GOVERNMENT OF WESTERN AUSTRALIA

OFFICE OF THE INSPECTOR OF CUSTODIAL SERVICES

Behaviour management practices at Banksia Hill Detention Centre

June 2017

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This report is available on the Office's website
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Inspector's overview

Banksia Hill has been unstable

Banksia Hill Detention Centre ('Banksia Hill') has been in the news for too many negative reasons. After a period of relative calm in 2015, the Centre became increasingly unstable, especially in the second half of 2016. Instability continued into 2017.

The media published stories about some serious incidents of damage and 'standoffs' between the youth and authorities. But there were also many other indicators of instability, including increasing incidents of self-harm and assaults on staff. These incidents are summarised in Appendix C.

It was also clear that staff morale and confidence were low. The Department of Corrective Services ('the Department') was driving a 'Transformation Project'. The aim was sound, to introduce a trauma informed and more individualised approach to managing the young people. But the project was poorly implemented. This led to distrust, division, confusion and inconsistency at the facility, and exacerbated risk.

By August 2016, I was so concerned about Banksia Hill that I decided to bring forward this review. I also raised my concerns with the Minister for Corrective Services and the Commissioner throughout 2016, especially in the second half of the year. Unfortunately, the situation deteriorated after we began the review.

Between September 2016 and May 2017, the Department resorted to its specialist tactical response body, the Special Operations Group (SOG) to bring some incidents to a close. On a number of occasions, SOG deployed distraction devices ('flash bombs' or 'flash bangs'), shotgun laser sights, and chemical agent. Nobody was seriously injured in these incidents, and legislation does permit the use of such armoury under strictly controlled conditions. However, its use was unprecedented in either adult or youth facilities in the state. It was the most tangible and telling sign of a facility that was failing the basics.

During the course of this review, we have conducted numerous visits to Banksia Hill and have closely watched incident management. In February 2017, after viewing footage of an incident on 31 December 2016, I issued a 'Show Cause Notice' to the Department about aspects of the use of firearms and distraction devices. I am pleased to say that the Department has now agreed to examine and improve its management and recording of serious incidents. We will continue to monitor this.

The first part of 2017 saw fewer incidents of damage than 2016. However, levels of self-harm, attempted suicide and assault remained high.

The situation came to a head on 4 and 5 May 2017. On 4 May, seven young people caused extensive damage to an accommodation unit and some of them threatened staff. SOG deployed distraction devices and chemical agent to restore control. Within hours, another serious incident occurred. Ten young people went on the roof of an accommodation unit. From here, they managed to access the rest of the site. They also got hold of power tools with which they caused fires and other damage.

The government needs to examine alternative youth custodial options

Managing young people in detention will always be difficult. Almost all the young people who are held at Banksia Hill face complex layers of dysfunction, disengagement, and disadvantage. In my view, it is the most complex and challenging custodial facility in the State. It must hold males and females; children as young as 10 and young adults aged 18-plus; young people from every part of the state; and both sentenced and remand youth.

Banksia Hill faces particular problems because, as a result of the previous government's decision to convert the Rangeview Juvenile Remand Centre to a different use, Banksia Hill has been WA's only youth detention facility. All other Australian jurisdictions have smaller facilities, usually divided by age, gender and status. None of them rely on one large facility to do everything.

There is no 'silver bullet' to improving youth custodial services. However, it is difficult to avoid the conclusion that the 'one-stop shop' model has been a failure. Banksia Hill has been unstable for most of the past five years, despite its high cost. In 2015-2016, the average cost of keeping just one detainee in custody was close to $1,000 per day, or $360,000 per year for each young person. Obviously, incidents will sometimes occur at detention centres. But for that level of investment, the public has a right to expect greater stability, safety, and service delivery.

I have therefore recommended that the government investigate opportunities for smaller facilities across the State. This would allow better separation and better targeted programs for youth in conflict with the law. I acknowledge the challenges with the State's finances, but the current situation is not sustainable and some investment in custodial infrastructure is needed. And if Banksia Hill is no longer to be used as a youth custodial facility, it can be re-purposed. With some modifications, it could work well as either a female prison or as a drug rehabilitation centre.

The Labor government's 'Machinery of Government' changes are yet to come into effect. However, I hope they will promote more coordinated planning for youth justice. The decision to merge the Department of Corrective Services and the Department of the Attorney General into the Department of Justice may allow a less siloed approach to issues such as bail, remand, sentencing and rehabilitation. The decision to move the community based elements of youth justice to the new Department of Communities

should also help to prompt new thinking on reducing the use of custody as well as improving custodial facilities.

Banksia Hill needs to become a stable, positive environment, and to improve accountability

Even if funding was allocated today for new facilities, Banksia Hill would continue to operate for many years to come. This report has identified numerous failings in the way that the Centre has been managing poor behaviour. As I said earlier, it is not easy to manage young people but the Centre must focus on the basics. In all these areas it has been falling down:

- there must be a clear and consistent sense of purpose, driven by management and head office leaders
- responses to poor behaviour must be timely, fair and consistent
- staff must feel confident they will be supported if they follow proper procedures or make an honest and reasonable mistake
- the Centre needs to improve its processes in relation to reporting, recording and accountability for incidents
- there must be an active, positive, stimulating regime for the young people
- there should be a clear and defined system of incentives / rewards for good behaviour
- children in crisis and need must be given psychological and other specialist support
- the Centre needs to deliver on positive initiatives, too many of which have stalled or barely started.

In short, Banksia Hill must become stable and it must become a positive place for both staff and young people.

I am pleased that the Department has accepted the key findings in this report and has supported all bar one of our 17 recommendations. We are conducting a full inspection of Banksia Hill in mid-July and will assess progress again at that time, as well as through our regular monitoring visits.

Neil Morgan

2 June 2017

Executive summary

Background

Behaviour management practices in youth custodial facilities have received national media attention following an ABC's *Four Corners* program in July 2016 about the Northern Territory's Don Dale Youth Detention Centre (Meldrum-Hanna, 2016). The following day the Royal Commission into the Protection and Detention of Children in the Northern Territory was announced.

In September 2016 an independent inquiry was commissioned in Queensland to examine incidents in youth detention centres. New South Wales Juvenile Justice was then publicly exposed for underreporting the use of solitary confinement for youths in custody (Guardian Australia, 2016). Soon after, a Tasmanian report into the Ashley Youth Detention Centre became public, with allegations of 'worrying behaviours' by staff towards the centre's young people (The Australian, 2016).

Quite independently, during 2016, we had become increasingly concerned at the growing instability of the Banksia Hill Detention Centre ('Banksia Hill'). After a period of relative calm in 2015, 2016 saw a wave of self-harm and serious damage. We raised our concerns with the Department of Corrective Services and the then Minister, and also decided to bring forward this planned review of behaviour management practices.

Behaviour management in youth custody is a longstanding concern for us. Our 2011 inspection of Banksia Hill found that punishment was indistinguishable from practices which were supposed to allow personal development (OICS, 2012). We also found a disturbing lack of transparency and accountability in the use of restrictive practices.

In October 2012 the State's two youth custodial facilities amalgamated into a single facility. Three months later there was a riot at Banksia Hill, with a large number of detainees escaping their cells and causing widespread damage. The then Minister directed us to review the incident, its causes and its aftermath. We made several recommendations, all of which were accepted by government.

As a result, the Department made several changes at Banksia Hill, including implementing individual behaviour management plans and a project to transform the facility. Our August 2014 inspection found some progress, but more was needed.

This review discusses behaviour management practices at Banksia Hill and the impact of the transformation project.

Key Findings

The single facility has not worked

Banksia Hill has struggled since becoming the state's sole youth custody centre. There are not enough dispersal options to manage the complexity of the population. A single unit (Harding) is used for multiple disparate purposes which are constantly changing. There are physical deficiencies across the site and in the Harding Unit. New facilities have been needed for some time, especially for crisis care and intensive management.

Control has slipped

In 2016, despite the population being lower than in the past, there were several incidents of serious damage, and self-harm reached unprecedented levels. The increase in critical incidents and self-harm has continued in 2017, including two major incidents on 4 and 5 May 2017. The transformation project was cancelled after these incidents.

A poorly implemented transformation project caused confusion and inconsistency in treatment of young people

The Department was right to promote a stronger rehabilitative model. However, the transformation project was poorly implemented. Four years after the riot, the model was still only being developed. A number of positive initiatives had stalled or were still only in the pipeline. Staff were uncertain and divided about the model, leading to inconsistency in the management of young people.

Staff morale at Banksia Hill has been low

Many staff reported feeling unsafe at work, and increasing numbers of assaults on staff affirmed their concerns. Staff also reported being disempowered, unheard by head office management, and had little confidence in behaviour management practices. In addition, they were fearful of investigations. This dangerous mix hampered their ability and willingness to respond to the behaviour of some of the young people.

Management responses to incidents conflict with rehabilitation

Management responses to critical incidents have conflicted with a rehabilitative, trauma-informed model. Young people have spent more time confined in cell and some have even been denied their legislatively mandated time out of cell for exercise every day. There have been increases in restraint use and high level tactical response, and the centre continues to increase physical security, making the environment more punitive.

Conclusion

Behaviour management practices at Banksia Hill have been inconsistent, inexplicit, and ineffective. The problems are exacerbated by the lack of options created though having only one facility.

Staff have been understandably confused and frustrated by the poorly implemented attempt to move Banksia Hill towards trauma-informed practice. However, the concept of trauma-informed care is sound, and should be pursued. International evidence shows that it offers the best prospects for rehabilitation and community safety.

For a successful shift in practice, Banksia Hill must become a stable and positive environment. Young people need consistent, appropriate responses to their behaviour. Staff need to feel confident, safe, and empowered. Given this is not currently happening, the Department will need to establish a clear way forward which focuses on supporting staff.

Recommendations

1 Behaviour is compromised by having a single youth custodial facility

Western Australia has only one juvenile detention centre. For many years, Western Australia had two youth custodial facilities, Rangeview Remand Centre ('Rangeview') and Banksia Hill Detention Centre ('Banksia Hill'). In October 2012 they were 'amalgamated' into one centre at Banksia Hill, and a facility for young adult offenders was opened at Rangeview. Since the amalgamation Banksia Hill has struggled.

Shortly after the amalgamation, in January 2013, there was a major riot at Banksia Hill which led to most of the facility being unusable for several months. During that time, the majority of young males were held in units at Hakea Prison. By October 2013 all the young people had returned to Banksia Hill.

The Department of Corrective Services ('the Department') has put Banksia Hill's total capacity at 260, though we believe a more realistic figure is around 180. At the time of the riot, it held 207 young people. However, numbers dropped during 2013 and have remained well below 2012 levels. In 2015, the average daily population was 143 and in 2016 it was 136.

1.1. Banksia Hill is the most complex custodial facility in the state

Viewed in terms of numbers, Banksia Hill is one of Western Australia's smallest custodial facilities. Viewed in terms of population and functions, it is the most complex of all custodial facilities. This is because it holds many different cohorts with very different needs. The population comprises:

- children, not adults
- males and females
- a broad age-range (from 10 years of age up to 18 or more)
- young people from all parts of the state (remote, regional and metropolitan Perth)
- a large proportion of young Aboriginal people
- remand as well as sentenced
- high needs in physical health, mental wellbeing, and lifetime trauma.

As Banksia Hill is Western Australia's only youth custodial facility, it has no ability to move young people to another facility for security, safety, or rehabilitative purposes.

1.1.1. Capacity to separate different cohorts is limited

Staff at Banksia Hill do what they can to separate the young people by gender, age, and legal status. However, it has very limited capacity to do this. For example, young women have generally been held in their own unit (Yeeda), but it has sometimes been necessary

for the Department to place young boys in the same unit (with appropriate separation). Two of the male accommodation units (Jasper and Karakin) have mainly served a remand role. Another unit (Urquhart) has previously served as a unit for the older age group.

The young people can be managed according to maximum-, medium- or minimum-security regimes, and under various supervision levels. In 2016, approximately 85 per cent of the population were rated maximum-security. Around 11 per cent were rated medium-security and only 4 per cent were rated minimum. Similarly, 96 per cent of young people were under the highest level of supervision ('direct' supervision). Very few had the lower levels of supervision (2% were rated 'standard' supervision and 2% as 'earned' supervision).

A number of young people require one-to-one management. In August 2016, four young people had this status. There were also a number who required protection-like status because of conflicts with other young people.

1.1.2. There are no dispersal options

The Department is required to provide a safe and secure environment for young people while they are in custody. This is very difficult to achieve when there is only one centre. For example, in 2016:

- 203 young people were identified as a risk to or from other young people
- 73 young people were assessed as 'not to share' a cell
- there were 212 incidents that were classified as a fight, eight of which involved young people who were at-risk from each other.

When Rangeview was in operation, the two facilities permitted greater dispersal of the young people. They could be accommodated in 11 units across the two centres. This allowed staff to separate young people with conflicts who were in custody at the same time. Having two centres also permitted the separation of co-offenders, known associates, and young offenders from their victims. Now, all of the young people must be held in just seven mainstream units.

We raised the need for dispersal options in our review of the 2013 riot (OICS, 2013a). We also referred to the importance of dispersal options to provide relief for staff from particular young people.

