHYSICAL CONTACT PERMITTED

8.1. *Section 6* above, does not prevent physical contact from being used for the proper care, supervision, training, discipline and development of a detainee. This is provided that the physical contact does not exceed that which would be consistent with the actions of a responsible parent, having regard to all the surrounding circumstances.

9. WRITTEN RECORD

9.1. A report for any incident involving the use of reasonable physical force shall be provided by the relevant Juvenile Detention Centre staff with respect to each detainee restrained. All reports, along with any medical reports raised, shall be counter-signed by the Designated Superintendent and are to be bought to the attention of the Director, Juvenile Custodial Services.

10. PARENTAL INVOLVEMENT

Where practical the parents, caregiver or significant others shall be contacted by the Designated Superintendent and invited to attend the Detention Centre to promote their role and involvement in the management of a detainee following a serious incident which had resulted in the use of physical force.

Footnote: AJJA Standards for Juvenile Custodial Facilities (March 1999)

Standard 7.1. Personal and Social Responsibility
Standard 7.3. Disciplinary Scheme
Standard 7.7. Use of Force
Rule made pursuant to Section 181 (1) of the *Young Offenders Act 1994* by the Director General being the Chief Executive Officer of the Ministry of Justice with the approval of the Minister.

Rule last updated 11 January 2001

Appendix 3

VICTORIAN OPERATIONAL PROCEDURE 6.11 – DE-ESCALATION

6.11 REACTIVE STRATEGIES — DE-ESCALATION

INTRODUCTION

Reactive strategies are immediate responses to address inappropriate behaviour as it occurs. These strategies must take into consideration the safety of clients and staff, and focus on intervening early to minimise an escalation of the behaviour.

Reactive strategies may be categorised on a continuum, with interventions ranging from the least restrictive de-escalation strategies through to the most restrictive measures.

De-escalation strategies provide staff with the tools to address inappropriate behaviours, intervene early, and minimise escalation of the behaviour with the aim of preventing a serious incident from occurring.

In emergencies, procedures in 'Chapter 9A — Emergency procedures' of this manual should be followed.

LEGAL AND POLICY MANDATE

Children and Young Persons Act 1989

Standards to guide the delivery of services in juvenile justice custodial centres, Department of Human Services (2004)

Victorian juvenile justice case practice standards manual, Department of Human Services, (2002)

AUTHORISATION

- The unit manager has responsibility for ensuring that staff are familiar with the reactive strategies outlined in this procedure.
- The unit coordinator is responsible for ensuring that unit staff are aware of behaviour management strategies, and the range and level of consequences for individual clients, and for providing guidance to unit staff for their implementation through the supervision process.
- The unit supervisor is responsible for providing advice and leadership in the day to day management of clients.

PROCEDURES

This procedure provides staff with tools to help address inappropriate behaviours, intervene early and minimise further escalation of the behaviour.

It is important to have a planned approach for when inappropriate behaviour occurs.

Know the client

- What are their warning signs?
- What works, and what does not work when their behaviour is escalating?

- Staff should speak to other staff members about strategies that have worked with particular clients and develop new strategies.
- A consistent response across the staffing group is required.

Deciding when to intervene

Some questions to consider when deciding whether to intervene:

- What behaviour is inappropriate and why?
- Consider the nature of the behaviour — is it 'typically adolescent' for example, testing boundaries, risk taking, the client's personality and so on.
- Whether the effect of the intervention may be more negative than the effects of the behaviour.
- Consider the circumstances under which the behaviour occurred, including the behaviour of the other clients and staff.

Individual behaviour management plans

Where possible, staff should implement strategies outlined in the individual behaviour management plan (see procedure '6.10 — Proactive strategies — individual behaviour management plans').

Where strategies are found to be ineffective, the unit coordinator and health services should review the individual behaviour management plan.

Observable (warning) signs in clients

Physical and behavioural signs can signal that the behaviour of a client is escalating. By identifying and responding to a client's warning signs, staff can intervene early, and might prevent a serious incident from occurring.

Warning signs are the not the same in all individuals. Examples of physical and behavioural signs are outlined in 'Supplementary information 1: General strategies', at the end of this procedure.

Individual warning signs can be identified and, if appropriate, documented in the client's individual behaviour management plan (see procedure '6.10 — Proactive strategies — individual behaviour management plans').

Interactions with clients

When addressing inappropriate behaviour of a client, staff should:

- Clearly communicate to the client what is acceptable behaviour and what is not.
- Briefly explain why it is inappropriate.
- Direct any confrontation to the behaviour, and not the person (for example, if a client has lied, staff should not call them a liar, but focus on the behaviour).
- Provide firm boundaries.
- Keep any commitments that they make.

