



OFFICE OF THE INSPECTOR
OF CUSTODIAL SERVICES

2017 INSPECTION OF
BANKSIA HILL DETENTION CENTRE

116

FEBRUARY 2018

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accountable public sector*

2017 Inspection of Banksia Hill Detention Centre

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Inspector's Overview

SIGNS OF IMPROVEMENT AT BANKSIA HILL, BUT WILL IT LAST?

BANKSIA HILL IS THE STATE'S MOST COMPLEX CUSTODIAL FACILITY

This is the report of an inspection of Banksia Hill Detention Centre ('Banksia Hill') in July 2017. As a result of the previous government's decision to re-purpose the Rangeview Remand Centre, Banksia Hill has been the State's only juvenile detention centre since 2012.

The inspection took place at a difficult but important time. The centre had been unstable for most of the previous seven years, and particularly volatile for the last 12 months. We had also just released a report on behaviour management practices that had attracted considerable media support (OICS, 2017). We concluded that Banksia Hill had not worked as a one-stop shop, and called for a major overhaul of youth custodial services, including more placement options.

Banksia Hill's population is complex, diverse, and challenging. In the last five years, the centre has generally held 140–150 young people but numbers have been trending upwards, and recently went over 170. It holds both males and females and, at the time of the inspection, a young transgender person who identified as female. Some detainees are as young as 10, others are 18 or more. And they come from all parts of the State, many from as far away as the Kimberley, the Pilbara, and the Ngaanyatjarra Lands. Aboriginal children comprise 70 per cent of the total population, and almost all of the younger and regional children.

The young people at Banksia Hill invariably face major social and developmental challenges, and the majority have experienced abuse or trauma. The Telethon Kids Institute recently concluded that more than a third have Fetal Alcohol Spectrum Disorder (FASD) and 90 per cent have significant neurodevelopmental impairment (Bower et al, 2018).

Despite this complexity, Western Australia holds all the young people in one place and has no separation or dispersal options. For good reason, no other State or Territory believes it is appropriate to hold such a large and diverse group of young people in one place.

I am required to report on Banksia Hill every three years, but the centre's problems have been such that this is now my sixth report in six years. I have also recently been directed by the Minister to review allegations made by Amnesty International about the treatment of two young men in the centre's Intensive Support Unit (ISU). This report was prepared before those allegations were made. It includes some discussion of the ISU as at July 2017, but does not address Amnesty International's allegations. We will report separately on those later this year.

2016 TO MAY 2017: VOLATILITY, DYSFUNCTION, AND A FAILED TRANSFORMATION

It is not possible to understand the current situation at Banksia Hill without understanding the recent past.

The badly-managed project to amalgamate Rangeview and Banksia Hill was a key causal factor in a major riot in January 2013 (OICS, 2013). The riot caused so much damage that most of the male detainees were moved to the nearby Hakea Prison until October 2013. During 2014 and 2015 there were signs of more stability, but many areas were still under-developed (OICS, 2015).

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By mid-2016, instability and deep dysfunction had returned. Critical incidents occurred with alarming frequency, including assaults on staff, self-harm by detainees, rooftop incidents, and extensive damage to the centre. The situation was so bad in the second half of 2016 and early 2017 that the Department of Corrective Services (as it then was) was regularly resorting to its tactical response capacity (the Special Operations Group, or SOG). On several occasions, SOG deployed distraction devices (flash bombs) and chemical agents, and pointed firearm laser sights on the youth to restore order (OICS, 2017).

There was no precedent for deploying SOG this way in adult or juvenile facilities in Western Australia, probably in Australia. The message for people working at the centre was negative and disempowering – that they were incapable of doing their job without resorting to outside help and tactical weapons.

The Department pointed out, correctly, that nobody was seriously physically hurt in the events. But the financial cost alone of responding to incidents and repairing the physical damage ran to millions of dollars.

The non-monetary costs were even greater. Many young people did not feel safe, and they also had to endure increased lockdowns and less access to education, recreation, and other much-needed services. The young women were particularly badly impacted. From December 2016 to April 2017, because of the amount of damage caused by the males, they were moved from a purpose-built, self-contained unit (Yeeda), to a wholly inappropriate unit in close proximity to male units (OICS, 2017).

Many staff, too, felt unsafe, and some now had multiple experiences of trauma. Their concerns were compounded by a ‘Banksia Hill transformation’ project driven by Head Office. The intention of the transformation was to implement a stronger rehabilitative focus. That intention was sound, but the project was badly managed. Departmental documents were changing, over-complex, and difficult to understand. Communication was clumsy, inconsistent, and disempowering to staff. Not surprisingly, staff were divided and uncertain. Internal head office reports from the time were totally out of touch with this reality. They claimed that the project was proceeding well. This bred further risk and loss of credibility.

Record-keeping and accountability were also poor (OICS, 2017). For example, records of out of cell hours were inaccurate, CCTV footage was wiped after we had requested it, and the Department took no steps to inform key parties of important decisions, including moving the young women out of Yeeda.

Even though SOG was deploying tactical weaponry in a youth facility, their interventions were poorly recorded. We were so concerned by some grainy footage from an incident on 31 December 2017 that we issued a Show Cause Notice to the Department about the way laser sights had been used. Their initial response was dismissive, but, after further follow-up and changes in leadership, they committed to better risk management, reduced use of force, and improved record keeping (OICS, 2017a, p. 20).

The situation was clearly unsustainable. Two serious incidents of damage on 4 and 5 May 2017 proved a turning point. The Department abandoned the transformation agenda with

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immediate effect, and transferred responsibility for the centre to the prisons branch of the Department. An adult prison superintendent was put in charge of the centre, and several other experienced prison officers were stationed there to provide guidance and support.

BANKSIA HILL IS MORE SETTLED, BUT STILL RECOVERING AND RE-BUILDING

At the time of the inspection, Banksia Hill was still trying to recover from the chaos. The new management's priorities were to ensure the safety of young people and staff, restore stability, and build staff morale and confidence.

To that end, they had imposed a restrictive regime. Activities and programs for all young people were limited, and their movements and interactions were tightly controlled. This was even more so for young people being held in the ISU after being assessed as a risk to institutional or personal safety. The aim was to loosen the restrictions as the centre stabilised.

Given the events of 2016–2017, a restrictive regime was the only prudent short term option, and it undoubtedly helped to improve stability. But 10 weeks later, it was still reducing young people's opportunities to engage in rehabilitative activities. Most of them had not been involved in the incidents. They were paying a high price for the misbehaviour of a few detainees. The problems were exacerbated by the lack of alternative placement options. If Banksia Hill is damaged or unstable, the whole facility will be clamped down.

Although the centre was still very much in recovery mode in July, we found a number of positives. They included the following:

- no serious incidents since May
- a sense of stability and safety was returning
- new management's commitment to improving the wellbeing of staff and young people
- some improved security processes and other operational improvements
- staff's sense of commitment and purpose despite events of recent years
- a far more realistic recognition of the problems and future challenges
- some improvements to record keeping
- movement of the orientation unit to a more appropriate location
- reduction in the number of strip searches
- good policies for managing transgender and transsexual youth.

I am also pleased to report that management have responded quickly and appropriately to a number of matters that we raised. These have included more confidentiality in accessing health services, improvements to young women's access to personal hygiene products, and improvements to strip searching procedures.

However, too many basic service areas needed fundamental redevelopment or reappraisal. Above all, in July, despite promises dating back at least five years, the centre still had no operational philosophy which articulated its aims and core principles, and tied them to operational practices. In response to this report, the Department has stated that an operational model has now been developed 'based on the Model of Care which is a

trauma-informed approach to delivering services' (see Appendix 3). It said it has set a three-year target for full implementation of the new philosophy.

Three years is a realistic timeframe, but it will not be met unless the centre maintains a far more sustained focus than in recent years. The signs are mixed. At the time of writing, the new model appeared to be positively influencing practice at the centre, but the Department had not yet formally signed off on either the model or the management structure designed to support it.

Education has been one of the biggest casualties of Banksia Hill's instability and lack of direction. Every child in Australia has a right to education, and young people in custody should not be receiving a lower standard of education than those in the community. In fact, they have higher educational needs and services should reflect this.

For years, the school at Banksia Hill has been poorly resourced and understaffed. Services have not met community standards for a 'normal' cross-section of young people, let alone the complex group at Banksia Hill. Again, there have been signs of improvement since July but this must be sustained. In my view, if significant progress is not achieved within 12–18 months, government should consider the option of transferring responsibility for education directly to the Department of Education (DoE).

The centre had identified a small number of boys who were considered to be high risk because of their involvement in serious incidents, and their ability to influence other young people. Management had decided to separate them from the main population by housing them in the Harding Unit (now the ISU).

We have been concerned about practices for the separation of young people at Banksia Hill for many years (OICS, 2012; OICS, 2017). Nobody doubts the need, on occasion, to separate some young people from others but there must be clear entry and exit criteria, services to address the young people's needs, and robust oversight and accountability.

Since May, we have regularly questioned the Department about the young people in the ISU, and have observed significant improvements in services, supports, and accountability. Most of the young people placed in the ISU spend only a short time there, but three boys have been there for extended periods since May. As stated earlier, this is a matter we are reviewing separately, at the direction of the Minister for Corrective Services.

CAN THE MOMENTUM BE MAINTAINED THIS TIME?

In summary, Banksia Hill has been far more stable since May 2017. The SOG has not been deployed and there are many positive indicators. Given the chaos of recent years, management and staff deserve respect and appreciation for staying committed to the centre and to the young people being held there. Importantly, too, the Department is currently more reflective, realistic, and responsive. There is markedly less obfuscation, defensiveness, and spin.

So there are grounds to be cautiously optimistic, but I also have a depressing sense of déjà vu. For the nine years I have been in this job, Banksia Hill has lurched from crisis to partial

recovery and then back into crisis. In the last six years alone, we have had the mismanaged amalgamation project (2012), the January 2013 riot, and the chaos of 2016–2017.

There are some common features to all these cycles. Every period of crisis has been preceded by poor leadership and management, compounded by denial and spin. Every time, experienced people from the adult prison system have been placed there to improve security, safety, and governance. And every time, progress has begun, only for mismanagement and chaos to descend once more.

This begs the important question: can Banksia Hill maintain the momentum this time round? As events across the country have confirmed, managing young people in detention is not easy. But in my view, we have seen too many attempts to reinvent the wheel and too little focus on delivering services and meeting the basics.

Looking ahead, the Department and the government need to focus on six core elements:

- ***Increase and diversify the placement options.*** In July 2017, after the release of our report on behaviour management, the government committed to examining alternative options for regional youth and girls. Since then, the need has become even more urgent as the number of children at Banksia Hill has grown to around 170. This has already led to some of the younger boys being placed in the girls' unit. More options are required.
- ***Invest in additional infrastructure at Banksia Hill.*** There are a number of infrastructure deficiencies at the centre. The most glaring example is the crisis care area of the ISU. It is counter-therapeutic and totally at odds with the trauma-informed model of care that the centre has developed. This has been known and accepted for years, but nothing has been done, even during the 2010–2012 expansion project.
- ***Have a plan and stick to it.*** As stated earlier, the centre has lurched from one unclear model to another. That is a recipe for instability and risk. The approach to managing young people in custody needs to be clear and well communicated at all levels of the organisation.
- ***Ensure clear, consistent leadership and management.*** Executive and senior management leadership has been constantly changing. It is no surprise that outcomes have been poor.
- ***Meet need.*** Too often, in recent years, the needs of specific groups have not been met. For example, in 2014, the centre was looking to develop a model for the older boys, focused on practical, work-ready training. It never materialised because the Department changed its priorities. And the girls should never have been in the position of being moved from Yeeda or required to share with boys.
- ***Deliver on promises.*** Too often, staff and young people at Banksia Hill have been given commitments that are not followed through. That has to change.

In conclusion, I am impressed with progress at Banksia Hill since May 2017. There are many promising signs but it is still rebuilding. That momentum has to be maintained.

Neil Morgan
26 February 2018

BACKGROUND AND CONTEXT

The recent history of Banksia Hill Detention Centre ('Banksia Hill') has been characterised by instability. From the start of 2016, serious incidents occurred with growing frequency, including assaults on staff, climbing fences and roofs, and extensive damage to the centre. In early May 2017, two extremely serious incidents took place on consecutive days. In response, an experienced superintendent from the adult custodial system was placed in charge of the centre, and several other adult custodial officers were stationed at Banksia Hill to provide additional guidance and support. The immediate priority was stabilising the centre. Our inspection took place in July 2017.

STAFF AND ADMINISTRATION

In 2015–2016, the Department of Corrective Services ('the Department') lost 1.6 per cent from its total budget at a time when the adult prison population was growing rapidly. Banksia Hill was hit harder than most facilities, losing 10.8 per cent from its budget for that year.

The relationship between head office and Banksia Hill deteriorated markedly in the years leading up to the 2017 inspection. Banksia Hill staff had very poor perceptions of head office, and there was a clear lack of trust between local management and upper management in Youth Justice Services.

In April 2017, the state government announced that the Department of Corrective Services and the Department of the Attorney General would be combined to form a new Department of Justice. Community youth justice services would not be part of the Department of Justice, and would instead move to a newly-formed Department of Communities. There was uncertainty about where Banksia Hill would fit in the new structure.

Instability in local management was a persistent problem. There had been nine superintendents at Banksia Hill in the past seven years. There had been no point in time during the preceding three years when all senior management positions had a permanent occupant. Senior managers who had transferred into Banksia Hill from the adult system had received no professional development on youth detention.

We have repeatedly highlighted the absence of an operational philosophy at Banksia Hill. During 2015, the Department began to develop its vision for a new operational model, underpinned by the concept of trauma-informed care. Unfortunately, the transformation project lacked clarity and was poorly managed. It was officially abandoned after the May incidents.

Recommendation 1:

Develop and implement an operational philosophy for Banksia Hill.

The resilience of the workforce had been pushed to its limits. Many custodial officers had multiple experiences of trauma dating back to the 2013 riot and earlier. They had been affected by the violent and destructive incidents in the preceding 18 months, and had felt

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unsupported by senior management and head office during that time. Changes in local management had brought a renewed focus on staff wellbeing and morale.

Banksia Hill had recruited a significant number of new custodial staff since the 2014 inspection. However, a combination of budget limitations and sector-wide recruitment freezes meant that no custodial staff had been recruited throughout 2016. The attrition rate among new staff had been high, and the centre had also lost several experienced officers over this period. As a result, in early 2017 there were approximately 37 vacancies within custodial ranks, close to 15 per cent of the workforce.

Recommendation 2:

Implement a regular program of Youth Custodial Officer recruitment that accounts for known staff attrition rates.

Shortly before the inspection, permanent appointments to senior officer and unit manager positions were finalised for the first time in several years. This provided an opportunity to improve consistency and raise standards, which would benefit both staff and young people.

The entry level training program had been shortened because of an urgent need for custodial staff. This seriously compromised the course, and involved the removal of important content.

Staff shortages became regular in 2016, and this meant it was difficult to deliver training to staff without disrupting the operation of the centre. By the end of 2016, training shortfalls had become so acute that senior management decided to reinstate the Wednesday afternoon lockdown of young people to facilitate staff training. We remain opposed to locking young people in cell for the purpose of staff training, and we are not convinced that the afternoon lockdown is the best model for delivering training.

Recommendation 3:

Deliver staff training without resorting to locking young people in cell.

CONTROL AND SAFETY

Frequent critical incidents in the preceding 18 months had affected staff and young people. High risk and volatility justified interim measures that would otherwise have been unacceptable. At the time of the inspection, the centre was operating under a tightly-controlled and restrictive regime. This reduced young people's freedom and movement around the site, and limited their involvement in activities. The restrictive regime had stopped certain types of incidents from occurring, but the number of critical incidents remained high during 2017.

The Department has often responded to major incidents at Banksia Hill by strengthening custodial infrastructure. But this needs to be balanced with improvements to the daily routine and the range of activities and services available to young people.

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Following the May incidents, there had been a much stronger focus on security procedures and intelligence gathering at Banksia Hill. The security team had identified a small number of boys who were considered to be high risk. This was based on their personal involvement in serious incidents, and their ability to influence other young people to take part in serious incidents.

Banksia Hill management had decided to separate them from the main population by housing them in Harding Unit, which was renamed the Intensive Support Unit (ISU) in the weeks after the inspection. The plan was to deliver a full regime, including programs and education, within the ISU. At the time of the inspection, the full regime had not been implemented, and access to services and activities for these boys was quite limited. This improved in the weeks and months after the inspection, but the boys in the ISU remained disadvantaged compared to the rest of the population.

Responses to poor behaviour had too often been applied to the whole population rather than to those requiring additional management and behavioural support. This remained the case even though the young people identified as leaders of the May incidents had been separated in the ISU.