1.1.3. The Harding Unit is serving too many disparate roles

The Harding Unit is Banksia Hill's 'multipurpose' unit. It has many roles and these roles continue to change. It consists of four wings:

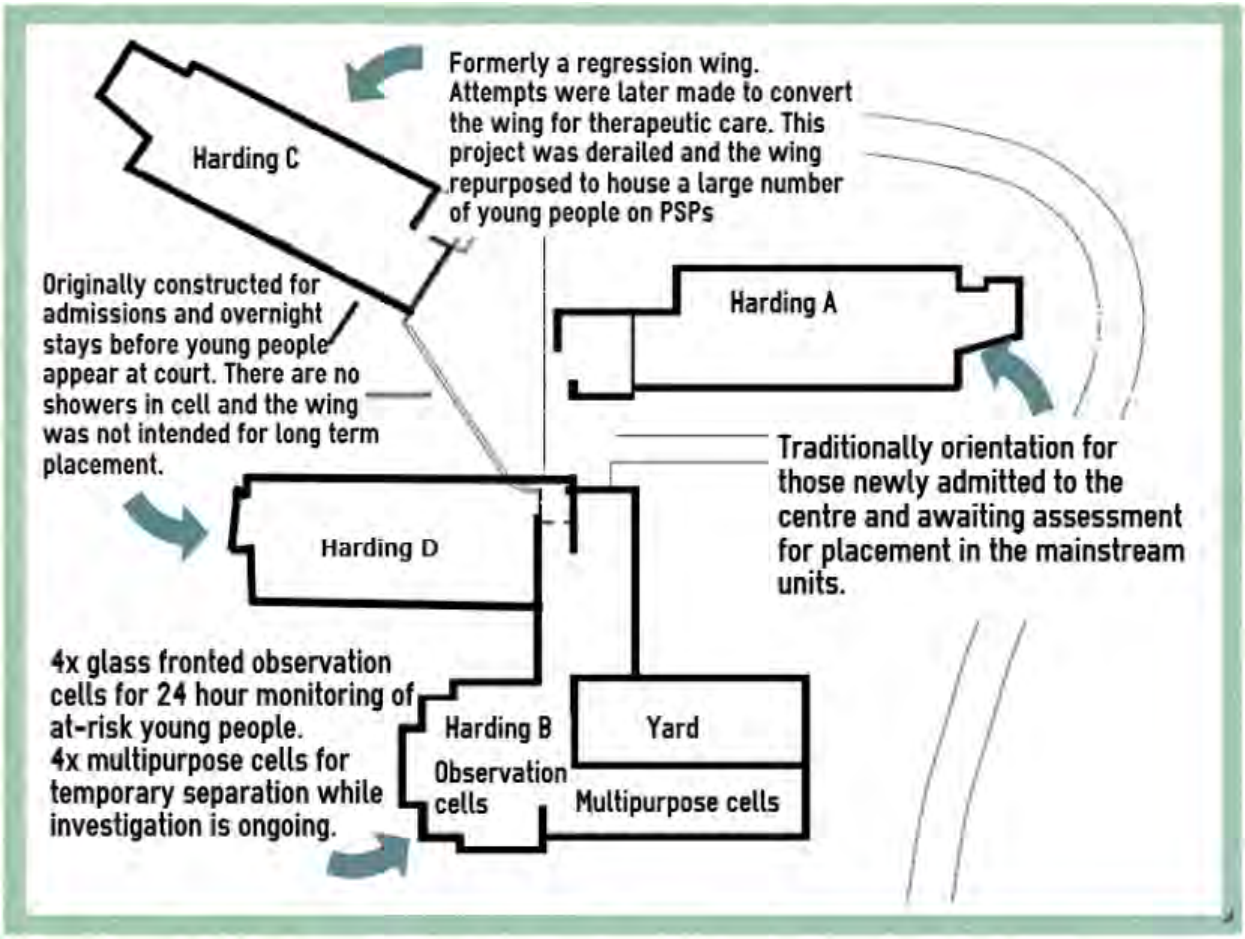

Figure 1
Harding Unit and wing functionality

We have pointed out the Harding Unit's physical deficiencies numerous times and have argued that new facilities are needed, especially for crisis care and intensive management (OICS, 2012; OICS, 2015b). Nothing has changed.

For many years, the Harding Unit ran a poorly governed punitive regime for young people involved in incidents (OICS, 2012). There have been some improvements (see Chapter 3). Management has also embarked on a plan to change the Harding Unit's reputation and to turn C Wing into a therapeutic wing. In mid-2016 some cosmetic changes commenced but in October 2016 progress ceased. Harding C remains a sterile, counter-therapeutic area, with inadequate separation from the other parts of Harding.

A good example of Banksia Hill's physical and operational limitations occurred in December 2016. In response to intelligence about the risk of serious disorder, the

Department relocated young women from their purpose-built unit (Yeeda) to Harding C Wing. They emptied Lenard and Turner units, which did not have demarcation fences, and relocated the young males to fenced units, including Yeeda. This decision may have averted the initial risk, but led to predictable disruption and distress for the young women. This in turn created a new risk and led to a spike in incidents from the young women (see Chapter 6).

1.2. Other jurisdictions have smaller centres and more diversity

In recognition of the complexity of young people's needs, the need to cater for different groups, and allow the separation of different cohorts, other Australian jurisdictions have smaller centres with more diversity and better options for separation by age, gender, location and need.

New South Wales has six 'juvenile justice centres' for a total population of around 300 young people ages 10 to 21 (NSW Department of Justice, 2014). The facilities are spread across the state. Some provide a suite of services to young people from the region and others perform more specific functions. The largest centre (Frank Baxter) has a capacity of only 120. It holds young people aged 16 to 21. The other facilities are smaller and allow separation by age, gender and location. New South Wales also has a pre-release unit for young people at the Reiby Juvenile Justice Centre.

South Australia has only one facility, the Adelaide Youth Training Centre. However, it is very different from Banksia Hill. It has a total capacity of less than 100, and is split into two separate campuses. One campus has a capacity of 36. It houses males aged 10 to 14, females, and young people who have been denied police bail and are awaiting a court hearing. The other campus has a capacity of 60. It houses males aged 15 and over.

The Northern Territory has juvenile detention centres in Darwin and Alice Springs. Queensland also has two, one in Brisbane and another in Townsville. Tasmania and the Australian Capital Territory each have one small facility but that is entirely understandable given their size and numbers.

Victoria has had two Youth Justice Centres (Melbourne and Malmsbury). However, after serious trouble at these centres, it has announced that a new 250-bed facility will be constructed. Details of the new facility are still unknown but it appears to be based on a model of separating cohorts.

1.3. Young people at Banksia Hill have high levels of need

Almost every young person at Banksia Hill has high needs. Most have experienced trauma or abuse, many have serious mental health issues or cognitive impairments, and most have led chaotic, dysfunctional lives.

Not surprisingly, a significant number of young people are under the care of the Department of Child Protection and Family Services (DCP). On 31 March 2017, Department of Corrective Services data showed 21 young people to be in DCP care.

1.3.1. Many young people have a cognitive impairment but are not identified by the Department

Managing a person with a cognitive impairment or behavioural disorder in custody requires adjustments. But the Department does not know how many people in its care have these issues. Research indicates that the number is likely to be very high. A New South Wales survey found around 82 per cent of females and 68 per cent of males in youth custody have behavioural disorders (Indig, 2011).

The Department does not routinely assess young people when they are admitted to custody. If an assessment has been requested by the court, this may come to the Department, but this only happens intermittently. Additionally, staff can request information which may be held by other Departments, such as DCP or the Disability Services Commission. But staff only do so if they are aware of an existing diagnosis. In other words, if they do not know the young person has been assessed by another agency they will not seek further information. Clearly better cross-agency information sharing is needed.

The Telethon Kids Institute conducted research at Banksia Hill between May 2015 and November 2016 into the prevalence of Fetal Alcohol Spectrum Disorder (FASD) and other neurocognitive impairments. The research included assessments by a paediatrician, neuro-psychologist, occupational therapist, and speech pathologist. Preliminary findings show that most young people in custody had some level of neurological deficit (Telethon Kids Institute, 2016).

If a communication deficit in a young person in custody is not obvious, the young person's behaviour may be considered to be naughty or defiant, rather than the result of a communication challenge (Telethon Kids Institute, 2016). At Banksia Hill this may be compounded given the predominantly Aboriginal population where English may be a second or third language.

With the young person's consent, assessments conducted as part of the research were shared with staff at Banksia Hill. Yet, when we requested to know the number of young people who had been admitted to the centre since January 2014 with diagnosed behavioural concerns, the Department was unable to provide us with information.

The Department stated that 'given that only some and not all young people participated in this study, the Department cannot provide a true reflection of the number of young people admitted to Banksia Hill since January 2014 with diagnosed… [behavioural concerns]. Any information provided would have been potentially misleading.' This indicates the Department's only source of information to identify the needs of these young people is the research project and even this is not complete. It is unclear how the Department will identify these young people when the research ends.

1.4. Trauma-informed care is a sound approach

The January 2013 riot was a turning point. Our review of the management of the incident, its causes, and aftermath, made 35 recommendations, all of which were accepted by government (OICS, 2013a). They included recommendations to improve safety and security, and to re-engineer the regime to reflect a clear and consistent philosophy of rehabilitation, and to improve the level of services.

The Department acted on this report with good intentions. During 2013 and 2014, the primary focus was to 'get back to basics' and restore stability. Our mid-2014 inspection concluded:

> Banksia Hill has made significant progress since the depths of 2012/2013. However, it still has some way to go before it will be totally confident, clear in its sense of direction, and meeting high performance standards…. [I]t will need a clear sense of direction, a good deal of nurturing, improved services, and a set of priorities, targets and outcomes (OICS, 2015b).

During 2015, the Department began to develop its vision for the 'transformation' of Banksia Hill. The transformation plan was said to be underpinned by concepts such as trauma-informed care. It drew on internationally-recognised projects and research such as the Sanctuary Model, the Missouri Model, and the We Al-Li model nationally pioneered by Professor Judy Atkinson. Further information on these models can be found in Appendix B.

The intent and core principles behind trauma-informed care are sound. But, as the rest of this report shows, the transformation project lacked clarity and was poorly managed. It has now been officially abandoned after two serious incidents of disorder on 4 and 5 May 2017.

We have concluded that although the transformation project will not proceed, its intent is sound and was grounded in international best practice for dealing with children in detention. The intent, therefore, should be retained.

Importantly, a trauma-informed approach will allow a more nuanced and effective approach to dealing with problematic behaviours. It will also allow a more holistic rehabilitative approach generally. However, it will be difficult, if not impossible, to deliver such a model at Banksia Hill because of its size, its design, and the complexity of

its cohort. The evidence base underpinning this approach specifically states these models do not work in large custodial environments. Models of trauma-informed care work on the basis of small, intensive, locally-based units.

It is therefore important for government to examine alternatives for juveniles and to re-purpose Banksia Hill for adult offenders. With some re-development it could become the site of a new prison for women.

Recommendation
Continue to pursue a trauma-informed model of treatment for young people in detention.

Recommendation
Investigate opportunities for small residential youth justice facilities across Western Australia to keep young people close to their families and networks, and to increase the prospects of successful rehabilitation.

2 Control and safety have slipped

After our mid-2014 inspection, Banksia Hill moved into a period of relative stability and improvement. During 2015 the number of incidents dropped, and assaults against young people and staff were much lower.

However, this was not sustained in 2016. There were several serious incidents of damage, the number of assaults rose (particularly against staff), and incidents of self-harm reached unprecedented levels.

2.1 Critical incidents have doubled

The facility has not been consistently safe or stable since mid-2016 (see Appendix C). During 2016, the number of critical incidents more than doubled even though the average daily population decreased. There were 69 critical incidents, more than one per week. Critical incidents are those that significantly affect safety and security. They include escapes, serious assaults, rooftop incidents, bomb threats, natural disasters, contraband that may impact on good order and security, and disturbances which involve multiple young people disobeying lawful directions.

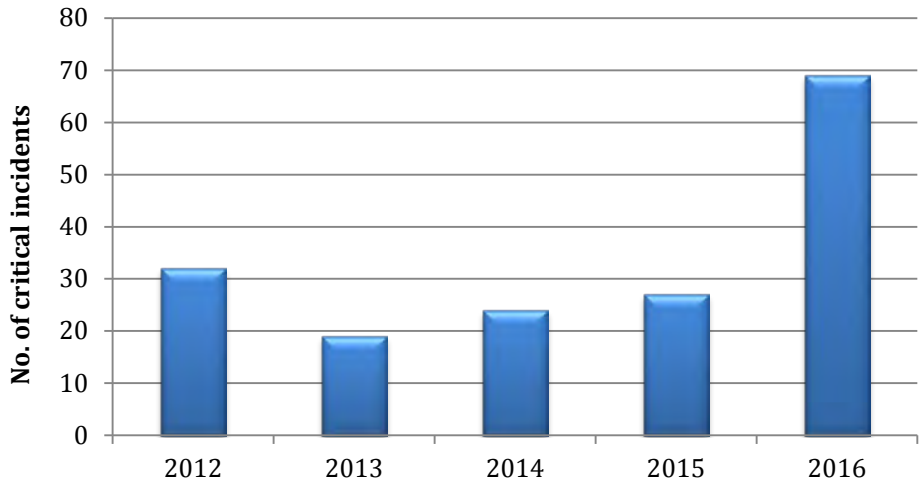

Figure 2
Critical incidents in Youth Justice Services , 2012-2016

The second half of 2016 was particularly volatile. It included six incidents where young people assaulted staff, three barricading incidents, and 11 occasions when young people ascended roofs.

The Department told us that the damage caused during just four of these incidents was estimated at $600,000. A number of these incidents were only resolved by armed response teams using distraction devices ('flash bombs'), chemical agent ('pepper spray') or shotgun laser sights (see Chapter 5).

The rate of critical incidents at Banksia Hill in 2016 was by far the highest of any custodial facility in the state (50.8 per 100 people in custody). Acacia Prison had a similar number of critical incidents but has a population ten times Banksia Hill's. Hakea Prison had twice the number of critical incidents, but a rate of just 15.6. While more incidents might be expected in facilities housing young people, age alone does not explain the high incident rate at Banksia Hill.