For more information see procedure '6.5 — Proactive strategies — interaction with clients'.

Increasing or decreasing situations related to behaviours

Increasing situations that produce appropriate behaviour

As a short-term strategy, staff can increase or reproduce situations that have previously produced appropriate behaviours.

To identify these situations staff should use information collection strategies outlined in procedure '6.10 — Proactive strategies — individual behaviour management plans: Supplementary information 1: Information collection and use'.

Examples of these types of strategies include:

- Engaging the client in constructive activities (for example, sport, playing games).
- Using clearer instructions with the client.
- Scheduling one to one sessions with preferred staff.

Decreasing situations that produce inappropriate behaviour

As a short-term strategy, staff can decrease or eliminate situations that previously produced inappropriate behaviours.

To identify these situations staff should use information collection strategies outlined in procedure '6.10 — Proactive strategies — individual behaviour management plans: Supplementary information 1: Information collection and use'

Examples of such strategies include:

- Reducing demands at certain times of day, where the environmental context may inflame the situation.
- Rephrasing instructions to the client (for example, speaking to the client in a nonconfrontational way rather than being directive).
- Giving 'cool off' space for a client when they are upset (for example, instead of asking lots of questions and demanding things of them).

By themselves these strategies are unlikely to bring about long-term change, but can provide space and stability to implement other interventions.

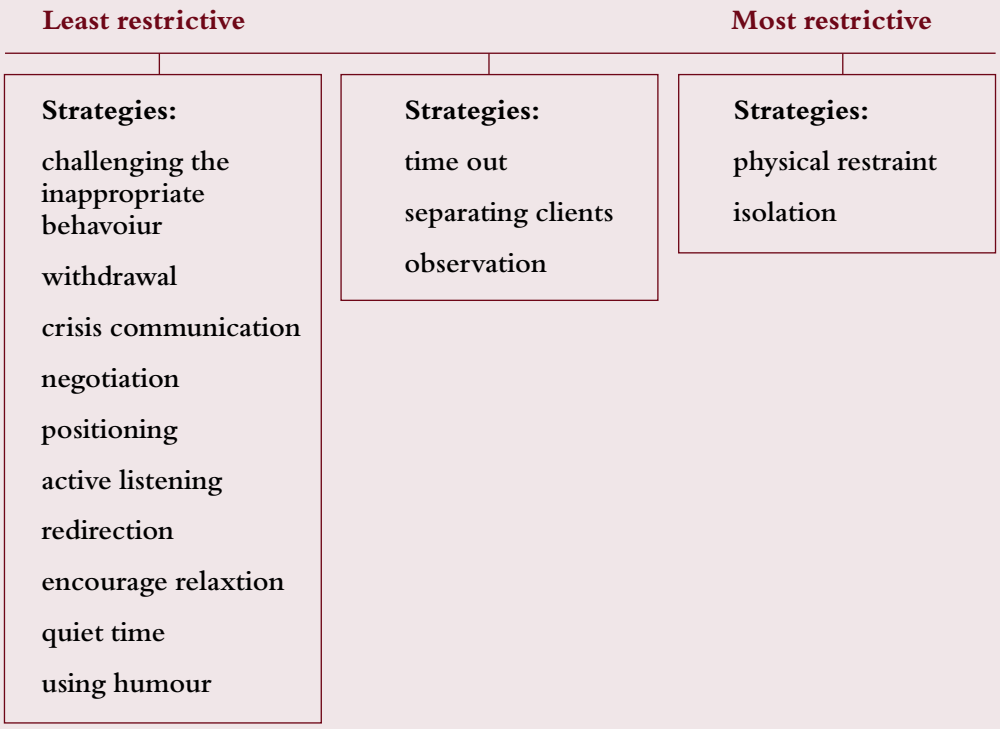
Staff tips

Staff also need to be aware of their own behaviour and use strategies to maintain their control in difficult situations. Staff's reaction to an incident can often determine whether the incident escalates.

Tips for staff on how to remain calm are outlined in 'Supplementary information 1: General strategies' at the end of this procedure.

Range of intervention strategies

When the behaviour of a client is escalating, staff should intervene using strategies that range from the least restrictive to the most restrictive level of intervention.



Refer to '6.11 — Supplementary information 1: General strategies' at the end of this procedure, for tips in implementing these strategies or interventions.

Additional strategies

Use of radio

If the behaviour of a client is escalating, staff may also call on other staff to assist with the situation (see procedure '9.16 — Radios').