The number of routine strip-searches had decreased significantly since 2015 following implementation of new procedures. In most situations, strip-searches at Banksia Hill were carried out according to the 'half-and-half' procedure. Essentially, the young person removes the top half of their clothing and replaces it before removing the bottom half, ensuring that they are never fully naked. However, the standing order provides an exception – a full strip-search is to be conducted when a young person is first admitted into the facility. We do not consider this to be necessary or appropriate.

Recommendation 4:

Use the half-and-half procedure whenever a young person is strip-searched at Banksia Hill.

Young people were frustrated by the length of time that they were spending in cell. Both staff and young people stated that the lockdowns contributed to behaviour management issues and incidents. The number of lockdowns resulting from critical incidents had decreased since the May incidents, but lockdowns caused by staff shortages and staff training sessions continued to have an impact.

The accuracy of recording time in cell had improved. A new system of recording daily observations for young people on Personal Support Plans had been implemented. However, the new system collected data in a spreadsheet that was not linked to TOMS (the Department's offender management database).

Recommendation 5:

Build the new system for recording daily observations of young people into TOMS.

LIVING AT BANKSIA HILL

Reception unit staff were appropriately focused on the wellbeing of young people arriving at Banksia Hill. However, holding cells in the reception unit were bare and featureless, providing young people with nothing to occupy their time, or distract them. Boredom and anxiety often lead to aggressive or non-compliant behaviour, creating risks for both staff and young people.

The orientation unit for boys at Banksia Hill had moved from Harding Unit to Karakin Unit, which provided a much calmer and more settled environment. However, orientation processes lacked consistency because there was no dedicated orientation officer.

The centre had recently introduced a new operational model that delivered services to each young person based on where they were accommodated. Young people would remain in their unit-wing group when attending education, recreation, and other activities. The aim was to ensure consistency and stability for young people, but some early problems were evident. The combination of the restrictive security regime and the unit-wing model meant that young people had very little variety in their social interaction with peers.

Recommendation 6:

Ensure that young people have regular opportunities to mix with their peers in other accommodation units.

The visits room remained small and cramped, limiting the number and quality of visits that could occur. The centre needs to increase the use of video link, Skype, and other similar technologies to connect with families in regional and remote communities.

Towards the end of 2016, several of the boys' units had been extensively damaged during incidents and were uninhabitable. The girls were relocated from their purpose-built precinct (Yeeda Unit) to a wing within the centre's multipurpose unit (Harding Unit). This allowed the centre to house some of the more disruptive boys within the fenced precinct of Yeeda Unit. The girls were severely disadvantaged by this move, and effectively penalised for the misbehaviour of the boys. In May 2017, the girls returned to Yeeda Unit.

The girls felt marginalised. They had fewer privileges than the boys, and some of the criteria for earning privileges were unachievable for the girls because of their shorter average time in custody.

Recommendation 7:

Revise the policy for managing girls to give them fairer access to self-care privileges.

Senior management responsibility for girls was inconsistent and ineffective. The Assistant Superintendent Female and Cultural Services role had been unstable, with at least five different people in the role since 2014. The fact that the girls are a very small group

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makes service provision more challenging, and underlines the need for constant attention at senior management level. Staff attitudes to girls had improved and they were working hard to manage difficult cases.

Banksia Hill lacked a strong focus on Aboriginal culture. There was not enough support for the Aboriginal staff group, and the number of Aboriginal staff had not increased. Cultural awareness training provided to staff at Banksia Hill was limited.

REHABILITATING YOUNG PEOPLE

Case planning staff at Banksia Hill depend heavily on Youth Justice Officers in the community for information about the young people, such as court reports. However, information flow between community youth justice services and Banksia Hill was unreliable. Court reports were sent only exceptionally and, for the most part, case planning staff were working without this essential information.

Youth Justice Services had implemented a new assessment tool – the Youth Level of Service / Case Management Inventory 2.0 (YLS/CMI) – but assessment results were not readily available to case planning staff at Banksia Hill.

Recommendation 8:

Ensure proper information flow between community youth justice services and Banksia Hill.

The case planning unit struggled with a very challenging workload. This reflected the complexity of the centre population and an increasing range of tasks.

The centre had been required to compile Detainee Management Reports (DMRs) for the Children’s Court because of concerns about conditions for young people in detention. These reports included information on the young person’s access to education, programs, activities and services, and time spent locked in cell. The Department had not assigned adequate resources for DMRs, and consequently the case planning unit had reduced capacity to complete assessment, consultation, and planning.

Recommendation 9:

Provide additional resources for the preparation of Detainee Management Reports.

There had been significant investment in programs. Programs staffing had stabilised, which allowed more consistent delivery. In addition, the Department had secured a broader range of programs from community service providers, along with enhanced re-entry support services. Despite the investment, some significant gaps remained, and there was duplication between the programs offered by the Department and those offered by external providers.

Program allocations at Banksia Hill should be based on YLS/CMI assessments, but as discussed above, these had rarely been sighted by the case planning unit. As a result, most young people were being assigned to programs to fill vacancies, even when they had

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already completed the same or similar programs one or more times. The introduction of the unit-wing model meant that young people attended programs in unit-wing groups, regardless of whether they needed the program. This was counterproductive and a poor use of limited resources.

Recommendation 10:

Ensure that program delivery to young people is based on risk and need.

Psychological services lacked representation at management level, which contributed to their marginalisation. The flow of information between operational management and psychological services needed to improve.

Self-harm had risen to unprecedented levels at Banksia Hill in 2016. As a result, psychologists had little capacity to do anything other than immediate risk management. There was a reduction in other services such as initial interviews and assessments, and individual counselling.

EDUCATION

Education services delivered at Banksia Hill did not meet community standards. If significant progress is not achieved over the next three years, a fundamental reappraisal of service delivery options and methods will be necessary. At that point, serious consideration would need to be given to transferring responsibility for education at Banksia Hill to the Department of Education (DoE).

Education services lacked strategic direction. Staff throughout the centre (both teachers and other staff) still did not have a shared understanding of the purpose of education at Banksia Hill.

Recommendation 11:

Implement a strategic plan for education services at Banksia Hill.

Education delivery had been affected by unstable and ineffective leadership. The long-serving Principal accepted a voluntary severance package in 2015, which meant the position was abolished. For more than 12 months, there was a leadership vacuum, covered only by an acting Deputy Principal.

Recommendation 12:

Re-establish the Principal position and recruit a Principal to lead education services at Banksia Hill.

There had been considerable progress in developing a curriculum based on the Certificate in General Education for Adults (CGEA). However, there was no evidence on the success or appropriateness of the CGEA.

In the past two years, all schools have been required to develop a range of measures related to the prevention and reporting of child sexual abuse. Key to these measures has

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been the focus on mandatory reporting by teachers if a child discloses abuse, and the delivery of Protective Behaviours programs as part of the curriculum. There was no Protective Behaviours program at Banksia Hill.

Recommendation 13:

Introduce a Protective Behaviours program as part of the school curriculum.

The regime changes that followed the May incidents had profound impacts on education delivery. For several weeks, the education centre was closed. By the time of the inspection in July, full-time education had still not been restored.

Teachers felt that their work was undervalued and they were frustrated by constant change. Security was taking priority over education, and it was no surprise that education staff were thoroughly demoralised. Professional development was not linked to identified priorities or individual teacher needs.

A new memorandum of understanding was negotiated with DoE in late-2015, providing annual funding to the Banksia Hill school. There had been improvements in teaching and learning resources, but the level and quality of resourcing was still low compared with schools in the community. There had been significant investment in information technology, but this investment was in danger of being wasted without support and training.

Human resources management was challenging. The lack of administrative staff meant that managers were engaged in low level tasks. Fundamentally, there were not enough teachers at Banksia Hill. It was common for a class of young people to be supervised by a custodial officer because there were not enough teachers available.

Prior to 2015, the Principal was responsible for managing a separate budget for education. When the Principal position was abolished, the education budget was absorbed into the wider centre budget, and managed by Banksia Hill's Business Manager.

Recommendation 14:

Provide a separate education budget managed by the Principal.

HEALTH SERVICES

The medical centre infrastructure was ageing and in need of refurbishment. The centre was spacious, but the space was not well utilised. The nursing station for the girls in Yeeda Unit was not being used.

The level of service had decreased since 2014. Regular attendance by a paediatrician had stopped, and general practitioner services had decreased significantly. Drug and alcohol counselling had also ceased. Another significant gap was the lack of any Aboriginal health worker. We were not confident that the Department had a good understanding of the health needs of young people.

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Recommendation 15:

Review health service provision at Banksia Hill based on an analysis of the health needs of young people in detention.

There was no private booking system to request a medical appointment. Young people were required to ask an officer to make an appointment on their behalf, and they reported that officers would question the reason for the appointment.

In the 2014 inspection report, we highlighted the inadequacy of crisis care facilities. In 2017, there had been no progress. We reiterate the need to develop a crisis care unit where young people who cannot be managed in an ordinary unit can be kept safe.

Recommendation 16:

Prioritise the development of a purpose-built crisis care unit at Banksia Hill.

FACT PAGE

NAME OF FACILITY

Banksia Hill Detention Centre

ROLE OF FACILITY

Banksia Hill is a maximum-security facility, holding boys and girls, sentenced and unsentenced, from all regions. Young people range in age from 10 to 18 (and beyond). Located in Canning Vale, 20 kilometres south of the Perth central business district, it is the only juvenile detention centre in Western Australia.

BRIEF HISTORY

Banksia Hill opened in 1997. The centre underwent a major redevelopment from 2010 to 2012. Following this, the state's only other juvenile custodial facility, Rangeview Juvenile Remand Centre, was converted into an adult prison. From October 2012, all juvenile detainees in Western Australia were housed at Banksia Hill. In January 2013, a riot took place at Banksia Hill, resulting in extensive damage to the centre.

DESIGN CAPACITY

210

NUMBER OF YOUNG PEOPLE HELD AT COMMENCEMENT OF INSPECTION

124

PREVIOUS INSPECTION

10–22 August 2014

DESCRIPTION OF RESIDENTIAL UNITS

Unit	Description	Capacity	No. of young people
Harding	Boys – at-risk management, intensive support	28	19
Jasper	Boys – remand	24	14
Karakin		24	12
Lenard	Boys – sentenced	24	23
Turner		24	18
Urquhart		32	20
Murchison		16	7
Ravensthorpe	Boys – sentenced – self-care	4	4
Serpentine		6	0
Yeeda	Girls – remand, sentenced, arrestees	24	7
Peel	Girls – sentenced – self-care	4	0
TOTAL		210	124

Chapter 1

INTRODUCTION

1.1 BACKGROUND AND CONTEXT

The recent history of Banksia Hill has been characterised by instability

When Banksia Hill Detention Centre ('Banksia Hill') opened in 1997, it was considered to be at the forefront of youth custodial design and philosophy, with its campus-style layout and residential-scale buildings. The centre remained a leader in its field throughout the first decade of its operation. Our first inspection of Banksia Hill in 2005 found that it 'was certainly one of the best-performing institutions within the remit of the Department of Corrective Services' (OICS 2006, v).

More recently, Banksia Hill has been a far more troubled facility. In May 2009, the state government announced that Rangeview Remand Centre ('Rangeview') would be converted into a prison for young adult men, leaving Banksia Hill as the only youth custodial facility in Western Australia. In preparation for this change, Banksia Hill underwent a significant expansion, managing major capital works while continuing to operate as a detention centre. This process was extremely challenging and unsettling for the centre.

The period from 2010 to 2012 was marked by delays in the building project, poorly managed risks, and an escalating series of serious incidents. There were significant fragilities at Banksia Hill including staff shortages, excessive lockdowns of young people in their cells, poor responses to misbehaviour by young people, and a growing divide between management and staff. The centre had also suffered from chronic senior management instability over a long period.

By October 2012, when the two juvenile centres were due to be amalgamated, Banksia Hill was in crisis. Yet the amalgamation went ahead. Over the next three months, rising tension and instability culminated in a riot on 20 January 2013, with around 60 young people breaking out of cells and causing extensive damage to the centre.

Immediately after the riot, most of the young people were moved out of Banksia Hill to Hakea Prison (a maximum-security facility for adult men) until repairs and security upgrades could be completed. There was a strong focus on hardening the centre by installing bars, grilles, and fences.

The day after the riot, the Minister for Corrective Services directed our office to undertake a review of the incident ('the Directed Review'). The factors contributing to the riot, the riot itself, and the responses to the riot are all examined in our report published in August 2013 (OICS 2013).

The riot and its aftermath generated significant parliamentary, community, and media attention. This ultimately resulted in a new senior executive team, a new structure for the Department of Corrective Services, and a new senior management team at Banksia Hill.

After about nine months, all young people returned to Banksia Hill from Hakea in October 2013. We conducted an inspection of Banksia Hill in August 2014, finding that

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the centre had stabilised, and that some progress had been made. But there was much work still needed to turn Banksia Hill into a well-performing facility.

For much of 2015, Banksia Hill remained settled. The number of serious incidents was low, the senior management team was relatively stable, and staff morale was improving. But there were some underlying problems. Budgetary pressures were ever-present and growing. A key initiative for young adult men had been seriously compromised by a withdrawal of funding, and several positions at Banksia Hill were abolished (including the crucial school principal position) after staff accepted voluntary severance packages. The centre faced significant budget cuts for the 2015–2016 financial year.

At the same time, head office at the Department was publicising big changes badged as the ‘Banksia Hill transformation’, aimed at revolutionising culture, philosophy, and operations. Practical detail on the transformation project was scant and confusing, and staff quickly grew sceptical of it. With this as a catalyst, the relationship between head office and staff and management at Banksia Hill became increasingly dysfunctional.

From the start of 2016, serious incidents occurred with growing frequency. There were several serious assaults on staff, and many incidents of young people absconding from their units and climbing fences and roofs. In the second half of the year, incidents escalated, with numerous incidents of young people barricading themselves inside wings and causing extensive damage. The Department’s response to incidents escalated in turn. On several occasions, the Special Operations Group (SOG) was called, and deployed tactical weapons such as chemical spray, distraction devices (flash grenades), and laser-sighted shotguns loaded with beanbag rounds. Self-harm by young people also increased significantly in 2016. In response to the growing risks, we commenced a review of behaviour management practices at Banksia Hill in September 2016 (‘the Behaviour Management Review’). These issues were examined in detail in that review (OICS, 2017).

For the first few months of 2017, incidents were less frequent, and the centre appeared to be settling. But then in early May, two extremely serious incidents took place on consecutive days. The first incident, on 4 May, involved seven young people taking control of a unit, trapping staff in unit offices, and causing extensive damage. The SOG attended, using distraction devices and chemical spray to regain control.

The following day, 10 young people escaped from a unit and climbed on roofs. They broke into a workshop and took tools which they used to break another young person out of a secure area. Other tools were used to cause significant damage, break into other areas of the centre, and start fires. In the midst of this incident, a further five young people escaped from 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 eventually found hiding in a roof space and surrendered to the SOG.

These incidents proved to be the catalyst for yet another round of major changes at Banksia Hill. Within days, an experienced superintendent from the adult custodial system

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was placed in charge of the centre, and several other adult custodial officers were stationed at Banksia Hill to provide additional guidance and support. This arrangement was initially for three months, and was subsequently extended until the end of 2017. The Acting Commissioner announced that the Banksia Hill transformation was over, and the immediate priority was stabilising the centre.

1.2 THE 2017 INSPECTION

Inspection methodology

This was the fifth inspection of Banksia Hill. The on-site inspection was conducted over seven days in July 2017, and included formal and informal meetings with management, staff, and young people. The inspection team consisted of 11 members, including expert advisers in the areas of education, and health services.

Prior to the on-site inspection, surveys were distributed to both young people and staff at Banksia Hill. In total, 120 surveys of young people were completed (78% of total population) and 75 surveys of staff were completed (27% of all staff). The survey results assisted in determining the focus of the inspection and provided a source of primary evidence during the inspection. Prior to the on-site inspection, we convened a meeting with various community agencies and organisations that deliver services inside the prison.

The inspection was guided by the Office's Code of Inspection Standards for Young People in Detention ('the Inspection Standards'). The findings and recommendations in this report are based on evidence gathered from multiple sources throughout the inspection process.

The Inspector presented preliminary findings to staff, management and departmental leadership at the conclusion of the inspection. A member of the inspection team also delivered a presentation to a representative group of young people.

Demographics of young people in custody

Since the closure of Rangeview in 2012, Banksia Hill has housed an extremely complex population of young people – male and female, sentenced and unsentenced, ranging in age from 10 to 18 years (and beyond). The number of young people in custody has remained relatively low since 2014, rarely rising much above 160 and occasionally dropping to 120 or lower.