Table 1

Critical incidents in custodial facilities in Western Australia, 2016

	No. of critical incidents	Daily average population	Rate of critical incidents per 100 people in custody
Banksia Hill	69	135.92	50.76
Maximum-security			
Albany	42	414.48	10.13
Bandyup	61	366.13	16.66
Casuarina	64	911.08	7.02
Hakea	149	955.27	15.60
Medium-security			
Acacia	70	1,433.60	4.88
Minimum-security			
Boronia	2	90.78	2.2
Karnet	20	329.89	6.06
Pardelup	6	81.63	7.35
Wandoo	15	74.59	20.11
Wooroloo	31	372.68	8.32
Multipurpose security			
Bunbury	31	326.02	9.51
Eastern Goldfields	18	102.63	17.54
Greenough	21	313.72	6.69
Roebourne	21	168.99	12.43
West Kimberley inc. Broome	23	280.55	8.2

In the first quarter of 2017, Banksia Hill recorded another 15 critical incidents. At this rate, the number of critical incidents in 2017 will parallel 2016.

Only one of the first-quarter 2017 incidents involved extensive damage to a unit. This incident involved three young people, and occurred in early January. However, the number of other incidents, particularly self-harm and staff assaults, remained high (see below).

Shortly before the draft of this report was sent to the Department for comment, there were two more extremely serious damage incidents (4 and 5 May 2017). These incidents will not be examined as part of this review but they reinforce our conclusions about the centre's instability.

2.2. Reductions in staff assault in 2015 have not been sustained

From 2014 to 2015 the number of staff assaults dropped, but in 2016 the number reverted to previous levels. These levels have remained in early 2017 with eight staff assaults recorded in the first three months. Five of these involved the same young person spitting at staff.

Not only has the number of assaults gone back to previous levels but the proportion of violence directed towards staff at Banksia Hill has also escalated. In 2015 one in five assaults were perpetrated against staff. In 2016 this rose to more than one in every three. By the end of the first quarter of 2017 it was one in two.

Table 2

Assault incidents at Banksia Hill, 2014 – 31 March 2017

	Assaults against staff		**Assaults against peers**		**Total no. of assaults**
	No. of assaults	% of total assaults	No. of assaults	% of total assaults	
2014	23	24.2%	72	75.8%	95
2015	10	20.8%	38	79.2%	48
2016	29	36.2%	51	63.8%	80
1st Qrt 2017	8	50.0%	8	50.0%	16

The number of peer assaults has also fluctuated over the last three years. In 2014, peer assaults were at their highest, with more than one every week. The figure almost halved in 2015. In 2016 it increased again, though figures for the first quarter of 2017 were low.

2.3. Self-harm has reached unprecedented levels

Self-harm and attempted suicide have dramatically increased. In 2016 there were 196 incidents of self-harm and attempted suicide. This was more than 2.5 times the number of recorded incidents in 2015 (77), and more than five times the number in 2014 (38).

In 2016, there were five reported cases of attempted suicide, an unprecedented figure. In the first quarter of 2017, the centre had already recorded 76 incidents of self-harm and one attempted suicide. We asked if a change in reporting practices could explain the high number of attempted suicides. Unfortunately, we were advised that this was not so, and that they were all very close calls.

Banksia Hill has never had a suicide, and it is a credit to the responsiveness of centre staff that these attempted suicides did not have more tragic results. But the figures are cause for serious concern.

Table 3

Incidents of self-harm and attempted suicide in Youth Justice Services, 2012- 31 March 2017

	2012	2013	2014	2015	2016	1st Qrt 2017
Attempted suicide	1	1	1	0	5	1
Self-harm	74	71	37	77	191	76

Youth Psychological Services staff said they had witnessed a contagion effect, particularly towards the end of 2016, when the number of self-harm incidents rose markedly. Young people who had not self harmed in the past were becoming a risk to themselves in the wake of other young people self harming at Banksia Hill.

This creates a 'vicious spiral'. High levels of self-harm necessarily mean that the psychologists must spend more time responding to immediate risk. But this increases the waiting list for proactive, preventive counselling services that would help reduce self-harm.

Some staff expressed concern that self-harm is under-reported. We were told that on occasions, self-harm is disclosed in other incident reports, but not subject to separate full reporting. It follows that the number of incidents recorded as self-harm is not the full picture of what is known to staff. Obviously, there will also be cases of self-harm committed in private that never come to the attention of staff.

3 The Banksia Hill Transformation project was poorly implemented

Our Report into the 2013 riot called on the Department to 're-engineer' Banksia Hill to better meet the purpose of rehabilitating young people and preparing them for release (OICS, 2013a). It also stressed that dynamic and procedural security needed to be improved if this was to be achieved.

The Department accepted that a different approach was required if it wanted to achieve better results for young people and their families (DCS, 2016b). From 2015 until 6 May 2017, the Department had therefore been promoting a 'transformation' of Banksia Hill through a new operating model. In effect it wanted the facility to move from a custodial model to a rehabilitative model (DCS, 2016b).

In the immediate aftermath of the serious incidents on 4 and 5 May 2017, the government announced that Banksia Hill will undergo another change program. The stated aim is to create stability, so that rehabilitative programs and education can be improved.

Details of the new change program are sketchy at the time of writing. However, lessons must be learned from the positive and negative features of the now-abandoned transformation project.

In our view, the core principles lying behind the transformation were sound and should not be lost. The evidence worldwide, and locally, is that trauma-informed care will improve the prospects of young offenders getting their lives back on track and reduce staff assault.

The project was undermined by poor implementation. Lessons do not appear to have been learned from previous failed transformations of Banksia Hill (OICS, 2013a). The key factors leading to the failure of the transformation were:

- Staff were 'transformation-weary' and this was not adequately recognised. Banksia Hill has been through a long period of upheaval, discord, and damage.
- There was little clarity on what was expected with the transformation and when this would occur. As the Missouri Model's designers warned, any new model requires 'constant creativity, commitment, and compassion from staff' (Mendel, 2010). It also requires staff to be confident. The lack of clarity precluded this from occurring.
- Despite promoting a move from a custodial approach to a rehabilitative trauma-informed model, some of the Department's actions in 2016 and 2017 pulled in the opposite direction (see Chapter 5). This caused confusion and frustration among staff, and reduced the chances of gaining their support. It also contributed to inconsistent and hesitant detainee management.

3.1. Communication has been poor and the workforce is unsettled

There was a great deal of talk about the transformation, but what exactly it meant for staff and young people, and when it would occur, was very unclear.

From mid-2015, Departmental representatives frequently referred to the transformation in media reports, and in communications between the former Commissioner and staff. There was also a considerable amount of promotional material around the centre.

This sent a clear message to staff and young people that change was coming. As late as November 2016, the Department told Parliament the matter was still being 'researched' (Hansard, 2016a). It is difficult to see how staff could reasonably be expected to commit to a model that was still just being 'researched' in head office. We were shown many complex head office charts and spreadsheets, but would have expected more concrete progress and certainty 'on the ground'.

The Department has argued that its initial priority was to secure a stable workforce through recruiting and training staff. Ensuring sufficient personnel before rolling out changes to the staffing structure is commendable. So too is thoroughly investigating large-scale philosophical changes before implementation. But in April 2017, these steps were still some time into the future, with training in trauma-informed care unlikely to occur before mid-2018 (Hansard, 2016a).

In short, the transformation project's intentions were sound. However, the Department should not have promoted the transformation before it was clear what it meant, before people could be trained, and without clear communication to bring people on board.

We conducted a staff survey for this review in October 2016. Many staff expressed concern. In the words of one respondent:

> The current 'transformation process' being forced upon us has no direction. We have no idea what the final outcomes are, how we are supposed to achieve them and how we are to get there. All this is impacting on both the detainees and staff and because of all these uncertainties the centre is quite unstable, staff morale is at the lowest ebb and detainees have no and show no respect. It is a very unpleasant environment to work in and I see no change for the better in the near or distant future.

It is worth noting that the Missouri Model took many years to implement and during the transformation there were control issues (Mendel, 2010).

> "We didn't know what we were doing [at first]. The boys ran us ragged", recalls Gail D. Mumford, who began working with DYS [Division of Youth Services] as a youth specialist in 1983 and later serves as the agency's deputy director. "They were acting up every day, sometimes every hour".

A Youth Justice Progress Report in 2016 stated that the expected timeline for implementing the operational model was March 2017 (DCS, 2016f). But by May 2017, there had been little change aligned with the transformation and the site was very unsettled. As a result the transformation was abandoned.

Lessons can be learned from the poor implementation of the transformation project. They have added importance as the Department moves to the next transformation after the incidents of 4 and 5 May 2017. The Public Sector Commission has recently released a guide on managing change which includes the following six key principles relevant as Banksia Hill moves forward (PSC, 2017):

- a clearly defined rationale and vision of the change is understood
- stakeholders are identified, appropriately consulted, and informed
- the system and processes developed to achieve the change are transparent
- collective and collaborative leadership is empowered
- there is a dedicated focus on people
- the change is systematically reviewed and adapted

Long-term transformation of Banksia Hill may also benefit from a staged approach with a simple structure and realistic timeframes.

> ***Recommendation***
> *Improve clarity and communication about short-term and long-term strategies for Banksia Hill.*

3.2. Staff are divided, leading to inconsistency

We found that many Banksia Hill staff were keen to move to a stronger rehabilitation model. However, many were not, and their concerns were compounded by a sense of disempowerment and fear for their safety. Without clear direction and consistent leadership, the different approaches have caused inconsistency in the treatment of young people and tension between staff.

Young people need fair and consistent treatment, and are likely to respond negatively to perceived unfairness. However, at Banksia Hill, there can be different consequences for a young person's behaviour on any given day, not based on their needs, but on the beliefs and expectations of the staff member.

Some staff survey respondents wanted tougher practices in the belief they would be a deterrent:

> Harsher consequences are required to act as a deterrent. When we previously had tougher regimes the young people had more respect for the staff. Staff assaults are at an all-time high now because there is no deterrent.

Some wanted a much stronger use of force:

> The one thing that the young people are afraid of is use of force e.g. Taser, chem agent. We need to be able to enforce rules in a manner that provides custodial staff with authority. The detainees in our care have had many chances in the community. They should be deterred from coming to detention. Many of them look forward to it and do not see it as a bad place to be. We need to make the place less like a holiday camp and more like a prison where rules are enforced as well as be able to rehabilitate the ones that are doing the right thing.

The focus on deterrence and greater use of force directly conflicted with the Department's espousal of a model of trauma-informed care. It also conflicted with the views of staff who supported a more rehabilitative approach. One staff member stated that what Banksia Hill needed was:

> A comprehensive and evidence-based philosophy of behavioural management that is operationalised as a whole of centre approach. Such an approach should be trauma-informed and empower operational staff to draw upon natural and restorative justice approaches to provide both rewards and consequences that are proportionate, swift, and age appropriate.

The result of divided staff views is an inconsistent, confusing environment for young people. Staff are all too well aware of the negative effects of this:

> Consistency in the direct and immediate application of effective behavioural management tools… is extremely inconsistent and almost non-existent from one staff member to the next… from my perspective inconsistency to standards, procedures, policy and protocol is very much a major reason as to why there is so much dysfunction within the environment collectively.

Recommendation
Improve consistency in the way young people are managed.

3.3. Behaviour management initiatives have stalled

In 2016, a number of potentially positive initiatives were introduced at Banksia Hill. They included Personal Support Plans (PSPs) and the Changing Habits and Reaching Targets (CHART) program. The principles underlying PSPs and CHART have merit. They have the potential to improve the management of young people's behaviour and their prospects for rehabilitation. However, both projects stalled. They, or similar models, need to be developed further, and used more consistently.

A young person can be placed on a PSP as a response to a critical incident or when all other means to address inappropriate behaviour are exhausted. PSPs are said not to be a punitive measure, but an individualised plan. PSPs replaced 'Individual Management Regimes' (IMRs).

A PSP is plan to help address young people's behaviour with measureable milestones that directly relate to that behaviour and encourage the young person to successfully return to the standard program as quickly as possible (DCS, 2016e). There are three types of PSPs; Unit Based, Change of Accommodation, and Special Needs. Unit Based (allows the person to be managed within their unit) and Change of Accommodation PSPs (where the person is managed in either Harding or Cue units) should include a plan for the young person to achieve their milestones and reward positive changes in behaviour. They should also include:

- information about any precursors to young person's inappropriate behaviour
- health and mental health concerns that may influence the young person's management
- the young person's involvement in therapeutic programs, psychological counselling, education, vocational training and recreation
- any supervision and escorting requirements
- interaction with other young people

A Special Needs PSP is developed for those young people who, due to their special needs such as a disability or medically diagnosed disorder, may need supervision to ensure their own safety, and the good order and security of the centre, is maintained.

In 2012, we criticised Departmental record keeping in relation to IMRs (OICS, 2012). The Children's Court was also very critical (Department of Corrective Services v RP, 2012). Record keeping has improved in the transition from IMRs to PSPs to the extent that information is now stored more effectively.

However, the plans and daily monitoring forms do not have sufficient information on the young person's behaviour, involvement in activities, and demeanour over the course of the day. We examined 39 active and inactive PSPs. Only 12 contained individualised information such as triggers and strategies to prevent misbehaviour. The other 27 lacked any personalised information specific to the young person. There was a large element of 'cut and paste'.

The policy governing PSPs gives psychologists a key role in assessing the young person and progressing them through milestones. This is clearly right in principle. However, less than a third of the PSPs we examined had consulted a psychologist (12). And we only deemed eight of the 12 to be comprehensive plans.

We were also advised that some psychologists felt their participation in PSP development and assessment was superficial. They felt they were only present at meetings to give credence to decision-making that did not take genuine account of their input.

Banksia Hill management acknowledged the inconsistent level of detail in the PSPs. They said that the comprehensiveness of PSPs, particularly those created at the end of 2016, had been dependent on staff resources, and that the sheer volume of young people on PSPs at the time had affected their ability to provide individualised plans.

The Department also acknowledged the shortfall during our briefings on this review. In January 2017, Departmental staff agreed there was still a good deal of work to do on PSPs. They said they wanted to move away from creating plans simply in response to poor behaviour, in favour of comprehensive case plans for all young people. In February 2017, the first four of these new-style case plans were developed.