Staff should assess whether or not a radio is more effective than using the duress alarm. Using the duress alarm could result in too many staff attending, which could escalate the behaviour of a client.

Duress alarm

In emergencies, the duress alarm can be used (see procedure '9.7 — Duress alarms').

If the duress alarm is used, several staff members will attend and assist in de-escalating the situation. In these situations, it is important to have a single person negotiating with a client, rather than a number of different people speaking to them.

FURTHER REFERENCES

6.2 — Introduction — behaviour management framework

6.5 — Proactive strategies — interaction with clients

6.10 — Proactive strategies — individual behaviour management plans

6.12 — Reactive strategies — post incident

6.13 — Reactive strategies — observation

6.14 — Reactive strategies — isolation

6.15 — Reactive strategies — reasonable force

6.16 — Reactive strategies — restraint techniques

9.7 — Duress alarms

9.16 — Radios

Chapter 9A — Emergency procedures

SUPPLEMENTARY INFORMATION 1

General strategies

This information outlines general strategies for dealing with inappropriate behaviour when it occurs and, where necessary, developing specific reactive strategies for individual clients.

Staff tips

Staff should be aware of their own behaviour and use strategies to maintain their control in difficult situations. Staff reactions to an incident can have a significant impact on whether the situation escalates or de-escalates.

KEY PRINCIPLE	TIPS
Remain calm	Speak to the client in a clear and calm manner – don't raise your voice or yell.
Listen	Don't interrupt when a client is talking, listening will inform you of what they want, and can make the client feel validated. Paraphase back to the client for clarification of the content if necessary.
Think positively	Be patient – an incident might feel like it has been going for 30 minutes, when in actual fact it has only been going for a few minutes. Don't take it personally.
Think of a plan	Look around you and assess the environment. Where are the other clients? Are there staff nearby and can they assist you?
Use deep breathing to calm yourself down	Focus on your breathing to calm yourself down. Count to three – it slows you down and lets you think about your plan of action.

Observable signs in clients

Physical and behavioural signs can indicate that a client's behaviour is escalating.

Individual signs should be identified and documented in clients' case notes and individual behaviour management plans (see procedure '6.10 — Proactive strategies — individual behaviour management plans').

Examples of observable warning signs:

Physical changes	• sweating • rapid speech • rapid eye movement • red in face • rapid breathing
Behavioural signs	• pacing • clenching of fists • becomes withdrawn • voice gets louder • answering back, swearing • raising hands in the air • invades personal space – stands too close.

INTERVENTION

When an incident occurs there is usually an observable build-up that peaks at the incident. Staff can intervene at different levels during this escalation period. By intervening early, they could prevent a full-blown incident from occurring.

After an incident, it is quite common for the client to become subdued and depressed. If this occurs, staff should provide the client with a 'cooling off' period and space to calm down.

Intervention strategies

STRATEGY	TIPS
Challenging the inappropriate behaviour	Be clear about what behaviour is acceptable, and what is not. Confrontation must be directed at the behaviour, not the person. If a client has lied, staff should not call the client a liar, but focus on the behaviour. Provide very clear boundaries.
Crisis communication – 'talking the client down'	Speak slowly and clearly. Keep your communication short and simple. Use short sentences with simple and direct words. Give clear directions one at a time. Statements might need to be repeated.
Negotiation	Where possible, the situation should be defused before commencing negotiation. When negotiating: • Only one person should negotiate with the client. • Be patient. • Adapt the approach to the individual. • Be clear on what issue might be addressed • Consider the broader issues, not just the issue at hand.
Positioning	• Use non-threatening body language and tone of voice. • Provide space – don't crowd. • Remove others from the situation, if possible.

STRATEGY	TIPS
Active listening	Active listening is a strategy whereby you reflect back at the person's feelings. For example by: • Paraphrasing – repeating back to the client in a short statement clarifying what they mean (for example, 'X, you would like to be left alone? – 'Yes' – 'When you are ready, you can join us'). • Rephrasing or reflection – re-interpreting the client's experiences and making them meaningful.
Use humour	Humour can be used to defuse a potentially difficult situation. Humour is often an effective way of engaging clients and building rapport with them. It can also be used to defuse a potentially difficult situation. However, as humour might sometimes inflame the situation, staff should: • Use their judgement about when it is appropriate. • Be positive in the use of humour (that is, don't use sarcasm). • Be aware that some clients might use laughter to express discomfort rather than humour.
Redirection	Redirect the client to another activity, for example, 'X", why don't you help me with...' 'X, would you like a ...?' Take the client for a walk or bike ride (if approved by the unit supervisor).
Withdrawal	Withdraw yourself from the situation, or alternatively swap staff member with another who may have a closer relationship to the client.
Relaxation	If the behaviour of a client escalates, suggest doing an activity that you know the client finds relaxing.