Importantly, numbers have remained significantly lower than at the time of the 2013 riot when there were more than 200 young people at Banksia Hill. At the commencement of this inspection, there were 124 young people at Banksia Hill.

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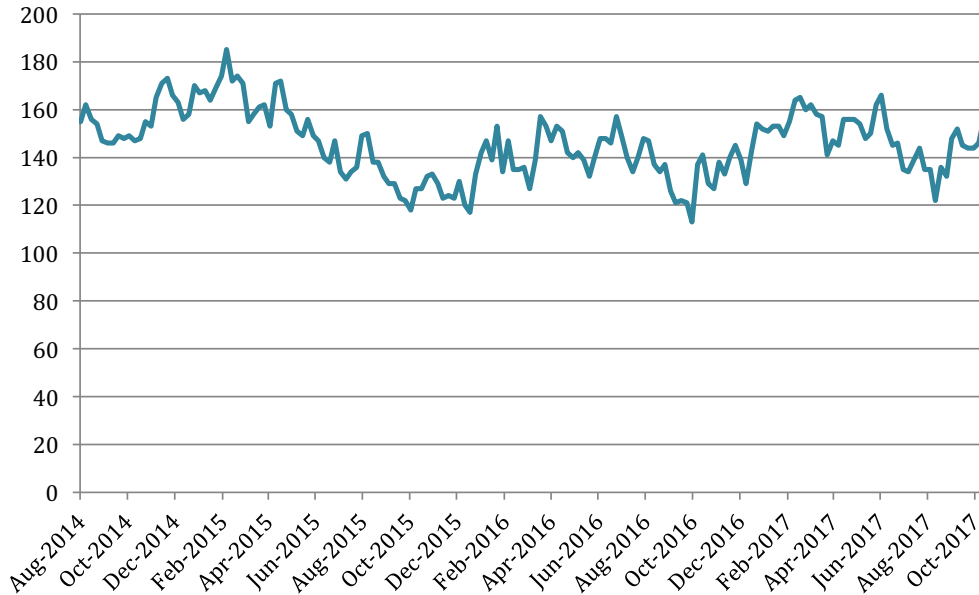


Figure 1-1: Number of young people at Banksia Hill, August 2014–October 2017

Girls have always represented a small minority of the total population of young people in custody. Since the last inspection, there have rarely been more than 10 girls in custody, and often fewer than five. At the commencement of the inspection in July 2017, there were seven girls at Banksia Hill representing six per cent of the total population.

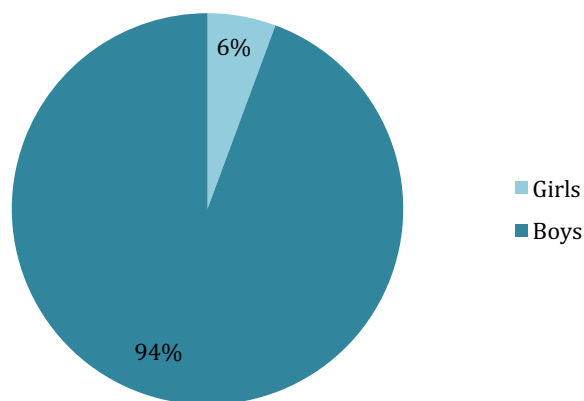


Figure 1-2: Proportion of girls and boys at Banksia Hill, 18 July 2017

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Aboriginal young people continue to be overrepresented at Banksia Hill, and made up 68 per cent of the custodial population at the time of the inspection.

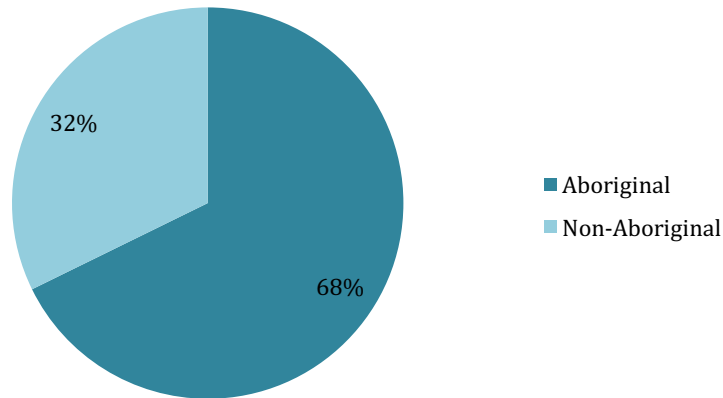


Figure 1-3: Aboriginal and non-Aboriginal young people at Banksia Hill, 18 July 2017

From a snapshot taken on 18 July 2017, 61 per cent of young people were from the Perth metropolitan area. The remaining 39 per cent were displaced from their homes and families, in some cases by many thousands of kilometres. There were small but significant cohorts from the Midwest-Gascoyne region (12%), Kimberley (9%), and Pilbara (7%).

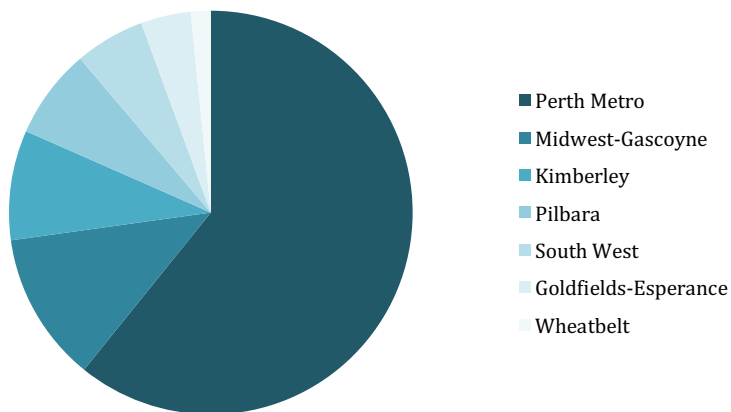


Figure 1-4: Home region of detainees at Banksia Hill, 18 July 2017

The two youngest people at Banksia Hill during the inspection were 12 years old (one boy and one girl), with 15 young people over the age of 18. The largest age groups were the 16 and 17 year olds who made up more than half of the population. There are vast physical, emotional, and developmental differences between the age groups, creating serious challenges for detainee management.

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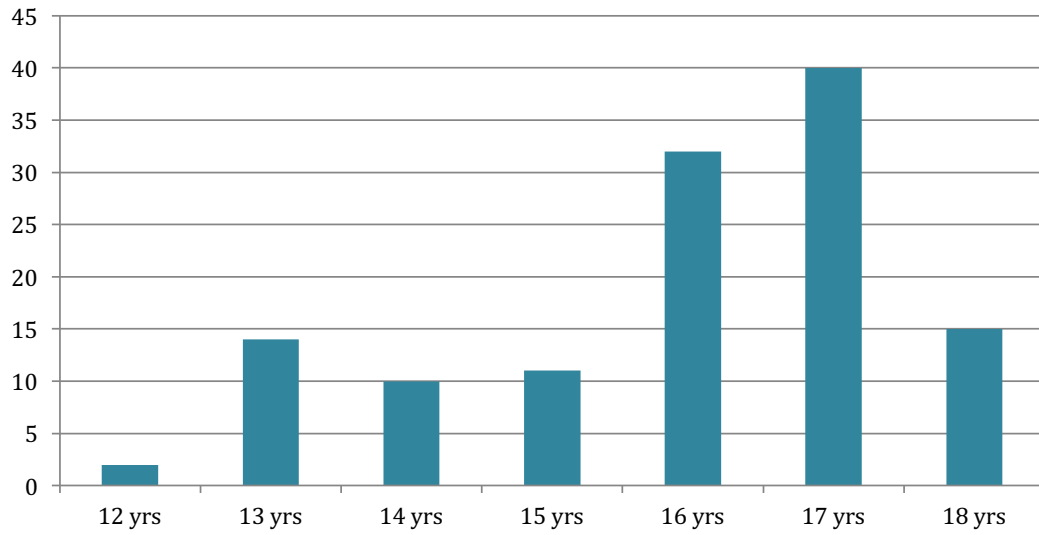


Figure 1-5: Age of detainees at Banksia Hill, 18 July 2017

Chapter 2

STAFF AND ADMINISTRATION

2.1 BUDGET

Banksia Hill had been subject to significant budget cuts over the preceding two years

In the aftermath of the 2013 riot, there was an acknowledgment within the Department and government that Banksia Hill needed more funding. The centre received substantial increases in allocated budget in both 2013–2014 and 2014–2015 – equating to an increase of more than 40 per cent above 2012–2013 levels. This was an overdue recognition of the fact that delivering youth custodial services is resource intensive and expensive.

However, the economic downturn in Western Australia resulted in budget cuts across the public sector in 2015–2016. The Department lost 1.6 per cent from its total budget at a time when the adult prison population was growing rapidly. Banksia Hill was hit harder than most facilities, losing 10.8 per cent from its budget in 2015–2016. This reflected the fact that most adult prisons were dealing with rising prisoner numbers and overcrowding, while Banksia Hill’s population had remained relatively stable.

This also illustrates the challenges Banksia Hill has faced as a small part of a large department. When numbers and complexity grow in the adult system, attention and resources tend to be focused there. As a result, Banksia Hill has not always received the support that it needs.

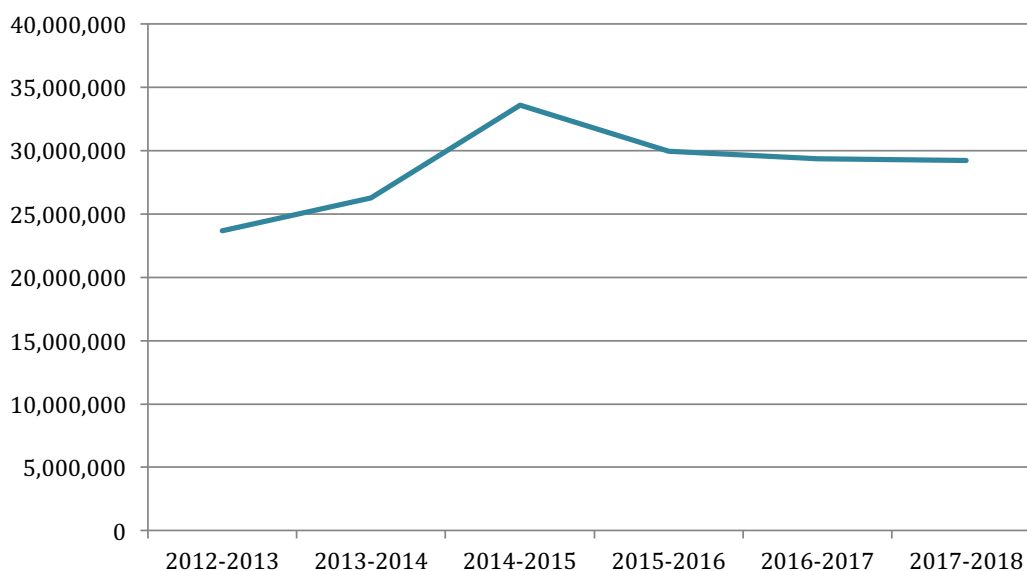


Figure 2-1: Annual allocated budget figures at Banksia Hill

2.2 LEADERSHIP AND DIRECTION

The relationship between head office and local management had previously been dysfunctional

Following the 2013 riot, the Department was restructured to create a Youth Justice Services division overseen by a Deputy Commissioner Youth Justice Services. This was intended to ensure that an adequate focus on Banksia Hill and other youth services was

maintained. The 2014 inspection concluded that this gave ‘youth justice services an appropriate level of attention and autonomy’ (OICS 2015, 14).

Unfortunately, the relationship between head office and Banksia Hill deteriorated markedly in the years leading up to the 2017 inspection. The results of our pre-inspection survey of staff reflected very poor perceptions of head office (see Table 2-1 below). Only three per cent of respondents reported that support and communication from head office was good. There was a clear lack of trust between local management and upper management in Youth Justice Services.

Table 2-1: Staff perceptions of Head Office – Banksia Hill compared to State average (adult prisons)

Overall, how would you rate each of the following?	Banksia Hill			State average		
	Poor	Mixed	Good	Poor	Mixed	Good
Support from Head Office	68%	21%	3%	48%	36%	10%
Communication from Head Office	65%	24%	3%	40%	41%	13%

Youth Justice Services at head office also had problems with external credibility. We grew increasingly frustrated by their unwillingness to acknowledge the gravity of the problems at Banksia Hill. They produced documents that were difficult to comprehend, lacked practical detail, and were complacent about progress at the centre. Our frustrations were shared by other external bodies such as the Children’s Court, and the Community and Public Sector Union / Civil Service Association (who represent staff at Banksia Hill).

A major contributing factor was the Banksia Hill transformation project. The changes associated with that project needed to be handled carefully to avoid destabilising the centre, but the change process was managed so poorly that most staff became alienated and resistant.

In short, relationships had broken down to the point where progress was unlikely.

‘Machinery of Government’ changes created further uncertainty

In April 2017, the newly-elected state government announced major changes to the machinery of government. As part of this, the Department of Corrective Services and the Department of the Attorney General would be combined to form a new Department of Justice. Crucially, community youth justice services would not be part of the Department of Justice, and would instead move to a newly-formed Department of Communities.

This meant that the majority of the Youth Justice Services division would be gone, and raised questions about where Banksia Hill would fit in the new structure. At the time of the inspection, these questions had not been answered, and the uncertainty was hindering action in several areas. As an interim arrangement, Banksia Hill was being overseen by Adult Justice Services, and the Superintendent was reporting to the Assistant

Commissioner Custodial Operations and the Deputy Commissioner Adult Justice Services. Reporting lines for services such as education and psychology were unclear, and would remain so until the new structure was finalised.

The Youth Justice Services division (including the Deputy Commissioner Youth Justice Services) was entirely focused on managing the transition of community youth justice services to the Department of Communities, and no longer had any involvement with Banksia Hill. Subsequent to the inspection, a senior staff member from Youth Justice Services was temporarily transferred to Adult Justice Services to maintain executive support to Banksia Hill. This arrangement was in place from December 2017, and intended to extend until June 2018.

Instability in local management was a persistent problem

Over many years, Banksia Hill has suffered from instability within its senior management team. There have been an astonishing nine superintendents at Banksia Hill in the past seven years, including two with no experience in youth custody prior to their arrival.

We identified high turnover as an issue in the Directed Review in 2013, and again in the 2014 inspection (OICS 2013, 81–82; OICS 2015, 20–21). At the time of the 2014 inspection, none of the positions on the senior management team had been permanently filled. Several permanent appointments were made in the intervening years, including the Superintendent and Deputy Superintendent. But there had been no point in time during the preceding three years when all senior management positions had a permanent occupant.

The senior management structure had been under consideration as part of the Banksia Hill transformation project. At least two positions had been under threat, but this risk had subsided with the abandonment of the transformation project following the May incidents.

Of course, the May incidents had triggered changes, with the appointment of a new Superintendent (from the adult system), and new members of staff in senior management and elsewhere. At the time of the inspection, there were also plans to redistribute responsibilities and rename positions in the senior management team. There were, however, no plans to cut resources in the senior management team. Adequate resources will be crucial in managing the changes ahead, both at the centre level and the Departmental level.

Senior managers from the adult system received no professional development on youth detention

The recent Royal Commission and Board of Enquiry into the Protection and Detention of Children in the Northern Territory (RCPDCNT) concluded that:

The lack of experience and qualifications in youth detention of senior managers contributed to a punitive and security-focused approach to the treatment of children and young people in detention (RCPDCNT, 2017, Vol 2B, 142).

The experience in Western Australia is different. The last two substantive Superintendents at Banksia Hill came into the job lacking any experience or qualifications in youth detention, and they certainly sharpened the centre's security focus. However, this had become absolutely necessary given the centre's volatility, its poor adherence to basic security practices, and the disruption caused by major incidents.

Furthermore, in the past, when the centre was managed by youth justice practitioners, there was at times a lack of governance and some inappropriate, punitive and unaccountable practices (OICS, 2012, 30–50; OICS, 2013, 95–115, 116–133).

An appropriately balanced security focus is necessary to provide the stability that is needed to run an active and less punitive regime. At the time of this inspection, the balance was not yet right after the May incidents. However, the Superintendent had a strong and genuine commitment to improving the regime and to embedding trauma-informed, child-centred practices. He was also responsive to many of the concerns we raised.

Neither of the Superintendents appointed from the adult prison system had any formal training in youth justice practices. They have both expressed a strong desire to develop their understanding in both theory and practice. It is incumbent on the Department to ensure all senior managers have those opportunities.