In March 2016, the Department introduced the CHART program (DCS, 2016f). CHART uses a problem-solving and cognitive-behavioural approach to address clients' criminogenic needs and 'distorted thoughts' (Vita, 2015). It helps young people to recognise the factors that contributed to their offending, and increases their capacity to make more pro-social decisions, by developing relapse prevention techniques (DHHS, 2015).

By the end of September 2016, CHART had been delivered to 70 young people at Banksia Hill (DCS, 2016c). However, due to staff shortages, the program stalled. It has not been delivered since December 2016. But even before this, the Department acknowledged that staff shortages had slowed progress because staff assigned to CHART were regularly re-assigned to different roles throughout the centre (DCS, 2016c).

Recommendation
Deliver PSPs and CHART or alternative programs based on similar principles.

4 Staff morale and confidence are low

Staff morale at Banksia Hill has been low. In our October 2016 survey, many staff reported they felt unsafe, and increasing numbers of staff assaults by young people have affirmed their concerns. Our frequent visits to Banksia Hill since the survey was conducted show little improvement.

Staff also reported being disempowered in their work, being unheard by management, and having little confidence in current behaviour management practices. In addition, there is a fear of investigations, and a perception that officers will not be supported if they make honest and reasonable mistakes.

Together, these factors are hampering staff ability, willingness, and certainty in responding to the behaviour of some young people.

4.1. Staff feel unsafe and disempowered

Many staff at Banksia Hill feel unsafe, even more so than immediately after the 2013 riot. A survey conducted immediately after the riot in 2013, found 45 per cent of staff respondents felt unsafe or very unsafe. The proportion of staff feeling unsafe by 2016 was higher with more than half the respondents to our October 2016 survey feeling this way (52 %). Some said they felt anxious attending work, fearing they would be seriously injured by a young person. They also stated that they felt less safe in 2016 than they had in 2015.

Staff anxiety is not unfounded. Assaults on staff, especially serious assaults, have increased. In 2016, there were 29 assaults on staff in total, and eight of these were 'serious assaults' (in other words, the victim needed overnight hospitalisation, overnight care at the Youth Custodial Services Health Centre, or ongoing medical treatment (DCS, 2015)).

Table 4

Assaults on staff by young people at Banksia Hill, 2014-2016

	Serious assaults	Total no. of assaults
2014	2	23
2015	0	10
2016	8	29

Staff have also felt increasingly disempowered. Over half our survey respondents said they were rarely or not at all empowered. By contrast, most said they had felt empowered to some degree in 2015. This was a substantial and damaging shift in a short period of time.

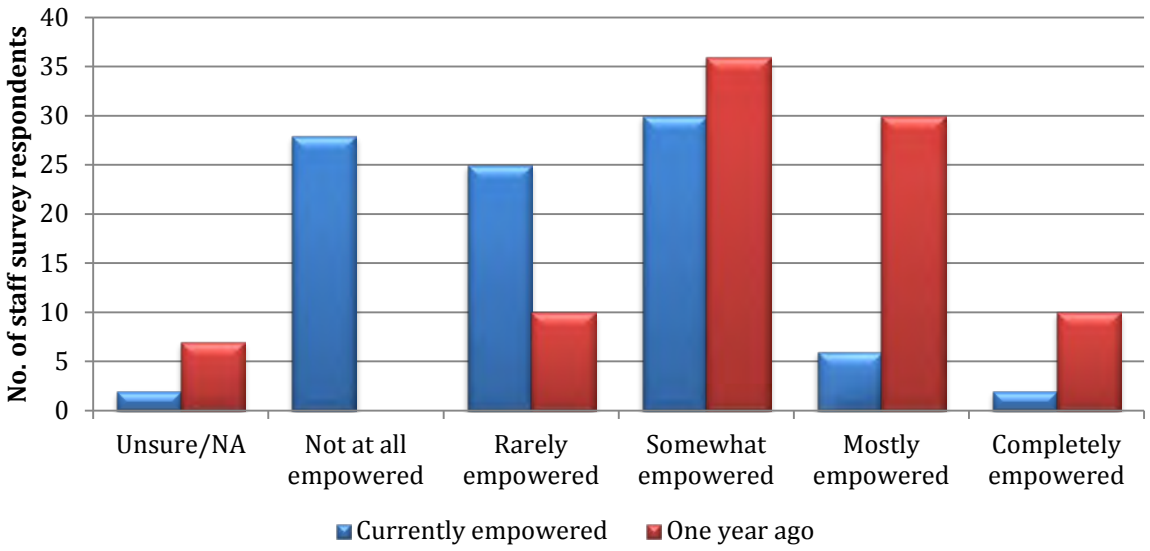

Figure 3
Banksia Hill staff feeling empowered to do the job, October 2016 and one year ago

4.2. Staff feel disconnected from central leadership

From 2015 onwards, we observed palpable tension between staff and central leadership. Relationships between local management and head office leadership have also been tense at times. Many staff told us of their frustrations and desire for their leaders to be more responsive and accountable. They suggested some critical incidents could have been prevented if their operational knowledge had been better respected.

Staff also felt that central leadership had disregarded their achievements in the way they had portrayed the 'transformation'. The message was that the staff had to move towards a more 'humane' environment based on 'child centred care' (McMahon, 2016). Many staff found this offensive. They said it failed to recognise that most of them had entered the job, and had stayed in it, precisely because they are committed to the care of young people.

A staff member's letter published in The West Australian newspaper in February 2017 reflected what we had heard from many staff in the survey:

> …the staff feel unheard, unappreciated, and unsafe. What is happening at Banksia Hill needs to be recognised for the crisis it is. It needs to be addressed and corrected. We aren't asking to be heard just for us. We can see, first hand, the detrimental effect these changes are having on the kids. (Cresswell, 2017)

4.3. Staff are fearful of frivolous investigations

We strongly support a proactive, fair, and robust approach to investigating allegations against staff. So do the vast majority of staff themselves.

In the last three years, the Department has taken a stronger stance on allegations of misconduct. Since 2014, there have been 106 reports to the Department's misconduct and investigations branches regarding staff at Banksia Hill. Investigation Services reported that there have been yearly increases in the number of investigations into staff conduct both at Banksia Hill and across the Department.

However, some staff feared that other staff or young people would report them if they issued consequences when managing behaviour, and some said they feared reprisals from management. They suggested that staff were being disciplined even when they had appropriately used the tools available to them.

Head office representatives said this was not the case, and that staff had only been disciplined when they had clearly transgressed the boundaries. It was beyond the scope of this review to assess the comprehensiveness or fairness of these investigations. But staff concern about frivolous investigations, and that they will not be supported, do seem to have reduced their ability to respond confidently and proactively to the behaviour of young people.

Identifying incidents and following up with an investigation is only one step. Staff must have confidence in the investigations process, and confidence that they will not be unfairly treated if they act within procedures or make an honest and reasonable mistake. At Banksia Hill, they have not had such confidence.

Despite this there are positive signs of a willingness to be more accountable. The number of security reports submitted by the centre has increased markedly since the 2013 riot. While most of these reports do not relate to staff actions, some do concern the treatment of young people.

> ***Recommendation***
> *Assess and mitigate staff concerns regarding the investigation process.*

4.4. Staff lack confidence in behaviour management practices

Banksia Hill uses a variety of behaviour management tools (see Appendix D). They have been used for a number of years. However, despite the events of recent years, the Department has not evaluated their use or effectiveness (see below).

As staff work directly with the young people, it is important to assess their views of what works. We found that their opinions vary greatly. The application of different tools reflects staff preference rather than the young person's needs.

The survey respondents felt that removing a privilege was the most effective tool available (see Figure 3). Under the *Young Offenders Regulations 1995*, a privilege is 'a concession or luxury extended to a detainee in addition to any rights provided by statutory or common law' (Regulation 46A). Regulation 46A permits authorised officers

to withdraw privileges under certain circumstances. It is a widely used tool, with more than 3,000 privileges revoked from 562 distinct young people since 2014.

The centre can also use the ability to earn privileges as an incentive or reward for good behaviour. The survey shows that staff believe this is also reasonably effective, but less than the removal of privileges.

Staff also perceived that time out in cell and accessing non-treatment programs (e.g. football clinics) were relatively effective.

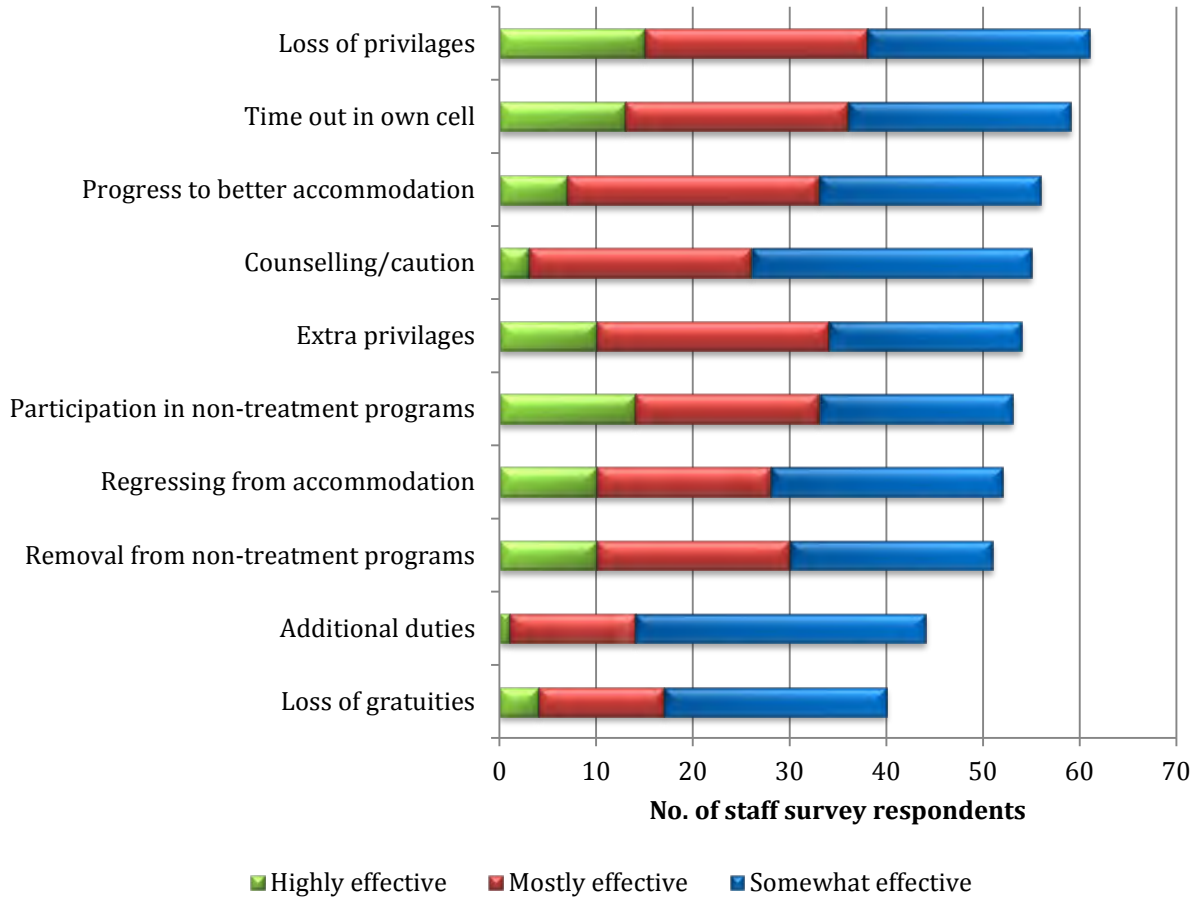

Figure 4
Ranked perceived effectiveness of behaviour management tools at Banksia Hill

We compared staff perceptions of the effectiveness of various tools with their perceptions about the use of such tools. The key finding is that staff have little confidence in the most widely used measures.

Table 5

Staff perception of the use and effectiveness of behaviour management tools at Banksia Hill

Behaviour management tool	Perceived frequency of use		Perceived effectiveness of tool			Proportion who responded*
	Number of respondents = 93					
	Often	Sometimes	Highly/ mostly	Somewhat	Barely/ not at all	
Counselling/caution	68	6	26	29	16	50%
Progress accommodation	38	23	33	23	8	60%
Time in own cell	35	28	36	23	6	70%
Participation in non-treatment program	35	27	33	20	9	60%
Loss of privileges	30	29	38	23	6	60%
Regress accommodation	25	36	28	24	12	50%
Additional duties	24	40	14	30	24	40%
Extra privileges	14	38	34	20	13	60%
Loss of gratuities	8	38	17	23	25	40%
Removal from non-treatment program	3	23	30	21	11	60%
Removal from preferred education	3	23	4	21	36	20%

* Median of responses to the question 'what percentage of young people respond to this tool?'

Survey respondents believed that counselling and cautioning techniques were the most common responses. This was supported by Departmental data (in 2016 there were 2,727 formal cautions and 3,202 formal counsels). However, staff were not at all confident in the effectiveness of these tools.

In recent years, the centre has made much greater use of loss of gratuities and paying restitution.[1] In 2014, there were 107 cases of loss of gratuities and 188 of restitution. In 2015, numbers dropped to 31 and 177 respectively. They increased sharply in 2016, with 72 loss of gratuities and 385 restitutions. However, staff survey respondents had little confidence that such tools were effective.

4.4.1. Staff feel that consequences are not immediate, consistent, or reflective of community standards

Many staff believed that the rewards and consequences issued to young people to reinforce good behaviour and to curtail misbehaviour were not immediate, proportionate, consistent, or reflective of community standards.

Many felt particularly unable to adequately manage the higher-end behaviour issues which are referred for detention centre or criminal charges. They were concerned that

[1] Our staff survey did not separate losing gratuities from paying restitution.

placing a young person in the Harding Unit would be viewed as punishment by the courts, and that this would affect the outcome of charges because a young person cannot be subject to double punishment for the one incident.