STRATEGY	TIPS
Separating clients	Sometimes a client may need to be separated such as when there is conflict/disagreement between clients or a client is being targeted by other clients. Staff can suggest that a client engages in quiet time, or if the situation is escalating, suggest time out.
Quiet time	Quiet time is where a client with settled behaviour requests to go to their bedroom to relax, study and so on. The door can be locked at the client's request however the client must be let out as soon as they request to leave.

Observation

If staff identify that the behaviour of the client is unsettled or unusual, they should monitor the situation. This can be achieved through observation. See procedure '6.13 — Reactive strategies — observation' for information on how to determine observation levels and conduct observations.

Time out

If the behaviour of a client is escalating, it might be useful to remove them from the situation, and provide them with an unlocked space to calm down.

The staff member could also suggest to take the client outside the unit for a walk, with unit supervisor approval, in an attempt to calm the client down.

The guidelines below outline how time out is used:

- Time out is when staff directs a client from a situation to an unlocked space to calm down.
- The door must be left unlocked, otherwise this would constitute isolation.

What is time out?	Time out is where a client is directed from a situation, to an unlocked space in which to calm down.
Where to use time out	Time out can occur in the bedroom, a separate section of the unit, a time out room or outdoor area. Under no circumstances is the client to be locked in an area or led to believe they cannot exit the area of their own volition. If the client is locked in an area, staff must follow the procedure for isolation (see '6.14 – Reactive strategies – isolation).
When a client is in time out	Speak to the client in a clear and calm manner. Inform the client that they are going into time out for a specified period or until they calm down. Inform them that they can come out at any point if they are calm and ready to rejoin the group. Inform other staff of the situation. Monitor the behaviour of the client (random observation is required, unless the unit manager decides differently. See procedure '6.13 – Reactive strategies – observation').

	Ignore all distractive behaviour (for example, slamming doors). Do not negotiate with the client. If the client walks out of their room prior to calming down, redirect them back.
Ascertain whether the client has calmed down	Knock on the client's door, but do not enter the room. Ascertain whether the client has calmed down or continues to display signs of agitation and escalation. Speak to the client in a clear and calm manner. From questions and observation, you must make an assessment of the client as to whether they are ready to exit time out. If at any time the staff assess that the client is at risk of self-harm or is placing other clients or staff at risk, they should be placed on constant observations and isolation may be considered (see procedures '6.13 – Reactive strategies – observation' and '6.14 – Reactive strategies – isolation').
If the client is ready to exit time out	Inform them that they can leave the room/area if they choose and are ready to do so. Provide them with a positive reinforcement for regaining control, for example, 'That's great, X, you have calmed down'. Provide them with the opportunity to complete a thinking report (see procedure '6.10 – Proactive strategies – individual behaviour management plans: Supplementary information 4: Thinking report proforma'). Provide them with personal space for five minutes. After this time, provide an opportunity for the client and a staff member to go through the contents of the thinking report, discuss how they might have handled the situation differently, and discuss other strategies they could have utilised.

Isolation

In order to prevent a client from harming themselves or others, damaging property, attempting to escape, or threatening centre security, it might be necessary to place a client in isolation. Isolation (the most restrictive strategy) must only be used as a last resort and must be authorised by an appropriate staff member (see procedure '6.14 — Reactive strategies — isolation' for information on how to use isolation appropriately). A client must be released from isolation when they no longer pose an immediate threat.

When isolation is used regularly to respond to the behaviour of a client, an individual behaviour management plan must be developed and implemented to reduce the need for isolation (see procedure '6.10 — Proactive strategies — individual behaviour management plans').

Physical management or restraint

Staff are expected to use a range of behaviour management strategies to deal with inappropriate or aggressive behaviour. However, if other methods are unsuccessful, and there is an immediate threat to safety or security, some level of physical intervention by staff may be required (see procedure '6.15 — Reactive strategies — reasonable force' and '6.16 — Reactive strategies — restraint techniques'). Physical management may only be used as a last resort.

If physical management of a client is used regularly, an individual behaviour management plan must be developed and implemented (see procedure '6.10 — Proactive strategies — individual behaviour management plans').

Procedure released 5 December 2005

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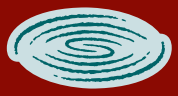

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