2.3 OPERATIONAL PHILOSOPHY

The centre had failed, yet again, to implement an operational philosophy

We have repeatedly highlighted the absence of an operational philosophy at Banksia Hill. The Directed Review found that the lack of a clear and consistent philosophy had contributed to instability and drift, and recommended the development of a new philosophy (OICS, 2013, 46–48, 59). The 2014 inspection found that:

The chronic absence of an agreed philosophy to unite staff and provide direction to the way they go about their work permeates all aspects of centre functioning. Staff were unable to articulate their purpose in the centre (OICS, 2015, 15).

We again recommended development of an operational philosophy (OICS, 2015, 16). Unfortunately, efforts to implement an operational philosophy in the intervening years had been confusing and counterproductive, and ultimately took too long.

The Youth Justice Framework was not released until the end of 2015. This provided an operational philosophy and guidance for Youth Justice Services as a whole, but not specifically for Banksia Hill. During 2015, the Department began to develop its vision for a new operational model. This was intended to drive cultural change and became known as the 'Banksia Hill transformation'. The proposed operational model was underpinned by the concept of trauma-informed care, and drew on internationally-recognised models and research. It is discussed in more detail in our Behaviour Management Review (OICS, 2017, 10–11, 50–51).

The intent and core principles behind trauma-informed care are sound, but the transformation project lacked clarity and was poorly managed (OICS, 2017, 16–18).

The project was driven from head office, and did not adequately consult with staff at Banksia Hill. As a result, it failed to obtain the support of staff. It was officially abandoned after the May incidents. This meant that Banksia Hill still had no operational philosophy at the time of the 2017 inspection.

Although the implementation was flawed, the intent of the Banksia Hill transformation was grounded in international best practice and should be retained. To be worthwhile, however, an operational philosophy must be:

- realistic (simple, practical, and achievable)
- real (known, supported, and reflected in operations)
- evidence-based (in notions of trauma-informed care)
- balanced (covering staff as well as young people).

Recommendation 1:

Develop and implement an operational philosophy for Banksia Hill.

2.4 STAFF MORALE

The resilience of the workforce had been pushed to its limits

Working with young people in custody is a difficult job. Dealing with traumatised children every day is traumatic in itself, and the events of recent years had compounded this at Banksia Hill. Many custodial officers had multiple experiences of trauma dating back to the 2013 riot and earlier. They had been affected by the violent and destructive incidents in the preceding 18 months, and had felt unsupported by senior management and head office during that time.

Officers genuinely believed that they would be subjected to investigation and disciplinary action if they physically intervened in an incident. They felt persecuted rather than supported by senior management. This was reflected in the pre-inspection staff survey. Only 15 per cent of respondents stated that support from local management was good, and only nine per cent said communication from local management was good.

Many officers openly acknowledged their low morale and high stress. Some were visibly emotional when discussing their experiences. Staff across all areas had shown remarkable resilience and commitment in extremely challenging circumstances. They deserved credit for this, but were also desperately in need of support.

Changes in local management had brought a renewed focus on staff wellbeing and morale

The new Superintendent recognised the poor state of staff morale soon after arriving at Banksia Hill. He had taken an officer offline to act as a full-time staff support officer in the immediate aftermath of the May incidents. Banksia Hill already had a strong staff support team with 14 members, but these were voluntary roles undertaken alongside normal duties.

The addition of a full-time position provided capacity to initiate a range of staff wellness strategies. These included staff walks around the centre at lunch time, staff barbeques, and picnics. The staff support officer was able to contact staff who were on workers' compensation leave, and was more readily available to staff on shift.

In reviewing procedures and restabilising the centre, the Superintendent rightly emphasised the need to provide support and guidance, rather than to blame or criticise staff. He had made a concerted effort to support the actions of staff, and clearly communicated his support to staff. This included giving commendations to staff for their actions during incidents. Staff confirmed that they felt the new Superintendent was more supportive, and they were more confident about intervening in incidents.

However, staff were understandably sceptical about how long this support would last. They had been through the recovery from major incidents before, and their experience was that little would change in the long term. They expected that the new Superintendent would soon leave the centre, and there would be yet another change of management and direction.

The number of workers' compensation claims remained high

Workers' compensation claims at Banksia Hill have historically been high. Prior to the 2013 riot, there were 48 active claims, which equated to 20 per cent of the workforce (OICS, 2013, 85). During the 2014 inspection, the number of active claims had risen to 54 (OICS, 2015, 27). Since then, the Department had created an Injury Management team at head office that provided support in managing workers' compensation claims and return to work programs. As a result of this, and the fact that the centre had stabilised for an extended period, Banksia Hill's active claims dropped to an average of 16–18. However, in late 2016, as the number of critical incidents continued to mount, claims again began to increase. Several staff were injured during incidents, but there was also an inevitable rise in mental health claims related to stress and trauma. By the time of the 2017 inspection, there were 30 active claims. Of these, 14 staff were on return to work programs, and the remaining 16 were unfit for work. This contributed to ongoing staffing shortages at Banksia Hill.

2.5 CUSTODIAL STAFF

Recruitment of custodial staff had not kept pace with attrition

Banksia Hill had recruited a significant number of new custodial staff since the 2014 inspection. There were several rounds of recruitment in 2014 and 2015, with multiple classes of trainee Youth Custodial Officers (YCOs) graduating in each of those years. However, a combination of budget limitations and sector-wide recruitment freezes meant that no custodial staff had been recruited throughout 2016.

The attrition rate among new staff had been high, and the centre had also lost several experienced officers over this period. As a result, in early 2017 there were approximately 37 vacancies within custodial ranks, close to 15 per cent of the workforce. Coupled with high workers' compensation and personal leave levels, this contributed to regular staff

shortages at Banksia Hill. This was recognised and recruitment was prioritised in 2017. By the time of the inspection in July 2017, a class of new recruits had graduated, and another was underway. This would cover most vacancies. However, there is still a need for Banksia Hill to recruit regularly to account for known staff attrition.

Recommendation 2:

Implement a regular program of Youth Custodial Officer recruitment that accounts for known staff attrition rates.

The filling of unit manager and senior officer positions was an important step

Shortly before the inspection, permanent appointments to senior officer and unit manager positions were finalised for the first time in several years. Prior to that, many of these positions were being filled by officers temporarily acting in the role. The permanent appointments provided an opportunity to improve consistency and raise standards, which would benefit both staff and young people.

Although this was a positive development, it is important to acknowledge that many officers had been disappointed to miss out on a permanent position after years of acting. This had been unsettling for some staff, and was one of the factors contributing to low morale.

2.6 STAFF TRAINING

The entry level training program had been shortened because of an urgent need for custodial staff

In early 2017, Banksia Hill needed to recruit and train custodial staff to cover shortages. This was exacerbated by the fact that the Department was taking back control of youth transport and the custody centre at Perth Children's Court at the end of March. These services had been contracted to private provider Serco since 2013, and would require additional staff to operate.

The standard training course for YCOs ran for 12 weeks, and therefore could not be completed before the end of March. To meet the deadline, the Department decided to cut the course down to eight weeks. This seriously compromised the course, and involved the removal of substantial important content such as Primary Response Team (PRT) training. For the second class of recruits in 2017, PRT training was restored, but the course was still shortened to 10 weeks.

The training lockdown had been reinstated because of serious shortfalls in staff training

In response to our recommendation to increase out of cell hours for young people (OICS, 2015, 59), Banksia Hill had eliminated the Wednesday afternoon lockdown at the start of 2015. This had previously been used to deliver training to staff. Instead, the centre had been able to increase staff numbers to a level that allowed introduction of training lines on the roster. This meant that staff were available to participate in training without the need to lock young people in cell.

Unfortunately, as noted above, Banksia Hill was not able to maintain staff numbers. Staff shortages became regular in 2016, and the training lines on the roster were increasingly used to cover other vacancies. This reduced disruption to the operation of the centre, but meant that staff had very limited access to training.

By the end of 2016, training shortfalls had become so acute that senior management decided to reinstate the Wednesday afternoon training lockdown. At the time of the inspection, some progress had been made towards addressing major training gaps. For example, compliance with PRT training had increased from just four per cent of staff to 26 per cent. Clearly, though, there was still much more work needed.

We acknowledge that action needed to be taken because training was simply not getting done. However, we remain opposed to locking young people in cell for the purpose of staff training. The young people are already locked down for 13 hours or more per day and should not have to spend another three or four hours in cell.

We are also not convinced that the afternoon lockdown is the best model for delivering training. A time limit of three hours (or less) restricts the type of training that can be delivered. Basic training such as first aid or use of restraints can be delivered in short sessions. But topics such as cultural awareness training or de-escalation techniques require more time. As a result, these are rarely covered. And Wednesday afternoon sessions do not necessarily reach all staff equally, being dependent on who is rostered on that day.

As an alternative, some staff suggested the introduction of non-leave periods during the year, a model used in adult prisons. This would provide a two or three week block when a large group of surplus staff would be available. Training could be provided intensively and reach more staff. It would allow delivery of topics over days rather than hours. This and other alternatives to the afternoon lockdown should be considered to maximise the time young people spend out of cell, and to optimise training delivery.

Recommendation 3:

Deliver staff training without resorting to locking young people in cell.

Chapter 3

CONTROL AND SAFETY

3.1 STABILISING THE CENTRE

Frequent critical incidents in the preceding 18 months had affected staff and young people

The escalating series of critical incidents in 2016 and 2017 had created a volatile and unstable environment at Banksia Hill. The number of critical incidents in 2016 was more than double the number in each of the preceding four years. The second half of 2016 was particularly unsettled. It included six incidents where young people assaulted staff, three barricading incidents, 11 occasions when young people climbed onto roofs, and a very high number of self-harm incidents.

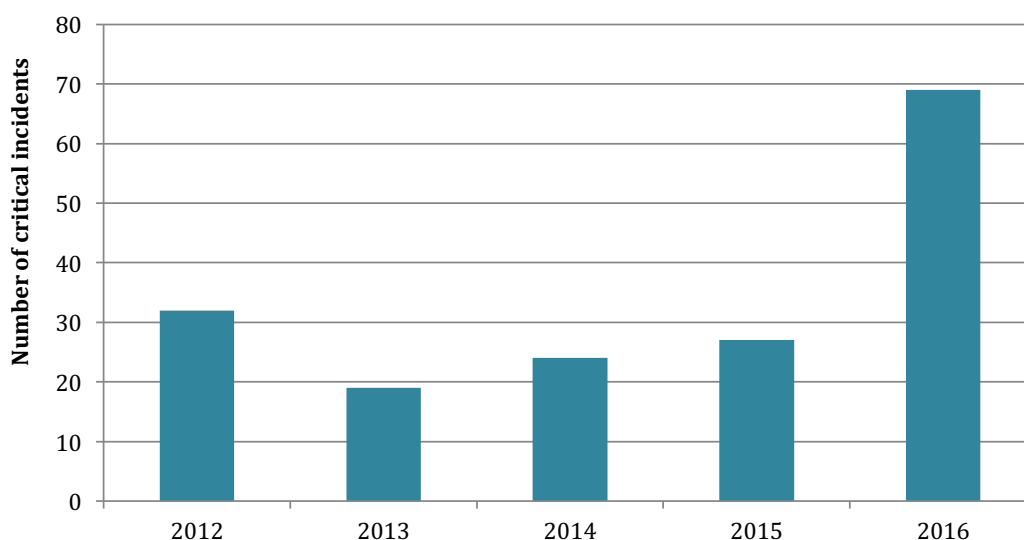


Figure 3-1: Critical incidents in Youth Justice Services, 2012–2016

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).

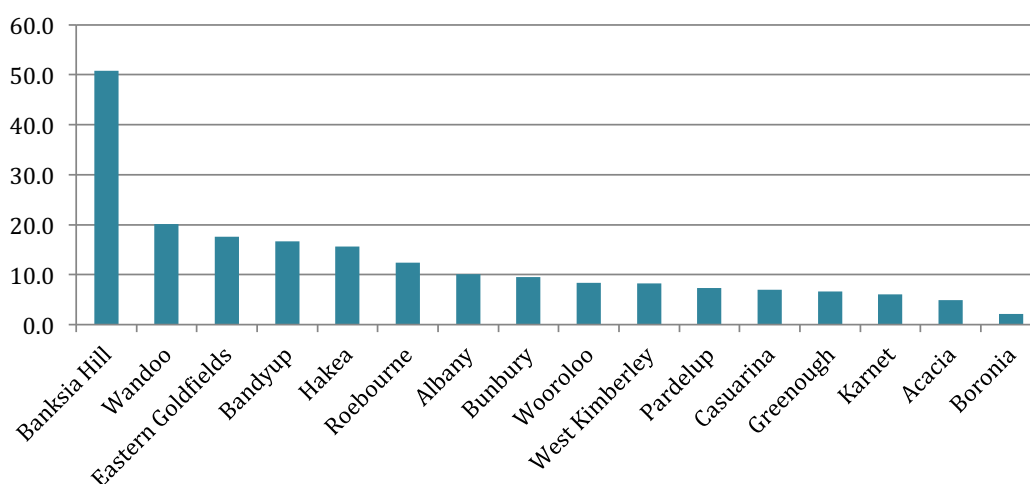


Figure 3-2: Rate of critical incidents per 100 people in custody, 2016

CONTROL AND SAFETY

In our pre-inspection survey of young people, 35 per cent of respondents stated that they never, or hardly ever felt safe at Banksia Hill. Several wrote down comments indicating that the frequent critical incidents were a factor in making them feel unsafe. Several mentioned fire as a particular concern – they were worried about being ‘burned alive’ – and one young person stated that ‘when there’s a riot I feel like I could die’. This was a reminder that the vast majority of the young people at Banksia Hill had not been involved in any of the critical incidents, and many had felt afraid or unsafe during such incidents.

Staff perceptions of safety were similarly poor. In our pre-inspection staff survey, more than a quarter of respondents (27%) stated that they ‘mostly feel unsafe’ at work. A further five per cent stated that they ‘almost never feel safe’. These results compared very poorly with the averages in adult facilities of seven per cent and one per cent.

Table 3-1: Staff perceptions of safety – Banksia Hill compared to State average (adult prisons)

How safe do you feel in your work environment?	Banksia Hill	State average
I almost never feel safe	5%	1%
I mostly feel unsafe	27%	7%
I mostly feel safe	40%	52%
I almost always feel safe	21%	37%

High risk and volatility justified interim measures that would otherwise have been unacceptable

As stated earlier, the incidents on 4 and 5 May 2017 were the final prompt for a major intervention, and a new superintendent from the adult custodial system was installed. In addition, two senior managers (also from the adult system) were brought in to join the Banksia Hill management team. A team of five senior officers from adult prisons was seconded to provide operational support, and undertake a review of security procedures.

The team of senior officers and the superintendent all wore prison officer uniforms while working at Banksia Hill. Our view is that paramilitary uniforms are not appropriate for a youth facility, and contribute to a more overtly custodial environment. It must be remembered that under legislation, a detention centre is not a prison.

At the time of the inspection, the centre was operating under a tightly-controlled and restrictive regime. This reduced young people’s freedom and movement around the site, and limited their involvement in activities. Under any other circumstances, this would be entirely unacceptable. However, we were willing to concede that this was necessary in the short-term to restore stability to the centre.

The challenge for the new superintendent and his team was to restore a more normal regime at Banksia Hill. Some aspects of the restrictive regime, such as boys only attending half-days at school, were wrong and unsustainable. The centre needed to get back to a better balance, with security aligned with rehabilitation and welfare.

Tighter controls and a restrictive regime had mixed success in reducing critical incidents

The restrictive regime had stopped certain types of incidents from occurring. The most destructive incidents in 2016 and 2017 involved young people absconding from units and inflicting damage throughout the centre, or barricading themselves in wings and causing extensive damage. This happened on multiple occasions. There had been no incidents on this scale after the May incidents.

However, the number of critical incidents remained high during 2017. Between the start of the year and the incidents on 4 and 5 May, there were a total of 22 critical incidents. Between the May incidents and 7 November, there were another 24 critical incidents. At that rate, the centre was likely to record more than 50 critical incidents by the end of 2017. This was lower than 2016, but far higher than previous years (see Figure 3-1 above).

3.2 CUSTODIAL INFRASTRUCTURE

New fences had been built in response to the series of incidents in 2016 and 2017

There were multiple incidents in 2016 in which young people caused extensive damage to the centre. This prompted the Department to build fences around two units (Lenard and Turner) in an attempt to better contain young people. Construction took place between February and April 2017, and represented a significant risk in an already unsettled centre. However, the project was completed without incident and with minimal disruption to the centre. This left Murchison Unit and the two self-care houses (Ravensthorpe and Serpentine) as the only accommodation units not surrounded by a fence.