Many also expressed concern that young people did not associate their actions with consequences because of the time it takes for detention centre charges to reach the Superintendent or Visiting Justice, or for criminal charges to reach the courts.

Staff also thought that some of the consequences were not proportionate to the severity of the behaviour or reflective of consequences for similar behaviour in the wider community.

Unfortunately, many of these staff concerns are the inevitable result of years of confusion about behaviour management practices, what they are for and when they are used. For a long time, placement in the Harding Unit as a behaviour management tool was punitive not therapeutic. Philosophies and policies were unclear, and documentation was very poor. Practices were inconsistent and young people were confused. As a result, both this Office and the judiciary were also confused about the actions taken and their intent (OICS, 2012; OICS, 2015b).

4.4.2. Too many staff are not confident in their ability to control behaviour

The result of all these factors is that some staff feel ill-equipped or unable to manage young peoples' behaviour, especially for more serious incidents. They suggested that they no longer had control and that the young people sensed this. One staff member wrote:

> These kids run the centre not us. We have no power or support to even try and manage their bad behaviour, because we are afraid of giving consequences because we will not be supported. We are even afraid to intervene in two boys fighting encase (sic.) we get charged with excess force and suspended. Bottom line we come into work stressed to the max and try get through our day the best way we can so we can go home safe to our families.

Other staff said their inability to adequately respond was because they had not received recent refresher training, specifically for the Primary Response Team (PRT), or as PRT Leaders. Some said it had been many years since they had received this training. Others suggested the PRT was limited in its ability to respond to violence and destruction because it was only trained in hand-to-hand defensive techniques, not in dealing with young people wielding improvised weapons.

In December 2016 PRT Leaders training was undertaken by some Banksia Hill staff for the first time since February 2012.

4.4.3. The Department has no evidence about the effectiveness of different measures

The current behaviour management tools at Banksia Hill have been in use for many years. As far back as 2005, we found that the techniques included informal warnings, a series of incentives, and movement through the hierarchical system of accommodation (OICS, 2006). The latest local governing order (Standing Order 9a Management of young people, effective 1 July 2016) includes the same techniques.

In 2010, the Department acknowledged the limitations of some of these tools. A Departmental report on the re-development of youth custodial services noted that the progression of young people through the hierarchy created constant shifting between units, and disrupted the restorative value of unit living (DCS, 2010). The report also noted that the use of privileges can affect a young person's behaviour while in custody, but does not necessarily continue when they are released to the community.

The policy has been amended three times since 2010 (in 2013, 2014, and 2016). A number of important changes have been made to improve governance and to reflect the renewed focus on rehabilitation. However, despite the conclusions of its 2010 report, the Department has left the basic framework in place.

We requested details of any reviews, analysis or impact statements the Department had undertaken since 2010 to assess the use and effectiveness of different measures, and to support its changes to Standing Order 9a. There was no evidence that any such work had been undertaken.

In the absence of evidence, the Department cannot claim to be making evidence-based decisions about behaviour management.

> ***Recommendation***
> *Evaluate the use and effectiveness of the different behaviour management tools.*

5 Recent management actions have conflicted with the transformation model

The Department promoted the Banksia Hill Transformation as a shift towards a rehabilitative model of corrections with a focus on trauma-informed practice. However, in the last 12 – 24 months:

- young people have spent more time confined in their cells
- some have been denied their legislatively mandated time out of cell
- use of restraints has increased
- use of tactical response has increased
- the centre continues to be target hardened, creating an increasingly punitive and negative environment.

5.1. Lockdowns, many of which are avoidable, have increased

Stable, well-run detention centres lock young people in their cells at night but provide an active 'out of cell' regime during the day. This gives them time to burn off energy, a positive attitude, a sense of achievement, and less time to plot mischief and behave badly.

Lockdowns, where young people are confined to their cell, are becoming more frequent.

- *Incident management lockdowns* occur so that staff can isolate the disturbance, prevent other young people from becoming involved and free up staff to provide support to those responding. The increase in incidents in 2016, particularly critical incidents, inevitably increased the number of lockdowns of young people not involved in the incidents.

- *Staff shortages* have led to regular rolling lockdowns, where only a limited number of young people are allowed out of cell at any one time. This is done to meet set staff-to-young person ratios. In 2016, staff shortage lockdowns occurred every 9 days on average.

- *Training lockdowns* increased from November 2016, when the Department reinstated the practice of locking young people in cell every Wednesday afternoon to accommodate staff training.

Lockdowns created through incident management are understandable. Lockdowns due to training or staff shortages are avoidable with appropriate resourcing, planning, and management.

The Department defended its decision to reinstate Wednesday afternoon training because staff had fallen so far behind in their training. It is true that training is essential

and 229 staff have since been trained in core areas including Cardiopulmonary Resuscitation and a PRT Leaders course (Green, 2017). But the real point is that basic training should not have fallen behind, and should not be provided at the cost of locking young people in cell.

Staff shortages reflect the fact that recruitment has not kept up with attrition and separation of staff. There were no recruitment pools in 2016. The Department completed a new recruitment process in early 2017, resulting in 16 new staff, but the vacancy rate following their' graduation was still 13.7 full-time equivalent positions. Another training course is due to begin in June 2017 (DCS, 2017a).

However, there will be continued strain on resources into the foreseeable future as the Department has resumed transport services for young people. After the 2013 riot, these services were outsourced to relieve some of the staffing pressures at the centre. This arrangement ceased on 24 March 2017. The Department has created 14 fixed term contracts with former contract staff but when these end in six months it is likely that staff shortages and lockdowns will again occur as staff are diverted to transport services.

> ***Recommendation***
> *Minimise the use of lockdowns for staff training and staff shortages.*

5.2. Out of cell hours records are inaccurate

Despite increasing lockdowns, the Department has publicly reported that the time young people spend out of cell has increased. This claim is based on inaccurate electronic records.

In its 2015-2016 Annual Report Hearings, it advised that the time young people spent out of cell increased by 1.2 per cent between 2014-2015 and 2015-2016 (Francis, 2016). The increase was reportedly from 10 hours 46 minutes to 10 hours 54 minutes, an average of eight extra minutes per day.

The official night-time lockdown period runs from 7.15 pm to 7.30 am. However, our observations showed that these times were not accurate. Lockdowns often started well before 7.15 pm and unlocks after 7.30 am. Logbooks from Harding Unit support our observations. In January 2017, logs often indicated unlock occurring at 8.00 am or later. The same logbooks also showed that young people were usually returned to cell from 6.45 pm.

We also found that the Department was excluding lockdown records for people placed in observation and multipurpose cells in Harding Unit from its standard reporting about lockdown hours. This means if a person is at-risk and confined to a cell under continuous observation all day, the records do not reflect the additional confinement.

We found one young person was placed in observation and multipurpose cells in the Harding Unit over a three-day period in September 2016. He actually spent almost 19 hours in cell in addition to scheduled night-time lockdowns. However, his 'out of cell hours' records say he only spent an extra 3.5 hours in cell. The Department said this was an error in the database, but we were given no further information if this was resolved, how many people it impacted, or if records would be updated.

We have raised concerns about out of cell hours and record keeping numerous times (OICS, 2009; OICS, 2012; OICS, 2015b). In 2014, we recommended that Banksia Hill increase out of cell hours for young people and monitor this using more accurate recording methods. The Department agreed to this recommendation and said improvements had been made.

It is worth noting that even using Departmental figures, out of cell hours for young people still fall short of what is provided for adults. Out of cell hours in the adult estate is a Departmental Key Performance Indicator. They have a target of an average of 12 hours out of cell each day for each person which they have reportedly surpassed consistently for the last four years (DCS, 2016a). The *Young Offenders Act 1994* specifically states that a young person who commits an offence is not to be treated more severely than an adult, but clearly young people at Banksia Hill are locked down for longer than adults in prison.

Recommendation
Implement an out of cell hours Key Performance Indicator for youth custodial services that matches or exceeds the adult custodial target.

Finally, the use of top locks has added to the time young people spend in cells. As discussed in Chapter 6, the Department sometimes uses a regime in which the young people are physically able to leave the cells because their doors are locked only with a Yale-style 'top lock'. The doors are not locked with a 'Jackson Lock' and are not secure. However, the young people may be subject to consequences if they leave their cells. The Department does not count this as a 'lockdown'. In our view, it is a lockdown, and should be recorded as such. In any event, the practice should cease for safety reasons.

Recommendation
Improve record keeping practices to accurately reflect the time young people spend in cell.

5.2.1. Some young people have been denied legally required time out of cell

The *Young Offenders Regulations 1995* require all detainees to have a minimum of an hour of exercise every six hours (r 79(4)). We were advised that insufficient staffing in Harding Unit meant that young people were not always getting out of cell for the legislatively required time.

Log books records show that on at least one occasion this was true. Young Person X was in Harding Unit from 1 January to 9 January 2017. There is a considerable amount of missing data in the log books, but the total time out of cell recorded in the log books over the 8.5 days is only 3.5 hours. On one day the log books only show the young person out of cell for 15 minutes, five minutes of which were to speak to a psychologist.

Table 6
Movements documented in log book for a young person in Harding Unit between 1 January 2017 to 9 January 2017.

Day	Logged movements	Minutes out of cell per movement	Total minutes out of cell for the day
1 January	12:56-13:24 (to yard) 15:20-unknown (all HD young people to HA yard) 18:08-18:18 (to yard)	28 minutes Unknown 10 minutes	38 minutes
2 January	14:35-14:56 (to yard)	21 minutes	21 minutes
3 January	11:10-11:15 (to yard for visit with psychologist) 11:57-12:07 (to yard)	5 minutes 10 minutes	15 minutes
4 January	All detainees given shower 13:55 No recreation recorded		Unknown
5 January	14:25-15:12 (to yard)	47 minutes	47 minutes
6 January	10:25 moved cell 10:50-11:05 (work time and to yard) 12:31-13:00 (visit with psychologist) 15:18-unknown	Unknown 15minutes 29 minutes Unknown	44 minutes minimum
7 January	No specific mention in log book 11:00-unknown (all HD young people to HA yard)	Unknown	Unknown
8 January	No specific mention in log book	Unknown	Unknown
9 January	13:40-14:25 (to yard) 15:35 (moved to Yeeda Unit)	45 minutes	45 minutes
	Total minutes out of cell (all days)		3 hours 30 minutes

Recommendation
Ensure all young people have a minimum of an hour of exercise every six hours as required by the **Young Offenders Regulations 1995**.

5.2.2. Lockdown records have been entered incorrectly and evidence wiped

We heard credible claims that some electronic records were deliberately being entered incorrectly to meet legislative requirements. In order to test these matters, we sought CCTV footage for the Harding Unit over several days. We wanted to compare the visual evidence with the log books and electronic records.

Despite ample notice, the Department failed to provide us with the requested CCTV footage. It then advised that the footage had been recorded over after we had requested it. That was true even of recent footage. This raised serious issues of whether the Department had breached our legislation in relation to access to information. We are dealing with this matter separately.

As there is no evidence to dispute the credible advice we received, we have concluded that records were altered to make it appear that the legislated requirement for exercise had been met.

5.3. Isolation is overused as a behaviour management strategy

Isolating young people who are involved in incidents in a cell remains a routine behaviour management strategy following an incident. While a short period of separation may be necessary and appropriate, the goal should be to move away from this as soon as possible.

The Vita review of youth detention in the Northern Territory found that too much reliance was placed on confinement and separating young people (Vita, 2015). Vita said this was 'probably due to the lack of appropriate cellular and other centre infrastructure as well as a lack of training and supervision of staff' (Vita, 2015). He went on to say:

> There is no doubt at all that sometimes detainees need to be isolated away for staff and other detainees' protection however, the review found evidence that on isolated occasions some of their basic rights were being withheld for inappropriate periods of time. This does not serve to help with behaviour management.

This finding is consistent with what we have found at Banksia Hill. Young people placed on PSPs following an incident are spending a considerable amount of time in cell. As Vita said, this does not help with long-term behaviour management. In fact, it is likely to promote further problems, as was the case when 'regression' and IMRs were used some years ago (OICS, 2012). It also conflicts with any concept of trauma-informed care.

5.4. Banksia Hill has increasingly relied on tactical response

The Department has increasingly relied on its Special Operations Group (SOG) to respond to incidents at Banksia Hill. In 2014, SOG responded to two incidents and in 2015 to six. However, in 2016, Banksia Hill required SOG to respond to 19 incidents.

There have also been a number of SOG interventions in 2017, notably on 4 and 5 May. In addition, SOG staff were permanently located on-site at Banksia Hill from late 2016 to mid-February 2017.

The fact that the Department has needed so often to invoke its highest response capacity in its only youth facility is proof again of a system under unsustainable stress. The presence of SOG on-site, and the use of tactical weapons sends a very negative message to Banksia Hill staff and young people – that they cannot manage the site without outside help. It also goes against all therapeutic, rehabilitative, and trauma-informed models of care.

SOG intervention is required when an incident exceeds the capability of the local PRT. The PRT are local staff trained to provide a planned emergency response function (DCS, 2017b). The PRT are not permanently in a response role, but come when needed from other duties in the centre.

In contrast, SOG team members are permanent. Their primary role is to respond to emergency incidents and requests for assistance in areas such as high-security prisoner escorts to court. During an incident, and provided there has been appropriate high level authorisation, a SOG officer can use a range of control weapons. In 2016:

- on one occasion firearms with beanbag rounds were taken on-site and aimed at three young people but not discharged
- on three occasions chemical agent and distraction devices were used

During the incidents on the 4 and 5 May 2017 firearms were again taken on-site but not discharged and distraction devices were used.

5.4.1. Tactical response records are inadequate

We accept that SOG officers are highly trained and that a number of checks and balances are in place for their work. However, we are concerned that SOG does not visually record their interventions, either at Banksia Hill or at adult prisons. These are high risk situations and need a high level of accountability which is currently not sufficient.