Photo 1: An internal unit fence

The Department has often responded to major incidents at Banksia Hill by strengthening custodial infrastructure, and yet major incidents continue to occur. In the Directed Review we observed that:

idle, bored children will invariably become frustrated and are very likely to act out their frustrations. Bars and grilles will not stop this and it is essential that Banksia Hill returns to providing a full and active regime including rehabilitative programs and recreation (OICS, 2013, viii).

The situation in 2017 was remarkably similar. There was still a need to invest more in programs and services for young people. New custodial infrastructure had not prevented the May incidents, and would not prevent future incidents.

The May incidents exposed weaknesses in custodial infrastructure that had to be addressed

The incident on 5 May, in particular, exposed major custodial infrastructure weaknesses. A group of young people were able to abscond from Harding Unit by climbing onto the roof. They then gained relatively easy access to tools and motorised buggies that assisted them in breaking another young person out of a caged recreation yard in Harding Unit, and breaching several unit fences. Perhaps most concerning was that several young people were able to escape from their cells during the incident.



Photo 2: Damage caused during the May incidents



Photo 3: Damage caused during the May incidents

As a result, in the aftermath of the May incidents, staff could not be confident in the custodial infrastructure at Banksia Hill. Cell integrity is crucial to the operation of the centre. Staff need to be able to rely on the fact that young people are safe and secure when locked in cell. It was necessary to address these issues, especially the cell weaknesses, with further strengthening works. Additional cowling was installed in Harding Unit to prevent young people from climbing onto the roof. Much of this work was ongoing at the time of the inspection and completed shortly after.

The weaknesses needed to be addressed. But, as noted above, Banksia Hill will only have long term stability if the daily routine and the range of activities and services available to young people are improved.

3.3 SECURITY AND INTELLIGENCE

The security team was adequately resourced but had suffered from unstable leadership
Staffing for the security team remained unchanged from the 2014 inspection, with an Assistant Superintendent Security, two Senior Officer Security positions, and one Intelligence Collator. A permanent appointment to the Assistant Superintendent Security position was made in February 2015. However, that person had been covering vacancies in other senior management positions for the past two years. In that time, there had been at least three different people acting in the role of Assistant Superintendent Security.

We were advised that prior to the May incidents there had been plans to downgrade the job classification of the Assistant Superintendent Security as part of restructuring. However, the new Superintendent argued strongly (and successfully) against this. The position needed to attract and retain suitably skilled applicants in order for the centre to develop its security expertise.

Focus on security procedures and intelligence gathering had increased significantly

Following the May incidents, there had been a much stronger focus on security procedures and intelligence gathering at Banksia Hill. The new superintendent and support team from the adult custodial system were reviewing all security procedures, and driving improved security compliance among staff. There had been a renewed emphasis on intelligence gathering, and the security team reported that the number of intelligence reports submitted by staff had increased.

The security team had been given responsibility for approving the movement of young people between units. The team, and particularly the Intelligence Collator, had been developing association charts, and analysing intelligence and behaviour trends. This information was used to predict and prevent disruptive behaviour and conflict between young people. All intelligence was considered before approving the placement of a young person in a unit. This allowed the security team to avoid placing a young person into an area where they may be at risk or pose a risk to others. Our concerns about the impact this had on freedom of movement and peer interaction for young people are discussed at 4.3 below.

The security team had also identified a small number of boys who were considered to be high risk. This was based on their personal involvement in serious incidents, and their ability to influence other young people to take part in serious incidents. Keeping these high risk boys separated from the main population formed a central part of plans to stabilise the centre in the future.

3.4 BEHAVIOUR MANAGEMENT

Young people identified as high risk had been separated from the main population

At the time of the 2017 inspection, there were two particular boys identified as high risk because of their involvement in incidents and influence on other young people. Banksia Hill management had decided to separate them from the main population by housing them in Harding Unit, which was renamed the Intensive Support Unit (ISU) in the weeks after the inspection. This arrangement was expected to continue on a long-term basis until these boys were released, or until an application could be made to transfer them to an adult prison (both would soon turn 18).

Management reasoned that returning these boys to the main population would result in further disruption, and that would be unfair to the majority of young people. In management's view, the centre had focused too much on the 10 per cent of the population who misbehaved frequently, and neglected the 90 per cent who behaved well.

The plan was to deliver a full regime, including programs and education, within the ISU. Boys in the ISU would have the same access to services and activities, but would be separated from the main population.

At the time of the inspection, the full regime had not been implemented, and access to services and activities for these boys was quite limited. This improved in the weeks and months after the inspection, but the boys in the ISU remained disadvantaged compared to the rest of the population.

We continue to hold concerns about the regime, and particularly the isolation experienced by the two boys in the ISU. For much of the time their social interaction had only been with each other, and one or two other boys who had shared a wing with them in the ISU at various stages. We have raised questions with the Department about whether the separation of these boys can be justified in the long-term, and whether it would be consistent with obligations under the *Young Offenders Act 1994* (WA).

Restrictions were applied to all young people regardless of behaviour

International standards on the treatment of people in custody oppose collective punishment. Our Inspection Standards adopt the same principle (OICS, 2010, Standards 16, 28, and 30).

At Banksia Hill, responses to poor behaviour had too often been applied to the whole population rather than to those requiring additional management and behavioural support. This remained the case even though the young people identified as leaders of the May incidents had been separated in the ISU. During the inspection we heard from many young people who were frustrated by the restrictions placed on them because of the actions of others.

As a response to the May incidents, all movements of young people occurred in small groups under close supervision. Young people from different units were not permitted to mix, and large gatherings of young people were not permitted. The number of young people taking part in activities (including education and recreation) at any one time was limited. These measures affected all young people at Banksia Hill, even though the majority had not been involved in the May incidents. Other restrictive practices, such as confining all young people to their wings at 6.00 pm every evening, had also been implemented.

In a number of the critical incidents since mid-2016, items in wing kitchens had been misused by young people to cause damage or injury. As a result, ovens and microwaves had been removed from mainstream units, and full-size refrigerators had been replaced with smaller bar fridges. This deprived the wider population at Banksia Hill of the opportunity to learn basic life skills. Only young people in Murchison Unit (the earned privilege unit) and the self-care houses had regular opportunities to cook for themselves, or engage in structured cooking activities with staff.

3.5 STRIP-SEARCHING

The number of routine strip-searches had decreased significantly since 2015

Our 2014 inspection criticised the high number of strip-searches being conducted at Banksia Hill. The vast majority were routine rather than targeted searches, and the number of contraband items found was extremely low. We made a recommendation to reduce the frequency of strip-searching (OICS, 2015, 49–50).

In February 2016, Banksia Hill implemented new procedures (set out in Standing Order 17) that significantly reduced routine strip-searching. In 2015, there were 9,067 strip-searches. In 2016, this dropped to 3,746. The number of contraband items found remained very low – seven in 2015 and three in 2016. The reduction in strip-searching is welcome, but the low rate of contraband finds still raises doubt about the need for so many strip-searches.

Conducting a full strip-search for each young person upon admission was inappropriate

In most situations, strip-searches at Banksia Hill were carried out according to the ‘half-and-half’ procedure. This is prescribed in detail in the relevant standing order. Essentially, the young person removes the top half of their clothing and replaces it before removing the bottom half, ensuring that they are never fully naked. This minimises the indignity of the process for the young person.

However, the standing order provides an exception – a full strip-search is to be conducted when a young person is first admitted into the facility. This is considered practical because the young person is required to shower and change into clothing provided by the centre.

We do not consider practicality to be sufficient justification for subjecting young people to a full strip-search. There is no reason not to conduct a standard half-and-half strip-search, then allow the young person to undress separately and shower unobserved. It is also particularly important to avoid unnecessary trauma on a young person’s admission.

The Royal Commission into the Protection and Detention of Children in the Northern Territory also saw no reason for a full strip-search. It recommended that it be:

stipulated that the strip-search [only] be conducted by having the detainee remove the top half of his or her clothing for the inspection and then re-dress before removing the bottom half of his or her clothing... (RCPDCNT, 2017, Findings and Recommendations, 31).

Recommendation 4:

Use the half-and-half procedure whenever a young person is strip-searched at Banksia Hill.

3.6 TIME SPENT LOCKED IN CELL

Young people spent too much time locked in cell

Pre-inspection survey results and discussions with staff and young people during the inspection indicated that young people were frustrated by the length of time that they

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were spending in cell. Both staff and young people stated that the lockdowns contributed to behaviour management issues and incidents.

Our Behaviour Management Review found that the daily regime at Banksia Hill had been regularly compromised by lockdowns since the beginning of 2016 (OICS, 2017, 29–30). This was caused by staff shortages, responses to critical incidents, and the reintroduction of the half-day training lockdown (discussed above at 2.6). The number of lockdowns resulting from critical incidents had decreased since the May incidents, but lockdowns caused by staff shortages and staff training sessions continued to have an impact.

Staff shortages were common on weekends, with the centre short staffed on seven out of the nine weekends in June and July 2017. In response to those shortages the centre often implemented a program of rolling lockdowns, with only a certain number of young people allowed out of cell at a time. The number of young people allowed out of cell depended on the number of staff available to supervise them.



Photo 4: A cell in Urquhart Unit

The accuracy of recording time in cell had improved

For many years we have criticised inaccurate recording of time spent in cell by young people (OICS, 2017, 30–31; OICS, 2014, 57–59; OICS, 2013, 104–105). During this inspection, there was evidence of improvement.

The time spent in cell during staff meal breaks was being more accurately recorded. The centre also acknowledged that previous reporting of time spent in cell for young people on Personal Support Plans (PSPs) had been inaccurate.

To address this shortfall, staff from the case planning unit had been manually collating data from written logbooks. This was time-consuming and diverted case planning staff from their core business (see further discussion at 5.1 below). A more suitable solution was implemented in May 2017, with a new system of recording daily observations for young people on PSPs. These improvements are a significant step towards rebuilding a system that had lost integrity. However, the new system collected data in a spreadsheet that was not linked to TOMS (the Department's offender management database). Local management advised that they would be seeking approval to build the new system into TOMS. This should be prioritised.

Recommendation 5:

Build the new system for recording daily observations of young people into TOMS.

The average time per day a young person spent out of cell for the first seven months of 2017 is shown below. A considerable drop of approximately two hours per day can be seen between April and May. Much of this can be explained by the lengthy centre-wide lockdowns implemented in response to the events of 4 and 5 May. However, some of the decrease can also be attributed to more accurate recording.

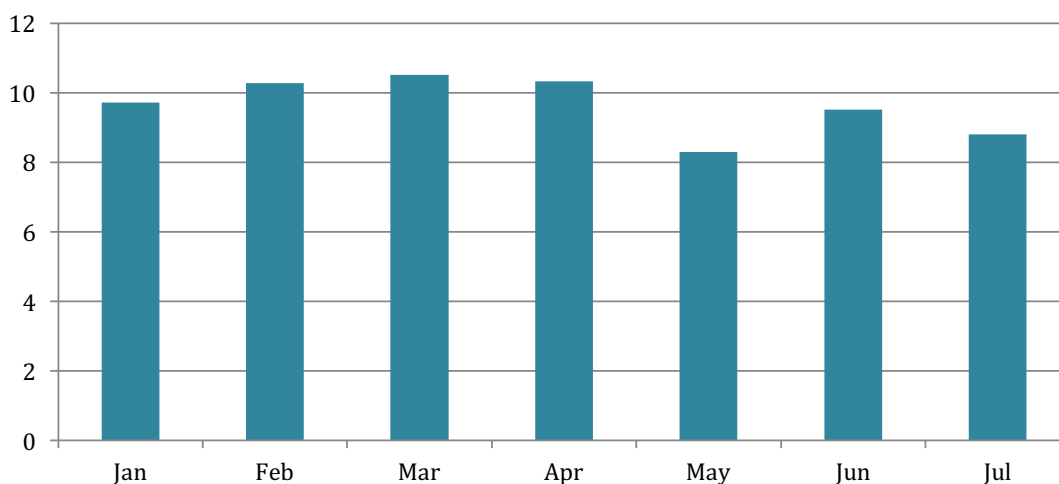


Figure 3-3: Average time out of cell per young person per day in hours, 2017

Chapter 4

LIVING AT BANKSIA HILL

4.1 RECEPTION

Reception unit staff were focused on the wellbeing of young people arriving at Banksia Hill

Custodial officers in the reception unit were compliant with relevant procedures, and appropriately focused on the wellbeing of young people arriving at the centre. Interactions between staff and young people were genuine and constructive. Staff displayed knowledge and understanding of the young person's circumstances, and most young people were willing to engage positively in response. Identifying immediate risks to the young person and keeping them safe was a primary focus. Staff were conscious of minimising the time that young people spent in the holding cells while waiting to be processed.

Staff were permanently rostered to the reception unit. This meant that they were familiar with reception procedures, and were experienced in dealing with young people who are often distressed and vulnerable upon arrival in custody. Nursing staff conducted a preliminary assessment to determine if the young person was medically fit to be admitted to custody. A more thorough medical assessment was completed after reception, and before the young person was taken to the orientation unit.

All arrivals were subject to a strip-search to ensure that they were not carrying any dangerous or contraband items. This also allowed staff to assess any visible injuries, and take this into account when assessing medical or other support needs. Strip-searching procedures are discussed at 3.5 above.

Holding cells provided nothing to alleviate boredom and anxiety

The five holding cells in the reception unit are bare and featureless, containing only an in-built concrete bench. There are no toilets or water fountains so that young people cannot hide contraband items before being searched. Young people have not been risk-assessed when initially placed in holding cells so they are deprived of any objects that might be used to harm themselves or others.

This can be problematic if the reception unit is busy and young people are waiting a long time to be processed. The holding cells provide them with nothing to occupy their time, or distract them. Boredom and anxiety often lead to aggressive or non-compliant behaviour, creating risks for both staff and young people. Holding cells in many other prisons and court custody centres have in-built televisions. This (or some other form of entertainment) would be beneficial to the good management and order of the reception unit, and the wellbeing of young people.

4.2 ORIENTATION

A new location for the orientation unit was a positive development

About one month prior to the 2017 inspection, the orientation unit for boys at Banksia Hill moved from Harding Unit to Karakin Unit. This move addressed concerns we had expressed in the 2014 inspection report about housing newly arrived young people in

Harding Unit. We noted that Harding Unit held the most disturbed and unsettled young people in the centre, including vulnerable and at-risk young people in observation cells, and those being managed because of misbehaviour. This created a potentially intimidating environment for newly arrived young people, and undermined attempts to set standards of behaviour for them (OICS, 2015, 56).

Karakin Unit, as a standard accommodation unit for young people on remand, provided a much calmer and more settled environment. New arrivals were mainly accommodated in one wing, but there was flexibility to spread into other wings depending on numbers and the needs of individual young people. For example, a young person could be placed with family and friends to provide support.

Staff from both the reception unit and Karakin Unit were supportive of the move. They acknowledged that processes were still developing, and there was a need to improve coordination and communication. But all agreed that the change would ultimately benefit the young people.

Orientation processes lacked consistency because there was no dedicated orientation officer

The orientation process is important as it gives the first opportunity to set out the rights and obligations of young people, and the rules and expectations of the centre. For most young people, entering custody is a stressful time so orientation should provide support and guidance.

The centre's requirements for orientation are detailed in policy (Standing Order 14a). Once a young person has been moved to Karakin Unit, orientation must be completed within 72 hours, and the young person should not be moved to another unit until the process has been completed in full. The officer conducting orientation must provide range of information about the daily operation of the centre, services available, and expectations of young people.

Staff should be monitoring young people for risk, and gathering information about family and personal needs. Staff should ensure that contact has been made with a young person's family or guardian, and check telephone numbers to be placed onto an approved list so that young people can initiate their own regular contact with family and friends in the community. A tour of the centre should be offered to all young people.

Because newly arrived young people were spread throughout Karakin Unit, each wing officer was responsible for delivering orientation to new arrivals in that wing. This was a significant workload to add to the regular duties of a wing officer. Depending on the number of new arrivals, staff sometimes struggled to complete all tasks to an acceptable standard. Staff rotated through the unit on the roster, and some were more experienced at delivering orientation than others. Inconsistency was inevitable, and we found that young people were not always receiving an adequate orientation.

4.3 DAILY ROUTINE AND INTERACTION

The restrictive regime and ‘unit-wing’ model had affected education, programs, and peer interaction

Following the May incidents, a security regime was implemented that restricted the movement of young people around the centre. Young people were moved in small groups closely supervised by custodial officers, and the centre limited the number of young people gathered in any one place. At the time of the 2017 inspection, only half of the centre’s population was allowed to attend education at one time. There were also limits on the number of young people participating in recreation together, or attending events such as NAIDOC week celebrations.