By contrast, if a PRT is engaged at Banksia Hill or an adult prison, an officer will record the intervention. Banksia Hill Recovery Officers (who are the staff who respond to a call for additional support), also wear lapel cameras to record their response.

On 31 December 2016 SOG were called to a serious damage incident at Jasper Unit. They used distraction devices and laser sights on three young males to persuade them to come down from the roof of the unit. The boys had gone onto the roof after smashing up parts of the unit, and had debris at their disposal to throw at staff. Fortunately, the incident was ultimately resolved without serious injury to anyone.

Nobody condones the boys' actions, the risks were obvious, and a response was needed. However, when we viewed some rather grainy footage from a CCTV camera in the

centre, and footage from a handheld PRT camera, we became concerned about aspects of the operation. As a result, we issued the Department with a 'Show Cause Notice' under s 33A of the *Inspector of Custodial Services Act*. Actions in response to that are still being finalised and we will provide further details in our 2016-2017 Annual Report.

We are very concerned that SOG do not have high quality visual and audio records of their interventions. Such footage is necessary to increase accountability, reduce false allegations, and improve training. Digital lapel cameras which record sound as well as vision should be mandatory for all cases of SOG incident management, especially in youth justice.

> ***Recommendation***
> *Ensure high quality audio and visual recording of Special Operations Group interventions at adult and youth custodial facilities.*

5.5. Restraint use has increased

The frequency of restraint use at Banksia Hill has fluctuated in recent years and reached record levels in 2016. In 2013, records were very poor. The number of mechanical restraints recorded that year was the lowest in recent years (219), and yet young people were being routinely moved around both Banksia Hill and the Hakea Juvenile Facility in handcuffs.

Table 7
Restraint use at Youth Justice Services, 2013-2016

	Mechanical restraints used	Controlled escorts	Physical restraints	Total no. restraints used	Distinct persons
2013	219	31	129	379	165
2014	486	90	261	837	241
2015	248	129	171	548	194
2016	394	244	266	904	221

Improved reporting practices undoubtedly explain some of the increase since then, particularly the jump in 2014. However, it is unlikely that further improvements were made in record keeping practices between 2015 and 2016. It follows that the gains made in reducing restraint use in 2015 have not been sustained.

The quality of information has also declined since November 2014. Formerly, the reasons why restraints were used were transparently recorded such that between January to November 2014, the reasons and frequency of use were:

- assisting a young person to follow an instruction (48)

- instructing a young person for movement away from an incident (40)
- safe movement of a young person within a facility (107)
- safe transport to the special purpose unit, Harding (312)
- the safety of the young person and others (68)
- the safety of the young person and staff (214)

However, restraints ceased being recorded in this way in November 2014. The information regarding why a young person has been restrained is now buried within individual incident descriptions. It cannot be accessibly searched and therefore cannot be analysed by the Department to identify high risk trends. This type of information is important to transparency and accountability.

> ***Recommendation***
> *Record the reasons restraints are used on young people.*

5.6. Hardening the physical environment has not prevented serious incidents

Banksia Hill was designed in a campus style to create a positive environment for young people (OICS, 2013b). The original plan was to ensure the facility had clear zones within which young people can be assigned without the use of oppressive fence structures.

However, almost all the accommodation units at Banksia Hill have now been fenced in response to the number of incidents where young people have run off from the units. This has reduced the number of out of bounds incidents, but has not stopped the overall number of incidents. It has resulted in the young people, causing extensive damage within the units instead (see Chapter 2). Paradoxically, the Harding Unit was not fenced, despite being used to house some of the more volatile young people. When serious disorder broke out there on 5 May 2017, the young men therefore had access across the site.

The Department has claimed that installing the fences (which will also surround a new, grassed recreation space) will provide young males with access to secure outdoor areas increasing their access to 'fresh air' (Green, 2017). However, this logic is flawed: there are no proposed changes to lockdown hours, and to date, fencing around the units has not led to any increase in time out of cell.

The Department has also suggested that fencing the units enables them to operate as small, relatively self-contained residential facilities. It has indicated that it will assign staff to work specifically in each unit so they become more therapeutic. However, this plan, if it is still seen as viable, is a very long way off.

6 Key decisions have been based on poor risk management

The Department has made a number of important decisions without undertaking full risk assessments, and has often provided conflicting explanations of those decisions. They include relocating young women to an inappropriate unit; introducing 'top lock' practices that increase lockdown hours and the risk of peer assaults; changing the diet of young people in Harding Unit; and removing spit hoods from the centre.

We have made numerous comments in recent years about the Department's poor risk analysis preceding key decisions. Examples include decisions made at the time of the 2013 riot, policy changes regarding funeral attendances, and restraint use during transport and external activities (OICS, 2013a; OICS, 2013c; OICS, 2015a).

Despite this, the Department has not yet embedded documented analysis and risk assessments in its processes.

6.1. Young women were moved to an inappropriate unit

Just prior to Christmas 2016, all the young women were abruptly moved from their purpose-built, self-contained, female accommodation precinct (Yeeda). They were placed in a section of the Harding Unit that has generally served as a placement for the short-term orientation, behaviour management, and observation of boys.

On 3 May 2017, when finalising this report, we were told that the young women had been moved back to Yeeda. However, it is still important to discuss their placement in Harding. In terms of lessons learned:

- the Department did not give a clear rationale for the move or its duration
- it did not inform the courts or oversight agencies of this fundamental change
- there were no documented risk assessments for key decisions

Yeeda was specifically designed for young women. It has dedicated spaces for their specific needs, including education facilities, self-care opportunities, a nursing station, and observation cells.

The area of Harding in which the young women were placed was oppressive in feel, strewn with male graffiti, counter-therapeutic, and had little by way of outside space. It also did not allow the young women to be adequately separated from the young men, especially verbally. We have always encouraged positive, supervised interaction between young men and women, and have criticised Banksia Hill for not doing more of this. However, this was not what was created by accommodating the young women in the Harding Unit.

The Yeeda precinct offered an appropriate range of assistance for young women through orientation, behaviour management, and observation. Their relocation to

Harding Unit removed all of this. Given Harding Unit's historically punitive associations, the young women felt they were being punished for the young men's behaviour.

The Department has acknowledged that there was no documented risk assessment for moving the young women to Harding. It could also give no clear verbal understanding of why the decision had been made or how long it would last.

We were given several different explanations for the move, including:

- It was part of a long-term plan to transform the Harding Unit, to make it therapeutic, and to remove its reputation as a punitive environment.
- It was a trial of indeterminate duration, to use the centre's accommodation in a more efficient manner.
- It was a short-term circuit breaker because a number of young men had damaged their accommodation units so badly that they were unusable (and the Department wanted to fence all male units before re-using them).

The outcome was inevitable. The previously stable female population at Banksia Hill became unstable, and incidents increased, including self-harm and roof ascent. In the three and a half months from 16 December 2016 to 30 March 2017, Banksia Hill had 78 incidents involving young women. In the preceding six months at Yeeda, there had been only 53.

Yeeda had its own observation cells for young women who needed continuous monitoring. The areas of Harding occupied by the females had no observation cells, so females who required observation were accommodated in an observation cell next to a male. Temporary screens were erected to prevent visual interaction between the young men in observation and the young women, but they were still able to hear each other. This was inappropriate and confronting for young women in distress and potentially created trauma. In one case, the situation was allegedly so dire for one young female that after 72 hours in an observation cell, and finding her soaked in her own urine, staff took her to a holding cell in the centre's admissions area.

> ***Recommendation***
> *Ensure that young females are not housed in inappropriate units.*

6.2. The practice of top locks increased risks and in cell time

In late 2016, Banksia Hill implemented operational plans which increased the risk of peer assaults and the amount of time young people had to stay in cell.

The plans stated that between 9.00 am and 12.00 pm only three young people at a time could be out of cell during weekend cell and unit cleans; two cleaning and the other

accessing the telephone. All other young people in the wing were to be in their cells with their doors 'top locked'.[2]

Cell doors have two locks, a 'Jackson lock' that can only be opened by an officer with a key, and a 'Yale-style top lock' that can be unlocked from the inside of the cell by the young person. Top locks allow young people to come out of cell when they choose but when the door is shut it can only be opened from the outside by an officer with a key.

The practice of top locks is fraught with risk. As a top locked cell is not secured by a Jackson lock, it provides opportunities for young people to secrete themselves inside when staff are distracted by other duties. This has the potential to lead to physical and sexual assaults.

In December 2016, a young person at Banksia Hill was allegedly sexually assaulted in an unsecured cell. There was no staff member in the wing supervising the young people at the time the cells were unsecured. This incident did not occur during a weekend clean, but does demonstrate the risk to vulnerable young people in the absence of constant and active staff supervision.

Recommendation
Cease the practice of top locks.

6.3. Food has been restricted as a behaviour management technique

In response to the increase in incidents, Banksia Hill provided a different, more restricted diet to young people in the Harding Unit. We were reliably informed that foods high in sugar were largely removed, including morning tea, dessert, and sugary drinks. Hot meals were no longer supplied, and were replaced by finger food, usually sandwiches and wraps.

Despite numerous conversations with the Department we remain unclear about whether the diet provided in Harding Unit differed to the rest of the facility. We also remain unclear as to why the diet would or should be modified. We were given several rationales for why it would be different:

- 'deterrence' ('we make no apology for doing what is necessary to stop young people coming into Harding')
- 'loss of privilege' for poor behaviour
- sugar causes bad behaviour
- removing cutlery to stop self-harm

[2] In its response to the draft copy of this report the Department stressed that these operational orders were 'discrete and finite' only in effect from 28-31 October, 2016 and 11-14 November, 2016. As time in cell with a top lock engaged is not recorded by the Department we are unable to confirm if the practice of top locks was effective on other dates.

In line with international standards, our Code of Inspection Standards for Young People in Detention prohibits the reduction of diet as a form of punishment or behaviour control (OICS, 2010). Some of the young people viewed the new menu as punitive because it further restricted the typically limited diet already in place in Harding Unit.

The various rationales demonstrate the centre's inability to articulate a measured, evidence-based approach to behaviour management. If the reason was that sugar increases poor behaviour, the menu for the whole centre should have been reviewed. This was not done.

If the reason was to prevent self-harm with cutlery, this does not explain removing morning tea from the menu nor explain why other methods were not used. Prior to the removal of cutlery, Youth Psychological Services had identified concerns that young people at extreme risk were being issued with plastic cutlery that was not accounted for when they finished their meals. Some young people had secreted the cutlery and used it to self-harm. However, this risk should be managed through alternatives such as cutlery return checks, increased supervision, or applying a soft-foods approach for those identified as at-risk.

Unfortunately, the restricted diet has had other effects. Staff advised us that some young people self-reported weight loss, were hungry, and were denied fruit upon request. We confirmed with some young people that they were often hungry while in Harding Unit. Youth Psychological Service staff believed this had led to lethargy in some young people who lacked energy to engage in coping strategies such as recreation and working out in cell. Youth Justice Workers advised it was also increasing irritability and frustration in other young people who on occasion were 'acting out'. For one young person with a trauma history of starvation, this culminated in him assaulting a staff member because he was hungry.

> ***Recommendation***
> *Do not use dietary restrictions as a behaviour management technique.*

6.4. The Department needs to evaluate the removal of spit hoods

Spit hoods were removed from the centre in the days immediately following the ABC's *Four Corners* program on Don Dale Youth Detention Centre in the Northern Territory. The program aired footage of a young person wearing a spit hood and strapped to a restraint chair for several hours.

The footage was confronting and the then Minister for Corrective Services for Western Australia quickly assured the community that similar responses were not occurring at Banksia Hill (Trigger, 2016). The Department reinforced this by removing spit hoods from use. It did not conduct a documented risk assessment.

Spit hoods have become very controversial because of the Don Dale footage. On the basis of what is known, it is difficult to see any possible justification for the spit hood being left on the young person for such a long time, especially when he was in a restraints chair. It is understandable that the Don Dale footage led to concern about the use of spit hoods. However, the unfortunate reality is that some offenders do spit at staff, and staff need protection (see also Chapter 2). There are only two means of protection: either staff wear protective gear or a hood is used on the young person spitting.

The hoods used at Banksia Hill before the ban were commercially manufactured and made of material and mesh, so that when placed over the young person's head they were deterred from spitting and biting (DCS, 2016d). Strict guidelines governed their use (Standing Order 18 Use of Force, Appendix 5, effective 10 February 2016 to 10 August 2016).

The hoods could only be used under constant supervision and were not standard or routine practice. Departmental data indicates that the hoods were used 14 times from the beginning of 2014 to August 2016, and the policy was strictly followed. The maximum amount of time a hood was used was 16 minutes. Most use was for five minutes or less. Without exception, the young person was under observation during the entire time. Since removing the hoods, the onus has been on officers to wear a face shield, much like a doctor's mask with a clear plastic segment that covers the officer's eyes. However, staff advised us that the shield is fiddly and takes time to put on. This can delay the time it takes to respond to an incident. The shield is not designed to be folded to fit in a pocket and will wear and crack over time, so many staff are not carrying them. The shield does not cover the officer's ears or any other part from bodily fluid contact.

The fact that an officer has a mask also offers no protection to other people in the vicinity, such as other young people, other workers, or visitors.

By December 2016, there had been at least four incidents since the removal of the spit hoods (10 August 2016) that had resulted in staff requiring medical testing due to bodily fluid contact.

Removing the hoods has also removed guidance and governance around managing young people who are spitting. This generates further risks. The section of the Use of Force policy which previously governed spit hoods stated that no other items should be used or improvised to manage the risk of spitting. This has now been removed from the policy. However, in the absence of spit hoods, we have seen one recorded incident when a t-shirt was placed over a young person's head to protect officers. One officer's report mentioned the use of the improvised spit hood but two other officers' reports did not. Previously, the policy directed that Shift Managers and the Superintendent (now General Manager) were to be notified as soon as possible when a hood was used.