Separate to this, the centre had introduced a new operational model that delivered services to each young person based on where they were accommodated. Each wing in the accommodation units houses eight young people. Under the new operational model, young people would remain in their unit-wing group when attending education, recreation, and other activities. This was known as the unit-wing model. The aim was to ensure consistency and stability for young people. There would be less movement of young people between wings and units, and they would interact with a more consistent group of staff.

The unit-wing model had only been recently introduced at the time of the inspection, but some early problems were evident. Young people had been sent to programs in unit-wing groups regardless of whether they all needed that program. Young people in unit-wing groups were not necessarily at the same level in terms of education or sporting ability. The model will only work if the centre is able to place young people of similar age and developmental level into unit-wing groups. This will always be challenging to maintain given the high turnover of young people in detention.

The combination of the restrictive security regime and the unit-wing model meant that young people had very little variety in their social interaction with peers. Young people complained about being unable to mix with their friends from other units, and being restricted to socialising with the same small group at all times.

Recommendation 6:

Ensure that young people have regular opportunities to mix with their peers in other accommodation units.

4.4 FOOD

Temporary staffing arrangements in the kitchen contributed to poor meal quality

Young people expressed strong dissatisfaction with the quality of meals at Banksia Hill. In the pre-inspection survey of young people, 89 of 120 respondents (74%) stated that food quality was poor. The feedback received from young people during the inspection, and our own experience of the food, was consistent with the survey findings.

One of the legacies of constant structural change and review at Banksia Hill was that no decision had been made about a permanent staffing model for the kitchen. As a result, the kitchen was entirely staffed by workers from an employment agency. This had been ongoing for many years. Kitchen staff were employed on three-month contracts, and turnover of staff was high. The kitchen manager was not provided with a specific budget for the kitchen, and simply followed the procedures and menu that were in place when he arrived. Under these staffing arrangements, there was limited impetus to drive improvement or explore better practices for the kitchen.

There are only two options: establishing permanent staffing for the Banksia Hill kitchen, or ‘outsourcing’ the catering. One option may be to use one of the two women’s prisons that have industrial-level kitchens and may also have the capacity to service Banksia Hill (Boronia Pre-release Centre and Melaleuca Remand and Reintegration Facility).

4.5 CLOTHING

Concerns about recycled or shared underwear had been addressed in policy

During the 2014 inspection, young people complained about receiving recycled underwear. We made a recommendation that ‘all detainees are provided with new underwear on arrival at the centre and that they are not required to share underwear’ (OICS, 2015, 60–61).

In response, the relevant policy had been revised. However, in 2017, we still heard complaints from girls in Yeeda Unit about receiving recycled underwear. After investigation, it appeared that the laundry process within the unit was not ensuring that girls had their own underwear returned. The problem was addressed immediately through more consistent supervision of the process by custodial officers.

4.6 RECREATION

Recreation was full and varied, but there was less for the girls

Recreation officers coordinated a wide range of recreation activities. A number of different sporting organisations from the community came into the centre regularly to provide training sessions in football, soccer, basketball, and athletics. Several teams from the community had come into the centre to play matches against teams of boys, but no such sessions were arranged for the girls. Recreation officers also provided sports classes as part of the education schedule for both boys and girls. These sessions were very engaging and well-received.

The recreation schedule had, however, been significantly disrupted by incidents within the centre.

The response to the May incidents had affected young people’s access to recreation

The regime introduced after the May incidents limited the number of young people gathered in any one place. This meant that fewer young people were able to recreate together. Previously, boys from different units would recreate together at the gymnasium, courts, or oval on the weekend and after school. But during the 2017 inspection,

interaction between the units was heavily restricted. Typically, only one or two units were permitted to use the recreation facilities at one time. A football competition had run on the oval during NAIDOC week, but apart from that there had been no team sports on the oval since May. Boys regretted the loss of opportunity to recreate with their peers.

4.7 FAMILY CONTACT AND VISITS

There had been no progress in upgrading the visits room or facilities for visitors

The 2014 inspection report made recommendations to ‘[i]ncrease the capacity of visits facilities’ and ‘[p]rovide a facility and support services for visitors’ (OICS, 2015, 63–65). These recommendations were not supported by the Department and no action had been taken.

The visits room remained small and cramped, limiting the number and quality of visits that could occur. There were eight tables with fixed seating, meaning only eight young people could have visits at any one time, and they were restricted to four visitors per young person. The tables were positioned very close together, so there was little privacy for each group. There was an outdoor visits area equipped with tables, which was not used.



Photo 5: The visits room



Photo 6: The outdoor visits area

Most adult prisons in the metropolitan area and some in the regions have a visitors' centre outside the front gate, usually run by staff from a community service provider. This service provides valuable support and assistance to families of people in custody. It is regrettable that no such facility exists at Banksia Hill, where support for families is particularly important.

Young people wanted more access to telephone calls, and other communication technologies

Young people received seven free telephone calls each week, and were permitted to purchase five more. Those with 'earned privilege' status received ten free calls and could purchase a further ten. The consistent feedback from young people was that they would like to be able to purchase more phone calls.

Young people from outside the Perth metropolitan area could apply for extra phone calls at no charge. However, we spoke to several who were not aware of this. Young people from regional and remote areas typically do not receive visits. Banksia Hill provided access to alternative visiting arrangements such as video link and Skype, but these were most often taking place with family members in other custodial facilities.

The centre needs to increase the use of video link, Skype, and other similar technologies to connect with families in regional and remote communities.

4.8 COMPLAINTS

Complaints processes had improved and young people were using them more often

Successive inspections of Banksia Hill have identified concerns with the complaints process for young people, including inadequate tracking and recording of submitted complaints, and low awareness of complaints processes among young people (OICS, 2006, 34; OICS, 2008, 16–17; OICS, 2015, 99–102).

In the 2017 inspection, we found that complaints submitted at the unit level were being properly recorded. Young people had a much higher awareness of options for making a complaint, and used them more often. The number of complaints submitted to the Department’s complaints administration branch – known as ACCESS – had increased from six in 2013–2014 to 30 in 2016–2017. This is a positive, not a negative indicator.

Volunteers from the Independent Visitors Service continued to visit Banksia Hill monthly and provided another avenue for raising complaints. The Western Australian Ombudsman also conducted visits to the centre to hear complaints from young people.

4.9 GIRLS IN CUSTODY

Girls had been placed in totally unsuitable accommodation for six months

Towards the end of 2016, several of the boys’ units had been extensively damaged during incidents and were uninhabitable. As a result, the centre had limited options available for housing boys. In December 2016, the girls were relocated from their purpose-built precinct (Yeeda Unit) to a wing within the centre’s multipurpose unit (Harding Unit).



Photo 7: Yeeda Unit

This allowed the centre to house some of the more disruptive boys within the fenced precinct of Yeeda Unit.

Our Behaviour Management Review examined the reasons for the move in more detail. We found it was an ad hoc decision for which multiple, conflicting explanations were offered by local and head office management.

There is no doubt that the girls were severely disadvantaged by this move. They were effectively penalised for the misbehaviour of the boys. During their time in Harding Unit the girls became more unsettled, and their involvement in incidents increased (especially self-harm). In May 2017, the girls returned to Yeeda Unit.

We recommended that the girls should not be housed in inappropriate units (OICS, 2017, 37–38). The Department supported this recommendation in principle. We will not repeat it here.

The girls felt marginalised

The girls had fewer privileges than the boys. For example, none of the girls at Banksia Hill attained self-care status in the 2016–2017 financial year. This meant that the girls did not have access to privileges such as extra canteen spends and wearing their own shoes.

The policy governing self-care status was not realistic for the girls. It required young people to display positive behaviour and engagement with certain activities for a minimum of four weeks. At the time of the 2017 inspection, the average length of stay for a girl at Banksia Hill was only eight days compared to 30 days for boys. This meant that self-care status was simply not achievable for many girls. We believe that the criteria for self-care status should be amended for girls.

Recommendation 7:

Revise the policy for managing girls to give them fairer access to self-care privileges.

The girls were acutely aware of weekly basketball and football training sessions with external sporting clubs that were only open to the boys. There were no such fixtures or regular games for the girls. They had appreciated a visit by Miss NAIDOC some weeks earlier, but they resoundingly wanted regular visits from female sporting representatives and teams.

The girls expressed a desire to learn skills to help them get a job and stay out of trouble when returning to the community. In the 2014 inspection report we commended the barista training course that was producing positive, tangible results (OICS, 2015, 91). However, in 2017, the one staff member qualified to run the course was acting in a higher position, so the course was not available.

The Department needs to provide more for the girls to ensure that it is not open to challenge for discrimination under section 8 of the *Equal Opportunity Act 1984* (WA). The RCPDCNT made similar findings. It found the situation of the girls in custody in the Northern Territory was:

inconsistent with the human right to be free from discrimination on the ground of sex which is a right that is recognised in Article 2 of the *Convention on the Elimination of All Forms of Discrimination Against Women* and Article 26 of the *International Covenant on Civil and Political Rights*, and which is embodied in section 22 of the *Sex Discrimination Act 1984* (Cth) ... (RCPDCNT, 2017, Findings and Recommendations, 12).

Senior management responsibility for girls was inconsistent and ineffective

At the time of the 2017 inspection, the distinct needs of girls in custody were meant to be championed by the Assistant Superintendent Female and Cultural Services (ASFCS). According to the job description form, the incumbent was required to provide leadership and oversight for the management and development of the girls' precinct.

It is an important position that provides a voice for girls (and Aboriginal young people) on the centre's senior management team. However, the ASFCS role had been unstable, with at least five different people in the role since 2014. The acting ASFCS at the time of the 2017 inspection had only moved into the position following the May incidents, and conceded that there had been minimal focus on the girls.

We were advised of plans to restructure Banksia Hill's management team, which would see the duties of the ASFCS absorbed by another position that would have responsibility for all offender services across the centre. There was a long-held view that the ASFCS was under-utilised, and the position had already been given additional duties such as managing the At Risk Management System (ARMS) process.

However, we would argue that the position has never achieved the intended level of focus on either the girls or on Aboriginal services. The fact that the girls are a very small group makes service provision more challenging, and underlines the need for constant attention at senior management level. Any restructure must ensure that the needs of the girls are not lost to competing priorities.

Staff attitudes to girls had improved and they were working hard to manage difficult cases

In 2014 some staff had negative attitudes to the girls at the centre (OICS, 2015, 89). This was no longer apparent and many custodial officers told us that they enjoyed working with the girls. During the 2017 inspection there were two girls being managed on PSPs for their special needs. This was resource intensive because one required a one-to-one officer and the other was a high risk to herself and others.

The young person receiving one-to-one officer support was transgender (identifying as female). On previous admissions to Banksia Hill she had been housed in the boys' units. On this occasion she was placed in Yeeda Unit and she stated that her treatment and management by staff was better, and the girls were respectful of her.

Importantly, unlike the adult system, Banksia Hill has a policy for managing transgender and transsexual young people. The policy states that the young person should be addressed by their preferred name and in gender-neutral terms. In spite of this policy, documentation including some incident reports, daily monitoring forms, and education reports referred to her interchangeably as female and male.

The other young person, who was a high risk to herself and others, was being closely managed under continuous observation. She had been involved in a high number of incidents, which included threats to self-harm or actual self-harm, and physical assaults on staff. Many of the assaults involved spitting at staff. Consequently, much of her face-to-face engagement with officers occurred while the staff wore protective face shields.

The experience of managing this young person had been traumatising to many staff. Many expressed concerns that the centre was incapable of dealing with her. However, it was a great credit to centre staff and management that they persisted. As a result, important progress had been made in developing a relationship with her. In the weeks following the inspection, her behaviour improved to the point where she was able to leave her observation cell and spend more time living alongside the other girls in mainstream accommodation.

4.10 ABORIGINAL FOCUS

Banksia Hill lacked a strong focus on Aboriginal culture

Aboriginal young people have historically been overrepresented in detention. During the 2017 inspection, they made up 68 per cent of the centre population. We have previously stated the need for Banksia Hill to reflect Aboriginal culture, and deliver services in a culturally relevant way (OICS, 2015, 16–19). The ASFCS position was created in 2014 to ensure that a focus on Aboriginal young people (and girls) was maintained. However, as discussed above in relation to the girls, the ASFCS role had lacked stability and had not consistently delivered the promised focus. The proposed renaming and reconfiguration of the role may reduce the focus even further.

There were no systems in place to provide local management with a regular assessment of service provision for Aboriginal young people. The centre had not convened an Aboriginal Services Committee, and the senior management team had not been meeting regularly with Aboriginal staff. Staff from the Aboriginal Visitors Scheme attended Banksia Hill four days a week, but there was no program of visiting Aboriginal elders.

The Aboriginal Welfare Officers (AWOs) provided the most consistent cultural presence for young people at Banksia Hill. Positively, there were more culturally appropriate programs available to young people, and several Aboriginal organisations were contracted to provide services in the centre (see further discussion at 5.2 below).

Visually, the centre had made some effort to emphasise Aboriginality. Aboriginal artworks featured prominently in the administration building, and in the education centre. Several large murals around the central open space also used Aboriginal imagery. Further into the centre, inside the accommodation units, that imagery was absent.

Aboriginal cultural food – in particular kangaroo meat and damper – had only been available during NAIDOC week. NAIDOC celebrations involved a full week of activities and a number of special guests, but the number of young people attending events was limited by security concerns.

There was not enough support for the Aboriginal staff group, and numbers had not increased

There had been no progress towards increasing the number of Aboriginal staff at Banksia Hill since the 2014 inspection. A large number of custodial officers had been recruited in that period, but very few were Aboriginal. No specific strategies had been implemented to attract more Aboriginal applicants. In total, Aboriginal staff made up around five per cent of the Banksia Hill workforce.

There were four AWO positions at Banksia Hill. These positions provide a crucial support mechanism, and a link to community and culture for young people. For extended periods in the preceding three years, only half of the AWO positions had been filled. A third AWO had been appointed a few weeks before the 2017 inspection.

The AWOs (like other Aboriginal staff in the centre) had the delicate task of balancing community and cultural obligations with their work responsibilities. They often felt criticised by non-Aboriginal officers for identifying too strongly with young people in the centre. But one of the great strengths of the AWOs was the ability to connect with young people using family and social networks. They felt that they were being pushed into ways of working that were less flexible, less culturally appropriate, and less effective.

During the 2017 inspection, we met with a group of Aboriginal staff from all areas of the centre. While they provided support to each other informally, there was no structured committee or support group for Aboriginal staff. Such groups have existed at Banksia Hill in the past, and Aboriginal staff were keen to revive this. They also wanted more communication with the senior management team, and more opportunity to provide feedback on Aboriginal services, cultural issues, and recruitment strategies.

Given the number of Aboriginal young people in Banksia Hill, it is obvious that Aboriginal staff have a key role to play. Currently, their skills and community connections appear to be under-valued, under-used, and not coordinated into the centre's operations. Indeed, some in the local management team described them as a 'distinct group'. There is a need to improve recruitment of Aboriginal staff, and consider ways to better support them and increase their involvement in the running of the centre.

Cultural awareness training provided to staff at Banksia Hill was limited

YCOs received cultural awareness training from a contracted Aboriginal service provider as part of their entry level training program at the Corrective Services Academy. But Banksia Hill did not have any ongoing Aboriginal cultural awareness training. Lack of regular training reduced the capacity of staff to manage the majority Aboriginal population, particularly those from regional areas. In 2017, two cultural awareness sessions had been developed on site and presented in May to coincide with Sorry Day and Reconciliation Week. This initiative was largely driven by two individual staff members, and reached a relatively small number of staff.

We found that staff awareness of social and cultural differences between metropolitan, regional, and remote Aboriginal communities was limited. While some staff members had long experience working with Aboriginal young people, there was a need to expand understanding of Aboriginal lifestyles, world views, aspirations, and social hierarchies across the state.

Increasing Aboriginal staff numbers and improving the way they are used will also be a good basis for enhanced cultural awareness.

Chapter 5

REHABILITATING YOUNG PEOPLE

5.1 CASE PLANNING

Information flow between community youth justice services and Banksia Hill was unreliable

Under youth justice reforms in 2012, the young person's Youth Justice Officer (YJO) was to be the primary case manager throughout their time in detention. YJOs are based in the community not in the detention centre. The intent was to provide continuity in case management and improve throughcare.

It follows that the case planning staff at Banksia Hill depend heavily on YJOs for information about the young people. The YJOs responsible for sentenced young people were required to send certain paperwork to the case planning unit, including relevant court reports. These contain information about the offending circumstances and social circumstances of the young person, as well as the YJO's own assessment of the offending issues and intervention needs.

Our examination of a sample of files suggested the model is not working well. Court reports were sent only exceptionally and, for the most part, case planning staff were working without this essential information.