Makeshift spit hoods are unlikely to receive this level of transparency. Their ungoverned use puts young people at greater risk of injury.

Several months have passed since the removal of spit hoods and the effects of doing so have been identified. It is time for the Department to review its responses to young people who spit and consider if spit hoods should be re-introduced, or to implement mitigation strategies to address the adverse consequences of spit hood removal.

Recommendation
Evaluate the safest and most humane way to deal with young people who spit and implement any required changes.

Appendix A: Department of Corrective Services response to recommendations

Response to the review of Behaviour Management Practices at Banksia Hill Detention Centre

Department of Corrective Services

May 2017

The Department of Corrective Services welcomes the findings of the Behaviour Management Practices at Banksia Hill Detention Centre (BHDC) review conducted by the Office of the Inspector of Custodial Services.

The Department has considered the report and noted a level of acceptance against the 17 recommendations.

The Department announced on the 8th May 2017 that decisions about the future of BHDC are being made in consultation with local management, staff and key stakeholders to ensure the ongoing safe operations at the centre.

The Department is looking at the operating model of BHDC, specifically the security and stability of the centre and a strategically focused project to look at youth custodial service delivery optimisation.

The Department is committed to providing a safe, secure and stable environment at BHDC that provides the best opportunity for young people in our care to rehabilitate through effective education and rehabilitation programs.

Appendix A contains a number of notes for your attention.

Response to Recommendations

1 The Department should continue to pursue a trauma informed model of treatment for young people in detention.

Response:
The Department acknowledges the Inspector's finding that the Department was right to promote a stronger rehabilitative model at BHDC and appreciates the Inspector's ongoing support for the principles that underpin a trauma informed model of care. The Department is committed to continuing trauma informed practice and evidence based behaviour management models, the implementation of which will continue as part of Project Banksia.

Level of Acceptance: Supported

2 Investigate opportunities for small residential youth justice facilities across Western Australia to keep young people close to their families and networks, and to increase the prospects of successful rehabilitation.

Response:
The Department supports the Inspector's findings that BHDC is a complex custodial facility housing young people with complex and diverse needs. While the Department agrees with the Inspector's premise that small, locally based custodial facilities for juveniles are a sound model of detention, the Department is limited to operations within its current infrastructure base. Significant capital investment would be required to comprehensively assess opportunities for small residential youth justice facilities across WA. The Department will consider this recommendation in line with government priorities and machinery of government changes across the youth justice portfolio.

Level of Acceptance: Supported in principle

3 Improve clarity and communication about short term and long term strategies of the Banksia Hill.

Response:
The Department has prioritised improved communication and clearer implementation of operational models at BHDC. The Department is taking learnings from the successes and failures of past program implementation.

Regular communications with BHDC and head office staff is occurring as a priority and all internal and external stakeholders will be kept updated and appraised of strategies at BHDC.

Level of Acceptance: Supported

4 Improve consistency in the way young people are managed.

Response:
The Department agrees with the Inspector's findings that the management of young people in detention should be based on fair and consistent treatment. The Department has always maintained a management approach that treats young people fairly and in line with the Young Offenders Act 1994.

The Department will improve the implementation of the models of care at BHDC by providing clearer direction, leadership and management to Banksia Hill staff.

Level of Acceptance: Supported

5 Deliver PSPs and CHART or alternative programs based on similar principles.

Response:
The structure, management and operational model for young people at BHDC will be reviewed as part of Project Banksia to ensure continuous improvement and better outcomes. The 2016 frameworks were established to consistently and objectively measure and evaluate the performance of programs delivered to young people. The implementation of these programs will continue, in line with any impacts that machinery of government changes may have on the delivery of youth justice services.

Level of Acceptance: Supported

6 Assess and mitigate staff concerns regarding the investigation process.

Response:
The Department has commissioned a review of the Investigations Services directorate to ensure that all investigation matters are dealt with in accordance with the principles of natural justice and procedural fairness.

Level of Acceptance: Supported

7 Evaluate the use and effectiveness of the different behaviour management tools.

Response:
The Department is committed to implementing a trauma informed practice model which will inform the range of appropriate behaviour management tools.

Level of Acceptance: Supported

8 Minimise the use of lockdowns for staff training and staff shortages.

Response:
The Department is in the process of building a structured day that will include staff training. There will be an operational requirement at times to restrict routine operations to facilitate staff training.

Level of Acceptance: Supported in principle

9 Implement an out of cell hours Key Performance Indicator for youth custodial services that matches or exceeds the adult custodial target.

Response:
The Department's KPIs for Youth and Adult Justice Services are agreed via the Government's Outcome Based Management Framework. Implementing additional KPIs will be considered via the implementation of Machinery of Government (MOG) changes in Youth Justice Services.

Level of Acceptance: Supported in principle

10 Improve record keeping practices to accurately reflect the time young people spend in cell.

Response:
This has been improved (recently) with the introduction of an on-line recording process that clearly identifies time in and out of cell (OOCH). This pilot document and process, once suitable for all parties, will be submitted for inclusion in the Department's IT system.

Level of Acceptance: Supported in Principle

11 Ensure all young people have a minimum of an hour of exercise six hours as required by the Young Offenders Regulations 1995.

Response:
The Department is committed to providing recreation opportunities as part of the structured day in line with requirements of the Young Offenders Regulations 1995. The Department accepts the Inspector's findings that improved record keeping will enhance the monitoring of time out of cell for recreation.

Level of Acceptance: Supported

12 Ensure high quality audio and visual recording of Special Operations Group interventions at adult and youth custodial facilities.

Response:
Lapel camera's and hand held video is used currently by Youth Justice Workers to ensure safe practices are used in all incidents and critical situations. The Special Operations Group and Adult Custodial currently use hand held cameras for planned use of force. Currently there is no budget appropriation for the wider rollout of Lapel cameras, however, it has been included on the agenda of the Security and Intelligence Committee.

Level of Acceptance: Supported in principle

13 Record the reasons restraints are used on young people.

Response:
The reason for the use of restraints on young people is currently capable of being extracted from TOMS. Reasons are obtainable within the Incident Report Description and also from Custom Reports and Data Extraction. Functionality of TOMS is continually improving and towards the end of 2014 a number of reports were removed. Whilst the Department recognises that the Restraints Used – Facility Report no longer exists, the information is still obtainable and in the current form, the reasons for restraint use is more descriptive than the previous 6 reasons contained in the former report.

Level of Acceptance: Supported

14 Ensure that young females are not housed in inappropriate units.

Response:
All living units within BHDC are similar in design and deemed suitable for all young people. All receive the same standards of care, access to education, programs and recreation, regardless of where they are housed. From time to time, decisions will be made on where young people are housed due to a variety of circumstances that can arise. The best interests of specific groups of young people and or individuals is always taken into consideration. Yeeda is considered the best option for young females at BHDC in normal circumstances. The Department is committed to reviewing best placement options for young females.

Level of Acceptance: Supported in Principle

15 Cease the practice of top locks.

Response:
The use of top locks is not an ongoing management practice at BHDC. Over two weekends in November, two discrete and finite operational orders were put in place in response to increasing incidents during the cleaning regime involving broom

handles and mops. To minimise risks to staff and young people, BHDC issued the orders that young people should return to their cells during cleaning time and for their own privacy and comfort their doors could be secured with top locks, meaning they were free to leave the cell at any time. A top lock prevents other young people entering cells, but does not prevent the occupant leaving their cell or staff entering the cell.
The Department agrees that constant and active staff supervision of young people in our care is required at all times of unlock.

Level of Acceptance: Not Supported

16 Do not use dietary restrictions as a behaviour management technique.

Response:
The Department agrees with the Inspector's comments that dietary restrictions should not be used as a behaviour management technique and can confirm that dietary restrictions are not used to manage behaviour at BHDC. Young people are offered and provided with appropriate and adequate amounts of healthy meals. These meals are prepared on site by our kitchen staff in accordance with the Food Act 2008 and Standard Guidelines for Corrections in Australia. An external Food Stars Audit was conducted and has confirmed that safe food practices and hygiene at Banksia Hill are compliant with all relevant standards. The Department commends the kitchen staff for providing a range of healthy and nutritious food options and we have included a list of these food options at Appendix A.

Level of Acceptance: Supported

17 Evaluate the safest and most humane way to deal with young people who spit and implement any required changes.

Response:
Since the removal of spit hoods, BHDC has introduced various forms of personal protective equipment for staff to utilise in different situations. This is accompanied with improved communication, use of intelligence and planning prior to interactions with young people that have a history of spitting or other behaviours that could pose a risk to staff safety. The Department considers these measures to be the safest and most humane for young people and staff.

Level of Acceptance: Supported

Appendix B: Evidence base for Banksia Hill's transformation project

Missouri Model

The Missouri Model of youth justice was originally developed in Missouri in the United States in the 1970's. The intent was to move away from traditional punitive practices which were achieving poor outcomes into a more humane, constructive, and positive approach. Specifically the model:

- replaced large institutions in favour of smaller group homes, camps, and treatment facilities which linked in with families;
- maintained safety through relationships and eyes-on supervision rather than isolation and correctional hardware; and
- provided intensive youth development by employing dedicated youth development specialists rather than correctional supervision through guards.

The Missouri Model has six key characteristics:

1. Young people in confined custody are housed in small residential-style facilities located close to their own homes and families rather than large detention facilities
2. Young people are placed in small, closely supervised groups and undergo a rigorous group treatment process where individual attention is easy to maintain.
3. Active measures are taken to protect young people from aggression and abuse through staff supervision and supportive peer relationships.
4. Education is prioritised, not just academic and vocational skills, but also communication and other life skills.
5. Family is involved in the treatment process while incarcerated as well as being involved in planning for success in transitioning from detention.
6. Support and supervision are provided to transition from detention in the form of extensive aftercare planning as well as monitoring and mentoring during the first few weeks of release.

As a result of implementing the model Missouri's recidivism outcomes have consistently been better than other US states. Other states also saw improvements in recidivism after implementing similar juvenile justice models.

Additionally, safety improved with the introduction of the model. When compared to Ohio youth custody, although Ohio confined just over twice as many youth as Missouri, they recorded over four times as many youth-on-youth assaults and almost seven times as many youth-on-staff assaults (Mendel, 2010). Ohio facilities also reported suffering theft or major property damage almost 10 times as often as Missouri facilities.

Behavioural management tools such as mechanical restraints and isolation are used comparatively less by Missouri facilities than other United States' jurisdictions. In

comparison, Ohio reported using mechanical restraints 2.5 times as often as Missouri, and placing youth into isolation 245 times more (Mendel, 2010).

Sanctuary Model and Trauma-Informed Care

Trauma Informed Care, such as the Sanctuary Model, is about providing support to staff to understand the impact of trauma and the way in which young people react based on their past traumatic experiences (Ford, 2013). Through better understanding and changes in practice, staff, management, and the physical environments can provide more support to the young person and avoid re-traumatisation.

Staff are expected to be role models for appropriate behaviour by being in control of themselves rather than exerting control over the youth. Punitive, intimidating, and coercive practices are discouraged in favour of supervision, monitoring, and discipline that are aimed at allowing young people to learn to identify and modify their own behaviour. One of the key aspects of this model is to provide a safe environment so the young person can learn to control their emotions, deal with feelings of grief and personal loss, and learn new ways to relate and behave.

Trauma-informed care is not limited to corrections facilities. This approach is currently being implemented in mental health and human service environments across Australia.

We Al-Li approach

The We Al-Li approach is an Indigenous model for trauma healing in the community (Atkinson, 2012). Similar to the Sanctuary Model, the key for this approach is to provide a safe environment for people to heal. The first step is to provide a way to find and tell the trauma story, not just in the spoken word but through art, clay work, theatre, dance, and music. This allows participants to share their story with others.

We Al-Li community work is an Indigenous therapeutic response to individual, family, and community pain that many people carry as part of their life experience. For Aboriginal peoples this pain is more specifically defined as the traumatic impacts of the multiple intergenerational experiences of colonisation resulting in ill-health, and individual, family, and community dysfunction.

We Al-Li specifically meets this need through tailored workshops. These workshops are built on the principles of integrating Indigenous cultural processes of education, conflict management, and personal/social healing with Eastern and Western therapeutic skills for trauma recovery. Workshops address domestic violence, sexual assault, childhood trauma, suicide, self injury, and addictions.

Appendix C: Timeline of various critical incidents since 1 August 2016

Date	Short description	Long description
10 August	Staff assault and property damage	One young person caused damage to property and used a broom handle to strike an officer multiple times on the head.
29 August	Barricade and property damage	Three young people caused extensive damage to a wing and armed themselves with make shift weapons such as broom handles. The young people barricaded themselves in the room with laundry equipment and the table tennis table.
1 September	Barricade and property damage	Four young people (2 of which were peer pressured) caused extensive damage to a wing armed with various weapons. Staff had to barricade the young people into the wing with the use of shields to prevent staff assault. Flash bang detonators and chemical agent were used by the Department's SOG to de-escalate the situation.
8 September	Staff assault	A young person spat at an officer making contact with the officer's face.
11 September	Staff assault	In an effort to restrain a young person who was armed with concrete, a staff member was seriously injured falling between the young person and a wall.
17 September	Out of bounds – rooftop incident	A young person ran out of bounds, armed himself with rocks and ascended the roof.
23 September	Out of bounds – rooftop incident	Four young people ran out of bounds and ascended the roof armed with rocks. The incident lasted approximately an hour.
24 September	Out of bounds – rooftop incident	A young person ran out of bounds, ascended the roof and was threatening self-harm and to jump while on the roof for several hours.
28 September	Out of bounds – rooftop incident	Two young people ran out of bounds, armed themselves with rocks and ascended the roof. The young people were on the roof for several hours.
28 September	Second out of bounds – rooftop incident	Two different young people ran out of bounds and ascended the roof. This incident lasted approximately 30 minutes.
2 October	Out of bounds – rooftop incident	Six young people armed themselves with make shift weapons, ran out of bounds and ascended the roof. The young people threw objects at staff, none making contact. This incident lasted approximately 3 hours.
2 October	Second out of bounds – rooftop incident	Two other young people ran out of bounds and ascended the roof, lasting about 1 hour.
4 October	Staff assault	A young person threw a metal tray at staff; however, it did not make contact. Staff then restrained the young person and once on the ground, the young person spat at 2 officers making contact with their face and eyes.