A new assessment tool had been implemented, but assessment results were not readily available

In August 2016, Youth Justice Services implemented a new assessment tool – the Youth Level of Service / Case Management Inventory 2.0 (YLS/CMI). The tool seeks to determine the level of offending risk posed by a young person, and to identify offending and developmental needs.

In most cases, a YJO should complete a YLS/CMI assessment as part of the court report when a young person is sentenced to detention. However, we found no completed YLS/CMI assessments in the sample of files we examined.

Electronic copies of YLS/CMI assessments are stored in the Department's document management system, but they were inaccessible to case planning staff. As a result, they did not have the information they needed to plan rehabilitative interventions.

The psychological services team was able to obtain copies for their purposes – probably because they were in the community youth justice services directorate, with better access to relevant systems and databases. However, there was no arrangement for psychologists to pass the assessments on to the case planning unit.

The YLS/CMI has recently been added to TOMS. This should make new assessments available to both community and custodial staff. However, we are concerned at the impact of pending machinery of government changes that will transfer community youth justice services to the Department of Communities. There is a real risk that this will further hinder information sharing.

Recommendation 8:

Ensure proper information flow between community youth justice services and Banksia Hill.

The case planning unit was struggling with its workload and practices lacked consistency

The case planning unit had a very challenging workload. This reflected the complexity of the centre population and an increasing range of tasks.

In addition to their responsibilities in relation to young people who had been sentenced (see above), they had a range of responsibilities to the remand population. They included:

- completing a YLS/CMI assessment for young people remanded for 30 days or more, and linking them with brief intervention programs
- liaison with courts and lawyers
- sitting with young people during video-link court appearances
- liaison with YJOs, child protection authorities, and other agencies.

Successful management of such a varied and complicated workload requires clear processes and staff must have a good understanding of what is required. However, we found that staff were unsure which planning meetings were required, who was to be involved, and what documentation was to be completed for detainees of different status.

We were not satisfied that basic case planning processes had been completed for most young people. This did not appear to be a failure of case planning staff, who were committed, knowledgeable, and experienced. The problems were systemic: three different managers since 2014, lengthy staff absences, and considerable turnover. In addition, the unit had often been unable to access young people when the centre was short staffed or disrupted by incidents.

The case planning unit had also been impacted by the requirement to complete Detainee Management Reports for the Children's Court.

The Department had not assigned adequate resources for Detainee Management Reports

The President of the Children's Court has been concerned about conditions for young people in detention for many years. The 2013 riot elevated his concern to the point that he required Detainee Management Reports (DMRs) to assist the court's considerations.

DMRs require information on matters such as the young person's access to education, programs, activities and services, and time spent locked in cell. Despite the information appearing factual and straightforward, Banksia Hill has struggled to provide accurate information, particularly in relation to time spent locked in cell. At the time of this inspection, case planning staff had resorted to manually checking written records to ensure accuracy.

DMRs add nothing in terms of assessment, case planning, or management of young people. But they are necessary. Banksia Hill has been anything but normal since 2013, and the Children's Court's concerns are understandable and well-founded.

However, the DMRs have reduced the capacity of the case planning unit to complete assessment, consultation, and planning. For as long as DMRs continue, at least one additional position is needed.

Recommendation 9:

Provide additional resources for the preparation of Detainee Management Reports.

5.2 REHABILITATIVE PROGRAMS

There had been significant investment in programs

In 2014 we stressed the need to develop evidence-based programs to address offending behavior, and re-entry support services (OICS, 2015, 75–78). Overall, by 2017, programs for young people were better-resourced. More offending issues and needs were covered, more programs focused on throughcare, and many used Aboriginal service providers. Better frameworks for monitoring and evaluation were also being established, and there was a new module on TOMS to assist in program administration.

Programs staffing had stabilised. This allowed more consistent delivery of three programs by psychological services: Emotional Management, Healthy Relationships, and the Girls' Program. However, Step Up, a more intensive program addressing aggressive behaviour, was not running in 2017 because of staffing and workload issues for psychological services.

In addition, the Department had secured a broader range of programs from community service providers, along with enhanced re-entry support services. The now-defunct Youth Justice Board's Innovation Fund had provided funding for programs from the Wirrpanda Foundation and As One Nyitting. A new tender process was finalised in March 2017, and the main provider selected was a consortium led by Centrecare, and also involving Uniting Care West and the Aboriginal Alcohol and Drug Service. Hope Community Services provided bail services and a life skills program.

Despite the investment, there were significant gaps

Almost all programs were targeted at young people who rated medium to high on the YLS/CMI assessment. Step Up is appropriate for those rated medium to very high but, as noted earlier, it was not being offered in 2017. Banksia Hill also still had no intensive addictions program appropriate for the older age groups, and no sex offender programs. There was some duplication between the programs offered by psychological services and those offered by external providers.

There were still too few programs for girls

Delivering programs for the girls is challenging, largely because of their low numbers and the short time they spend in custody. In 2014 we found that the girls had poorer access to programs than the boys (OICS, 2015, 93–94).

In 2017, some issues had been addressed by converting the Girls' Program into a rolling course, meaning that the girls were able to participate in whichever modules happened

to be running during their time in custody. This was positive, but the range of programs and services for young women and girls had not increased significantly. We were also concerned to hear that the programs offered to the girls were not based on assessed need. This reflected a wider trend in the centre, which is discussed further below.

Problems with administration and coordination undermined program delivery

Local and international research stresses the importance of delivering the right program to the right person at the right time (OICS, 2014, 21–22). Treatment programs that are wrongly allocated can be harmful, increasing the likelihood of reoffending (Andrews et al, 1990). Programs that adhere to the ‘What Works’ principles of risk, need, and responsivity are most likely to be effective (Bonta & Andrews, 2007).

The programs module on TOMS did not allow local managers to add or delete programs. As a result, none of the new programs appeared on TOMS, rendering the system ineffective. Instead, staff used a basic spreadsheet. TOMS needs a properly functioning programs module to enable effective referrals, scheduling, and reporting of programs.

Program allocations at Banksia Hill should be based on YLS/CMI assessments, but as discussed above, these had rarely been sighted by the case planning unit. As a result, most young people were being assigned to programs to fill vacancies. In many cases, they had already completed the same or similar programs one or more times. This was counterproductive and a poor use of limited resources.

The introduction of the unit-wing model also counteracted the intent of YLS/CMI because young people attended programs in unit-wing groups, regardless of whether they needed the program.

Not surprisingly, the psychology team expressed concern that young people were being placed in unsuitable programs, and this could have a negative impact upon them.

In the absence of an effective planning process, psychological services had been asked to vet some of the program placements, but this was a temporary and incomplete solution to a systemic failing.

Recommendation 10:

Ensure that program delivery to young people is based on risk and need.

5.3 PSYCHOLOGICAL SERVICES

Psychological services lacked representation at management level and information flow was poor

During the 2014 inspection, the psychologists at Banksia Hill were led by a Manager Psychological Services. The position was being incorporated into the senior management team by the Superintendent at that time as part of an effort to break down barriers between the different professional areas of the centre, and encourage a more

multidisciplinary approach. This was a very positive initiative. Unfortunately, the position was never permanently established, and budgetary pressures in 2014–2015 meant that it was lost.

In 2017, psychological services did not have an on-site manager, but psychologists reported to the Principal Psychologist, a position based outside Banksia Hill. Essentially, the team, many of whom worked in both the community and at Banksia Hill, provided an inreach service to Banksia Hill.

Standing Order 9a states that psychologists should be consulted on behaviour management plans – known as PSPs – and play a key role in assessing young people’s progress. But our Behaviour Management Review found that in 2016 less than a third of PSPs had involved consultation with a psychologist (OICS, 2017, 20–21). During this inspection, the centre was still not properly utilising the expertise of the psychology team. The flow of information between operational management and psychological services needed to improve.

Lack of representation at management level at Banksia Hill added to the psychology team’s marginalisation. Operational and security considerations were often prioritised, especially with the growth in critical incidents through 2016. Psychologists had difficulty gaining access to young people, and reported serious concerns about the centre’s responses to those young people.

Psychologists had little capacity to do anything other than immediate risk management

Young people in custody, both on remand and sentenced, often present with high risks of self-harm and require significant support. Our Behaviour Management Review found that self-harm had risen to unprecedented levels at Banksia Hill in 2016, with 196 incidents of self-harm and attempted suicide (OICS, 2017, 14–15). This rate of self-harm continued into 2017.

Table 5-1: Incidents of self-harm and attempted suicide at Banksia Hill, 2012 – 2017

	2012	2013	2014	2015	2016	2017
Attempted suicide	1	1	1	0	5	5
Self-harm	74	71	37	77	191	184

The frequency of critical incidents in 2016 meant that young people spent more time locked in their cells. This had the dual effect of increasing the risk of self-harm, and making it more difficult for psychologists to access young people to provide counselling.

The need to focus on immediate risk was also impacting on other services. The Step Up program had been abandoned for 2017 because psychological services did not have the resources. Psychologists also had less capacity to interview and assess the needs of newly sentenced young people, or to deliver individual counselling. Consequently, fewer young people received these services.

Pending changes to government departments will affect the delivery of psychological services

Under proposed machinery of government changes, all community youth justice services, including Youth Psychological Services, will move to the Department of Communities. It is not clear how psychological services will be delivered to Banksia Hill when this happens and there is a real risk that the psychology team will become further isolated.

However, the changes also represent an opportunity to restructure psychological services to improve service capacity at Banksia Hill, and ensure the needs of young people are met. It is essential that this happens.

Chapter 6

EDUCATION

For the 2017 inspection, we again engaged an education consultant experienced in reviewing government and non-government schools, and with particular knowledge of Curriculum and Re-engagement in Education (CARE) schools. CARE schools are registered non-government schools which cater for students who are disengaged or alienated from formal schooling and who require a specialised approach to learning.

We were disappointed but not surprised to find that there had been limited progress since 2014. A few areas had improved but most had stayed static or deteriorated.

6.1 THE FUTURE OF EDUCATION AT BANKSIA HILL

Education services delivered at Banksia Hill did not meet community standards

The rest of this chapter makes recommendations to improve the status, management, and delivery of education services. However, it is difficult not to be sceptical about the uptake of any of these new recommendations based on the inaction following our 2014 report, and known issues dating back at least six years.

Since the inspection, there have been moves to bring Banksia Hill education under the management of the Education and Vocational Training Unit (EVTU), which oversees education in all adult public prisons. The EVTU has achieved excellent results despite dwindling resources in the adult system, and would provide much-needed strategic direction and support for Banksia Hill. However, this arrangement was not yet formalised at the time of writing.

If significant progress is not achieved over the next three years, a fundamental reappraisal of service delivery options and methods will be necessary. At that point, serious consideration would need to be given to transferring responsibility for education at Banksia Hill to the Department of Education (DoE). DoE's mandate is to 'provide high quality education for every child throughout Western Australia – whatever their ability, wherever they live, whatever their background.' That extends to Banksia Hill to the extent that DoE provides funding for educational resources and for some teaching staff but it does not provide all the funding that is required. Nor does it deliver the services. It is unlikely that DoE would accept the standard of education provided at Banksia Hill if DoE was responsible for delivering the services.

6.2 GOVERNANCE AND MANAGEMENT

Education services lacked strategic direction

In 2014 education at Banksia Hill lacked a clear strategic direction, and we recommended implementation of a strategic plan (OICS, 2015, 71). Three years on, there had been little or no progress. Staff throughout the centre (both teachers and other staff) still did not have a shared understanding of the purpose of education at Banksia Hill.

The continued absence of a strategic plan is a serious barrier to the selection of curriculum and strategies to support teaching and learning. Without strategic direction, it is not possible to set performance targets and evaluate the success of the programs.

A strategic plan should:

- establish the purpose of education services at Banksia Hill, including
 - broad strategies to achieve objectives
 - key performance indicators
 - monitoring and reporting arrangements
- draw on research into effective teaching, including
 - particular reference to the youth custodial environment
 - consultation with experts from education backgrounds.

Recommendation 11:

Implement a strategic plan for education services at Banksia Hill.

Education delivery had been affected by unstable and ineffective leadership

Many of our concerns about the strategic direction of education at Banksia Hill could be traced to a lack of education expertise at senior management level and above. During the 2014 inspection, the Principal at Banksia Hill reported to a youth justice regional director rather than someone with expertise in education. Not long after, line management arrangements were changed so the Principal reported to the Banksia Hill Superintendent (who also had no education experience). At the time of the 2017 inspection, with machinery of government changes pending, there was no established line management for education.

Local leadership for education has been a major issue since 2014. The long-serving Principal accepted a voluntary severance package in 2015, which meant the position was abolished. The Department was under pressure to cut costs at the time, but it is difficult to understand how decision-makers could think that education would run effectively without a Principal.

For more than 12 months, there was a leadership vacuum, covered only by an acting Deputy Principal. This had a negative effect on the morale of teaching staff, and the teaching program drifted without any clear direction.

In June 2016, a new manager for education at Banksia Hill was appointed. However, it was not a permanent position and had to be designated as a Principal Project Officer because the Principal position had not been re-established. For ease of reference, we will refer to the position as the Education Manager.

The Education Manager was tasked with reform of education delivery, but faced major obstacles. As a result of the explosion in critical incidents in 2016, education had often been deprioritised. The response to the incidents in May 2017 had been especially disruptive.

The Education Manager did not have control of the budget for education, and there had been difficulties in obtaining funding from the Department of Education (see 6.5 below). Staff morale was low, and some teachers were resistant to change. The Education

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Manager's own job security was uncertain. Support and guidance from the executive level of the Department was limited and unhelpful.

The Department needs to re-establish the Principal position as a matter of priority. But reform of education services cannot be achieved by one person without appropriate prioritisation, support, and guidance from executive levels of the Department and senior management at Banksia Hill.

Recommendation 12:

Re-establish the Principal position and recruit a Principal to lead education services at Banksia Hill.

6.3 CURRICULUM

There had been considerable progress in developing a CGEA-based curriculum

We found considerable progress in developing a teaching program centred on the Certificate in General Education for Adults (CGEA). The CGEA curriculum was originally designed to help adults improve their literacy, numeracy, and general education skills. It is used widely in adult education and in improving skills for people with backgrounds other than English. The CGEA is also used with young people who have gaps in their educational background, and is used in many CARE schools.

Elements of the CGEA were in place in 2014, but there was now a more structured approach that aligned the various stages of the course to the academic development of each young person. Because it is a self-paced program, in theory the CGEA allows young people to have a more seamless learning experience despite interruptions. There is also capacity to use data from initial education assessments to develop individual learning plans. Young people can be placed at any level between introductory and Certificate III in line with educational backgrounds and achievement levels.

There was no evidence on the success or appropriateness of the CGEA

Although the CGEA curriculum had its strengths, there were also some potential weaknesses. Self-paced learning requires a level of self-motivation that may be unrealistic for the young people at Banksia Hill.

The length of time spent at Banksia Hill by young people is also problematic, with an average of 35 days in detention. For those on short stays, the full value of the CGEA will not be realised unless the student has the opportunity to continue the course following release. However, the centre was not collecting data on young people post-release so there was no evidence of re-engagement in education, training, or employment. There had been an ongoing focus on inputs into teaching and learning rather than outcomes for young people. This was evident in 2014, and persisted in 2017. The success of education services was measured on delivery of programs with little evidence of any positive impact on young people's learning, re-engagement, or options post-release.

Finally, it is not clear whether the CGEA is the best vehicle to engage young people at Banksia Hill. Many have an extended background of non-attendance in formal education, or an inability to process formal education because of mental health and low ability issues. Observation of classrooms and feedback from staff and young people showed many students had disengaged from the learning program and were playing card games or doing colouring-in activities.

Banksia Hill's teaching and learning needs to be more strongly focused on strategies to re-engage young people in learning. This means that there should also be a stronger emphasis on high interest courses including art, drama, music, and vocational training.

There was no Protective Behaviours program in the school curriculum

In the past two years, all schools have been required to develop a range of measures related to the prevention and reporting of child sexual abuse. The state government mandated these measures in response to the interim findings of the Royal Commission into Institutional Responses to Child Sexual Abuse. Key to these measures has been the focus on mandatory reporting by teachers if a child discloses abuse, and the delivery of Protective Behaviours programs as part of the curriculum.

Despite the backgrounds of trauma and abuse faced by most young people at Banksia Hill, there was no such program in the school curriculum. There should be a program delivered by teaching staff that encourages vulnerable young people to manage their own welfare, and helps them develop strategies to protect themselves against abuse. Several organisations offer training courses for staff, and age-appropriate courses for students.

Recommendation 13:

Introduce a Protective Behaviours program as part of the school curriculum.