6 October	Attempted suicide	A young person attempted to hang himself during an exercise break in Harding Unit.
7 October	Out of bounds-rooftop incident, arson	Three young people ran out of bounds. The young people started a fire in the staff room. Two of these young people ascended the roof, 1 located a mobile phone within the centre and called someone. The incident lasted roughly 6 hours.
22 October	Out of bounds – rooftop incident	Three young people ran out of bounds, armed themselves with metal poles and a fire extinguisher and ascended the roof. The incident occurred for about an hour.
24 October	Attempted suicide	A young person tied a jumper around his neck attempting to choke himself. He was subject to continuous checks but housed in Harding D Wing. Although these cells have cameras, the young person had covered the CCTV. The young person was found, the ligature untied and he began fitting. He recovered and was escorted to hospital via ambulance.
25 October	Staff assault and out of bounds	A young person ran out of bounds and armed himself with sticks and rocks. Rocks were thrown at staff, one connecting to the head of an officer and the sticks were used to strike 2 officers, causing injury.
2 November	Attempt to steal officer's keys	A young person attempted to take the keys out of an officer's pocket but was unsuccessful.
3 November	Staff assault	A young person was restrained for threatening behaviour. Once on the ground, the young person bit an officer on the leg drawing blood and struck an officer on their shin.
12 November	Barricade and property damage	Eight young people barricaded themselves in a wing; one was not involved in the extensive damage caused by the others. The young people removed bricks from the walls to use as weapons. SOG used flash bang detonators and chemical agent to de-escalate the situation.
18 November	Attempted suicide	A young person tied a bed sheet around his neck while in cell. He was found just prior to morning unlock.
4 December	Out of bounds – rooftop incident	Three young people ran out of bounds. They armed themselves with weapons and ascended the roof. Once there the young people threw projectiles at staff; SOG restrained the young people on the roof and escorted them to Harding.
4 December	Multiple cells damaged	During the above incident eight young people in another unit began damaging their cells. All of the young people eventually responded to counselling. They were mechanically restrained and escorted to Harding.
4 December	Possession of contraband weapon	A contraband weapon (wooden shank) was handed to staff. A young person was escorted to Harding for investigation into the incident.

12 December	Alleged sexual assault	A young person alleged that two other young people had indecently assaulted him in cell. Recovery took the accused young people to Harding for investigation and were both strip searched.
20 December	Staff assault	A staff member was seriously assaulted with a plastic chair receiving severe injury to her head and eye, the wound bled profusely. Two separate young people were under suspicion of the assault and were both escorted to Harding.
21 December	Self-harm	A young person was found choking themselves with a ripped pillow case in Harding. The young person was one of the accused from the 12 December alleged sexual assault. He was assessed at hospital and returned to Harding to an observation cell.
28 December	Out of bounds – roof top incident	Three females absconded from Harding; two climbed onto the roof and the third climbed up onto the perimeter fence. One attempted to spit on staff. All three girls descended on their own volition.
31 December	Out of bounds – roof top incident and cell damage	Three young people accessed the roof with projectiles, while four others severely damaged the unit and armed themselves with makeshift weapons. A fire was started in a wing. Incident lasted up to 3 hours; all young people involved were escorted in restraints to Harding by SOG. SOG control weapons include shotguns with bean bag rounds.
1 January	Security breach	A flare was fired into the centre. It landed on the education roof and started a small fire that was quickly extinguished by staff.
8 February	Out of bounds – roof top incident	Four young people absconded. One was apprehended while the remaining three ascended a roof and caused extensive damage. They armed themselves with projectiles and threw them at staff. The young people also attempt to start several fires. SOG officers with shotguns were in attendance. The young people descended the roof approximately 2.5 hours later.
10 February	Staff assault	A young person attempted to exit a cell and when advised she was not to, she spat in an officer's face hitting him mouth and eyes.
15 February	Staff assault	During a controlled escort a young person spat at an officer hitting him in the eye.
16 February	Attempt to steal officer's keys and staff assaults	A young person attempted to take keys from an officer. In restraining the young person, he assaulted several staff punching and kicking them. The young person also spat at staff hitting one officer in the face.
24 February	Staff assault	On issuing breakfast in cell to a young person, she spat at an officer hitting him on the head.
26 February	Staff assault	During a restraint a young person attempted to strike and kick out at officers. She was also spitting at staff hitting an officer in the mouth.

16 March	Attempted suicide	A young person tied several ligatures around his neck while in an observation cell. The ligatures were made from ripped clothing.
17 March	Staff assault	A young female unexpectedly punched an officer in the face as he followed behind her.
25 April	Self-harm	A young person engaged in significant self-harm using a piece of glass and clothing as a ligature. He was in a multipurpose cell at the time.
2 May	Attempted suicide	A young person was observed to actively search for a hanging point while in cell. As staff were forming a plan of action he tied a ligature around his neck. He was restrained and removed to an observation cell.
2 May	Attempted suicide	Another young person tied clothing around her neck forming a ligature. She was being counselled by staff when she placed her head in a toilet bowl for between 15-20 seconds. As her cell was being opened she punched an officer in the head. She was restrained and the ligature was removed. Approximately half an hour later it was suspected that the young person swallowed a piece or more of rubber glove left within her cell. She had trouble breathing and at one point stopped breathing. An ambulance was called and she was escorted to hospital.
2 May	Staff assault	A young person was being escorted back to his cell in Harding Unit when he attempted to abscond. During the restraint he elbowed an officer in the sternum.
4 May	Property damage and threats to staff	Seven young people caused extensive damage to a unit. Five threatened staff and two other young people retreated into two offices. The SOG used distraction devices and chemical spray. They were also armed with laser-sighted shotguns loaded with beanbag rounds.
5 May	Out of bounds – rooftop incident, property damage and threats to other young people	Approximately ten young people ascended the roof of Harding Unit. They also broke into education workshops and accessed a number of tools one of which was used to cut another young person out of a secure area. Other tools were used to cause significant damage, break into other areas of the centre and set fires to scrub areas. In the midst of this incident a further five young people escaped their cells. Those five surrendered but the remaining young people were at large and unable to be located for several hours. The young people were found hiding in a roof space and surrendered to the SOG.

Appendix D: Summary of behaviour management options

As per Standing Order 9a – Management of young people

Actions to support pro-social behaviour	Description
Counselling and cautioning	The first option in most circumstances, either formally or informally, when inappropriate behaviour is minor in nature and immediate cessation of the behaviour is required. Formal counselling and cautioning may be required when the behaviour is repetitive. Can be issued by Youth Justice Worker.
Imposition of additional duties	Additional domestic or other work duties include: Weeding Gardening Picking up rubbish Can be issued by Youth Justice Worker.
Time out in own cell	Time in own cell to manage inappropriate behaviour, or following an incident of non-compliance or misconduct where other management actions have proved ineffective. The young person shall be advised of the reason for time out. Time out shall not be longer than an hour. Can be issued by Youth Justice Worker. Jackson lock is to be engaged, Youth Justice Leader is to be notified, and welfare checks maintained and recorded for the duration.
Imposition of a loss of privilege	Privileges include: Use of audio system Use of television Use of personal property Participation in recreation activities Use of telephone for social calls Social contact visits Canteen Personal property in cell Removing a privilege requires an incident report. Authority up to max 5 days – Youth Justice Leader Authority up to max 10 days – Assistant Superintendent

Imposition of non-contact social visits (loss of contact visits)	Losing contact visits can be the result of: Unacceptable physical contact between the young person and their visitor Contraband being found on a young person and/or visitor before, during or immediately after a visit Young person's failure to comply with the Visits Centre – Code of Conduct A positive indication from a drug detection dog on a young person during or after a visit The young person being in possession of, or under the influence, of an illegal substance or refusing to undergo urinalysis after being suspected of using an illicit substance Removing contact visits requires an incident report. Can be issued for a period up to 28 days. Authority to approve – Assistant Superintendent Security.
Imposition of a loss of gratuities and restitution	Gratuities are paid in accordance with *Young Offenders Regulations 1995* and currently vary between $3.16 and $5.75 per day. Loss of gratuities can be imposed for non-participation in programs, education, work groups or unit duties ($2.00 per session or activity). Restitution for centre property purposely or maliciously damaged, destroyed or lost includes: Television - $150.00 Radio - $20.00 Remote control - $20.00 Linen or clothing - $5.00 per item Identification card - $2.00 Cell key - $2.00 Loss of gratuities or seeking restitution requires an incident report.
Loss of privileged placement or level of supervision	A higher level of supervision and loss of placement in a wing or unit associated with extra privileges can be imposed if the young person fails to continue to meet the standard of behaviour required to maintain the placement. An increase in supervision level requires an incident report.
Management of a young person on a Personal Support Plan (Unit Based)	PSP Unit Based for use when all other means to address inappropriate behaviour have been exhausted. Not to be considered a punitive measure.

	Authority to approve - Senior Youth Justice Worker or higher, with notification to Assistant Superintendent Operations. Documentary evidence (event log entries, notes and incident reports) must exist to justify the PSP.
Management of a young person on a Person Support Plan (Change of Accommodation)	PSP Change of Accommodation for use as a last resort to manage the resulting risk from a critical incident and segregation from peers is required. Or to manage ongoing inappropriate behaviour when every other available option has been exhausted. Not to be considered a punitive measure. Every young person placed on PSP Change of Accommodation is entitled to fresh air, exercise and staff company for at least 1 hour every 6 hours. Progress to PSP Unit Based as quickly as possible subject to the young person modifying their inappropriate behaviour or the risk to the centre has been addressed. Authority to approve – Assistant Superintendent or higher. Documentary evidence (event log entries, notes and incident reports) must exist to justify the PSP. Unless in exceptional circumstances where involvement in a critical incident only one incident report may provide sufficient justification.
Management of a young person on a Person Support Plan (Special Needs)	PSP Special Needs for use when the young person's special needs (including disability or medical diagnosed disorder) need to be managed to ensure the appropriate level of supervision is provided to ensure their own safety and to maintain the good order and security of the centre. Not to be considered a punitive measure.
Placement in a management in a multipurpose cell pending investigation into an incident	*Young Offenders Regulations 1995* designates certain cells in Harding and Yeeda units as suitable for the use for the purposes of investigation. In some circumstances immediate placement in a multipurpose cell may be necessary to ensure the continued good order and security of the centre or the safety of other young people or staff. Only facilitated by Youth Justice Leader or higher unless exceptional circumstances of imminent risk.

	When immediate placement in a multipurpose cell is required an incident report is required. Within the first 2 hours of the young person's placement a Youth Justice Leader or Senior Youth Justice Worker shall attend following initial investigation and either: Approve continued placement pending further investigation Permit the young person to return to mainstream placement and consider other action to manage the young person's behaviour and/or risk to the centre. Every young person placed in Harding Unit pending investigation is entitled to fresh air, exercise and staff company for at least 1 hour every 6 hours. Welfare checks maintained and recorded for the duration. Shall not exceed 24 hours without initiation of a Change of Accommodation PSP.
Detention Centre charges	Charges can be brought against young people are outlined in ss 170-175 of the *Young Offenders Act 1994* and rr 36-40 in the *Young Offenders Regulations 1995*. Can be recommended by Youth Justice Worker or higher but endorsed by Senior Youth Justice Worker. Recommendations for detention centre charges must be recorded in incident report minutes. Approved hearing authorities - General Manager or Visiting Justice
Criminal charges	A young person shall not be subjected to a detention centre charge until it is determined that the young person will not be charged with a criminal offence. Can be recommended by Youth Justice Worker or higher but endorsed by Senior Youth Justice Worker.
Placement in an observation cell	Not to be used as a tool to manage inappropriate behaviour.

Appendix E: Methodology

A series of data sets were obtained from the Department's Total Offender Management Solution (TOMS) database both through previously created Departmental reports and standard query language data extraction. These data sets were used to determine demographic information, the frequency behaviour management tools were used at Banksia Hill, and types of behaviour being exhibited by the young people at the centre. Thorough review of incidents reported on TOMS was also performed.

We conducted a series of announced and unannounced site visits to Banksia Hill between August 2016 and May 2017. During these visits we observed the treatment of young people both in the Harding Unit and in the other mainstream units. We also observed recreation activities and evening lockdown procedures. We spoke at length with young men and women, and held discussions with custodial and non-custodial staff, and various members of the centre's management team.

We analysed various Departmental policy and practice documents to compare them to our observations. Other documents were also examined including PSP and Daily Monitoring Checklists, CCTV footage, log books, internal investigation reports, security reports, and Banksia Hill Transformation progress reports. A literature review based on the Department's rationale for its operational model was also conducted.

In October 2016 we distributed a staff survey which yielded 93 responses. The survey was open to all levels of staff including local management, and respondents were from both the custodial and non-custodial streams at Banksia Hill.

We engaged with various external stakeholders including the Children's Court of Western Australia, Aboriginal Legal Service (WA), Kath French Secure Care Facility, the Community and Public Sector Union (WA), and the Telethon Kids Institute. A Community Consultation Forum was also held on 17 October 2016 involving a small number of community representatives and we received a written submission from the Western Australian Commissioner for Children and Young People.

Finally, meetings were held with central office staff including the Former Commissioner of Corrective Services, the Deputy Commissioner of Youth Justice Services, the Deputy Commissioner Regulation and Operational Services, the Director Security and Response Services, and the Director Investigation Services. A preliminary findings briefing by this Office was presented in February 2017 which was followed by a final findings briefing in April 2017.

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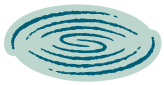

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