6.4 TEACHING AND LEARNING

Full-time education had not been restored

The regime changes that followed the critical incidents in May 2017 had profound impacts on education delivery. For several weeks, the education centre was closed, and any teaching was conducted in the accommodation units. This did not provide a suitable teaching environment. It also had a negative effect on the motivation and engagement of young people.

By the time of the inspection in July, full-time education had still not been restored. Boys were attending education for half-days only. The woodwork shop, metalwork shop, and horticulture workshop were not available to the boys (woodwork was available to girls only).

Disruptions to classroom time were too common

The widescale restrictions on attending education that were imposed following the May incidents were exceptional. But daily disruptions to classroom time have been common for many years.

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Students were routinely withdrawn from class to participate in counselling and programs associated with rehabilitation and court requirements. While these activities are important, they are disruptive to the learning environment. Although one of the strengths of the CGEA curriculum is that the self-paced learning approach caters for interruptions, when more structured instruction is necessary, the flow of students in and out of classes is problematic.

In early 2017, the Education Manager attempted to quarantine the morning session for education because this was when young people were most productive in the classroom. However, this initiative was short-lived and other services such as programs, case planning, and counselling quickly reasserted their right to access young people. Banksia Hill management need to improve coordination and oversight.

Education staff felt undervalued and morale was low

The loss of the Principal position and subsequent absence of leadership had contributed to a feeling that education was marginalised within the centre. Teachers felt that their work was undervalued and they were frustrated by constant change. Security was taking priority over education, and it was no surprise that education staff were thoroughly demoralised.

More positively, there had been an injection of new teaching staff since the 2014 inspection. They brought potential to refresh thinking about young people as students, and focus on meeting their needs. New staff had the benefit of not being tied to historical practices and events.

Professional development was not linked to identified priorities or individual teacher needs

Access to professional learning had improved for teachers since 2014. However, there was no consistent link between the performance management of staff, identification of individual training needs, and the development of priorities for professional learning. The lack of strategic direction also made it more difficult to identify teaching and learning priorities.

Some education staff had never participated in performance management sessions at the centre. There was also no best practice educational performance management framework such as the Professional Standards for Teachers developed by the Australian Institute for Teaching and School Leadership. This framework is used in all schools for self-reflection and improvement planning for teaching staff.

6.5 RESOURCING

Funding from the Department of Education had been resecured

A memorandum of understanding (MOU) with the DoE is intended to provide funds to supply the school with essential educational resources, materials, and equipment to deliver primary and secondary education programs for all young people at Banksia Hill. Under the MOU, DoE also provided funding for three full-time teachers.

Our 2014 inspection report highlighted deficiencies in budget and resources to support teaching and learning (OICS, 2015, 74). At that time, the MOU with DoE had expired, and funding from DoE was not provided in 2013 and 2014. Given the mandates of both Departments, and the clear needs of Banksia Hill, this seems extraordinary.

A new MOU was negotiated in late-2015, providing annual funding of up to \$2,497 per young person. Back payments were also made for 2013 and 2014.

We concluded that there had been improvements in teaching and learning resources, but the level and quality of resourcing was still low compared with schools in the community.

Investment in information technology was not being maximised

When the new MOU was finalised, Banksia Hill effectively received funds from DoE for 2013, 2014, and 2015 as a lump sum (totalling more than \$225,000). Sensibly, it was decided to invest in an extensive upgrade of information technology in education services. There was some delay in achieving this, but eventually the project was implemented in 2017.

Prior to the implementation of this project, the education network at Banksia Hill had been in disrepair. Numerous personal computers (PCs) did not work or were beyond their useful life, and software applications were not consistent across PCs. There was no ability to save work and access that work later from a different PC, and no access to shared learning resources.

In January 2017, work commenced to refresh the technology available to young people. A new education network was established, and a new server deployed. Teachers and young people were provided with network logons so that they could save work and share resources where necessary.

About 135 corporate PCs from throughout the Department that were due for replacement were repurposed for use in education. Each PC was loaded with a selected range of relevant software. A pool of 43 ruggedised laptops was provided to teaching staff to be allocated to students at the teacher's discretion. Printers and interactive whiteboards were purchased to be used by teachers as needed.

However, this investment was in danger of being wasted without support and training. In July 2017, only about half the new computers were connected. There were issues with connectivity because of limited available bandwidth. Software could not be downloaded because PCs were not connected to the internet so other installation methods were required.

Obviously, the success of the project was also contingent on staff understanding how information technology can be used to encourage engagement in education. Many of the teachers, particularly those who had been at Banksia Hill for some time, lacked familiarity with using technology in the classroom. Professional learning and training in this area is crucial.

Human resources management was challenging and there were often too few education staff

Unlike schools in the community, education services at Banksia Hill run for 50 weeks per year. However, teaching contracts still provide 12 weeks of annual leave. This meant there were typically at least five teachers on leave at any given time.

The need to employ a large temporary relief workforce to cover leave entitlements was a significant administrative burden. The pool of qualified teaching staff available to provide relief teaching is not limitless and constantly subject to change.

The lack of administrative staff available to manage systems and databases also meant that managers were engaged in low level tasks. Coordination of relief staff largely fell to the Education Manager herself, a questionable use of her valuable time. In most schools this task would be managed by an administrative officer who would also have responsibility for timetabling and attendance records. No equivalent resource existed at Banksia Hill. More effective database systems were also needed: the Department's intranet has little functional relationship to education.

Fundamentally, there were not enough teachers at Banksia Hill. It was common for a class of young people to be supervised by a custodial officer because there were not enough teachers available. These so-called 'custodial groups' were running almost daily. This is not a standard that would be accepted in the community, and it should not be accepted at Banksia Hill.

The education budget was not controlled by the Education Manager

Prior to 2015, the Principal was responsible for managing a separate budget for education. When the Principal position was abolished, the education budget was absorbed into the wider centre budget, and managed by Banksia Hill's Business Manager. This meant the Education Manager had less control over how education services could operate. Many of the issues discussed in this chapter — classroom resources and teaching materials, professional learning opportunities, information technology, and human resource management — are made more challenging by lack of budget flexibility.

Ideally, education services should be provided with a one-line budget that allows employment and deployment of staff to meet the needs of the teaching program, and purchase of resources that encourage young people to engage in education. Funding provided by both the Department of Justice and the Department of Education needs to be reviewed to ensure it is comparable to equivalent schools in the community.

Recommendation 14:

Provide a separate education budget managed by the Principal.

Chapter 7

HEALTH SERVICES

7.1 FACILITIES

Medical centre infrastructure was worn and dirty, and space was poorly utilised

The medical centre infrastructure was ageing and in need of refurbishment. Cleaning was undertaken by a contractor, but we observed dirty floors.

The medical centre was spacious, but the space was not well utilised. The main treatment area was an open space, separated from the rest of the medical centre only by a curtain. This compromised patient privacy, and needed to be managed carefully by nursing staff. There was a clinic room in the medical centre that was used only for storage.

There had been some minor improvements since the last inspection, including the hanging of Aboriginal art, and installation of televisions in the treatment area and waiting area. Young people were able to distract themselves by watching the television while waiting or receiving treatment.



Photo 8: Treatment area in the medical centre

The nursing station in Yeeda Unit was under-utilised

Yeeda Unit was designed as a self-contained unit with infrastructure that allowed services to be delivered to the girls without requiring them to walk through the wider centre. This included a nursing station. The nursing station was basic, and was never intended to fully service every medical need of the girls.

At the time of the 2014 inspection, the nursing station was used to assess minor medical issues and dispense medication (OICS, 2015, 78). However, these services had ceased, and the girls were now required to attend the medical centre. During the 2017 inspection,

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there was at least one girl receiving daily medication, and she was required to walk through the centre to receive it. She reported that she was sometimes subjected to harassment from boys. We asked local management why the girls were being exposed to this sort of experience, when it could have been avoided by utilising the nursing station and bringing health services into Yeeda Unit. Positively, local management shared our view, and arranged for nursing staff to start running clinics in Yeeda Unit for an hour each morning.

7.2 SERVICES

The level of service had decreased since 2014

The medical centre was staffed each weekday by a clinical nurse manager and two registered nurses. The night shift was covered by one nurse every night of the week. On weekends and public holidays, there was one nurse rostered from 7.00 am to 7.00 pm, and one from 1.00 pm to 6.30 pm. There were two medical receptionists, one full-time and one part-time. A sexual health nurse worked one half-day a week, and a dentist attended one day a week.

At the time of the 2014 inspection, a drug and alcohol counsellor was providing services for one half-day a week. This was no longer available.

Regular attendance by a paediatrician had also stopped. Young people were instead referred out to specialist paediatric services as required.

General practitioner (GP) services had decreased significantly since 2014, and provision was inconsistent. In 2014, two GPs (one male and one female) attended Banksia Hill for a total of three days per week. In 2017, a GP attended only one day a week.

There was no regular GP, and the service was provided by whoever was available from the Department's pool of doctors. When no GP was on site, there was an on-call GP available for e-consultations.

The drop in services was concerning. It certainly did not reflect the high health needs of young people at Banksia Hill.

We were also not confident that the Department had a good understanding of the health needs of young people. When we requested data on the prevalence of health conditions in the centre's population it was not readily available. Nobody at Banksia Hill had access to this information, and the data needed to be extracted from the medical records database by a staff member at head office. Ultimately, it took three months for us to receive this information.

It was clear that this information was not being used to guide health service provision. Although the data indicated that mental health, and drug and alcohol issues were the two most prevalent health conditions, drug and alcohol counselling services had disappeared from the medical centre since 2014.

Another significant gap was the lack of any Aboriginal health worker. Aboriginal young people have a right to access to culturally appropriate health care. Considering the

overrepresentation of Aboriginal young people in detention, it was surprising that the Department had not established an arrangement with the Marr Mooditj Training Aboriginal Corporation. Marr Mooditj train Aboriginal health workers in a number of specialised areas including mental health. The Department should explore opportunities to provide practicum placements for students, and recruit Aboriginal health workers for employment.

Recommendation 15:

Review health service provision at Banksia Hill based on an analysis of the health needs of young people in detention.

7.3 ACCESS

Young people's privacy was compromised by the medical appointment booking system

There was no private booking system to request a medical appointment. Young people were required to ask an officer to make an appointment on their behalf, and they reported that officers would question the reason for the appointment. The girls, in particular, felt uncomfortable, especially when dealing with a male officer.

Some young people said they would lie about the reason they wanted to see a nurse or doctor in order to get access. This undermined the ability of nursing staff to properly triage appointments.

We have previously raised concerns about this practice and have recommended an alternative booking method be introduced to preserve the privacy of young people (OICS, 2015, 80–81; OICS, 2013, 34). However, these recommendations were not supported by the Department, and no action was taken. As a result, the problem persisted.

When we raised the issue during this inspection, Banksia Hill management were more responsive. They agreed that young people should not be asked why they are requesting a medical appointment, and said they would reinforce this with staff.

7.4 MENTAL HEALTH SERVICES AND CRISIS CARE

Mental health staffing had been unstable but services were developing

The mental health team at Banksia Hill consisted of a full-time mental health nurse, and a psychiatrist one day a week. The psychiatrist at the time of the 2014 inspection had left the role, and securing a new psychiatrist had been difficult. As a result, psychiatrist attendance had been irregular and unreliable at times. But by the 2017 inspection, a psychiatrist was visiting consistently and was committed to Banksia Hill.

There had been some instability in that the mental health nurse had been on indefinite leave. The current mental health nurse had been acting in the position for 18 months and was unsure of her tenure. Despite this, the mental health team had made important progress in developing mental health services at Banksia Hill. Maintaining continuity in these positions will be vital to further development.

HEALTH SERVICES

The mental health team were building positive working relationships in Banksia Hill, and establishing referral pathways within the community. The psychiatrist was playing a crucial role in developing links with the Department of Health, and Child and Adolescent Mental Health Services. Much progress had been made in reshaping mental health services at Banksia Hill, but there was a need to formalise arrangements. Memoranda of understanding should be developed between the Department of Health and the Department of Justice to document roles and responsibilities, referral pathways, and information sharing.

Regular weekly meetings with the psychologists at Banksia Hill had been introduced to review shared caseloads. While these meetings were in their infancy, they provided a valuable potential avenue to integrate patient care, which had previously been lacking.

The mental health team had plans to establish monthly multidisciplinary team case conferences, which would include professionals from a range of disciplines to provide comprehensive health care and improved patient outcomes. This is a practice we support, and which is in line with previous recommendations (OICS, 2015, 80).

There had been no change to inadequate crisis care facilities

In the 2014 inspection report, we once again highlighted the inadequacy of crisis care facilities at Banksia Hill. We recommended that the Department and government ‘[p]rioritise the development of a purpose-built crisis care unit at Banksia Hill’ (OICS, 2015, 83–84).

In 2017, there had been no progress. There had been plans to convert one of the wings in Harding Unit into a therapeutic wing, but this had been derailed by the high frequency of critical incidents throughout 2016.

As a result, the four observation cells in Harding Unit remained the only option for managing young people who were acutely mentally unwell. In addition to these four observation cells, the Harding Unit included multipurpose cells for short-term confinement (typically occupied by detainees who have been fighting, or displaying unacceptable behaviour), as well as housing young people who had been separated from the mainstream population because of their misbehaviour. It was often an unsettled environment, and not appropriate for crisis care.

The observation cells themselves were stark and confining, and the windows and walls showed graffiti and signs of damage. The exercise yard was a bare, featureless caged area, and there was no area where young people could mix together.

This created a highly inappropriate and counter-therapeutic environment to house young people who are, or had been acutely mentally unwell.

We reiterate the need to develop a crisis care unit where young people who cannot be managed in an ordinary unit can be kept safe. They should be able to have supportive social interaction with peers and staff in a calm environment which supports their recovery. They should have access to activities inside and outside, and access to support by telephone and visits from family.

HEALTH SERVICES

The unit should be developed so it can act as a step up and step down unit to facilitate the return to custody of young people who have recently been inpatients, or to allow early intervention for those who may become inpatients, and hopefully actually avoid the need for admission. This unit should not be co-located with multipurpose or punishment cells. We repeat our recommendation from three years ago:

Recommendation 16:

Prioritise the development of a purpose-built crisis care unit at Banksia Hill.



Photo 9 and 10: The interior and exterior of an observation cell

Appendix 1

ACRONYMS

ARMS	At Risk Management System
ASFCS	Assistant Superintendent Female and Cultural Services
AWO	Aboriginal Welfare Officer
CARE	Curriculum and Re-engagement in Education
CGEA	Certificate in General Education for Adults
DMR	Detainee Management Report
DoE	Department of Education
EVTU	Education and Vocational Training Unit
ISU	Intensive Support Unit
OICS	Office of the Inspector of Custodial Services
PRT	Primary Response Team
PSP	Personal Support Plan
RCPDCNT	Royal Commission and Board of Enquiry into the Protection and Detention of Children in the Northern Territory
SOG	Special Operations Group
TOMS	Total Offender Management Solution
YCO	Youth Custodial Officer
YJO	Youth Justice Officer
YLS/CMI	Youth Level of Service / Case Management Inventory

Appendix 2

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Appendix 3

DEPARTMENT OF JUSTICE RESPONSE



Government of Western Australia
Department of Justice

Response to the announced inspection: Banksia Hill Detention Centre

DEPARTMENT OF JUSTICE RESPONSE

Response to the announced inspection:
Banksia Hill Detention Centre

The Department of Justice welcomes the inspection of Banksia Hill Detention Centre as part of the Inspectors announced schedule of inspections for 2017/2018.

The Department has reviewed the report and noted a level of acceptance against the 16 recommendations.

Appendix A contains a number of comments for your information.

Response to the announced inspection:
Banksia Hill Detention Centre

Progress since inspection

Since the inspection, the Department of Justice has further enhanced its operations at Banksia Hill Detention Centre.

Workforce

The Senior Management Team has been stable since May 2017. New and realigned positions in the proposed structure presented to OICS are currently being finalised. The Deputy Superintendent has been substantively filled and permanent appointments to the remaining vacancies are being progressed.

A recruitment campaign is underway for Youth Custodial Officers with the next school scheduled for April/May 2018.

New industrial agreements have recently been registered for Youth Custodial Officers and public service roles.

Services and Operations

The operational philosophy for Banksia Hill has been developed. It is based on implementing a Model of Care (MOC) which will produce a Centre based, trauma informed approach that will underpin the future direction for Banksia Hill Detention Centre. Youth Justice, including Banksia Hill, will be overseen by a joint administration group which will include representatives from both Department of Justice and Department of Communities.

As a result of the Program Tender process facilitated by the Department last year there has been an increase in programs. Certain programs are delivered by Unit/Wing such as Health in Prison Health out of Prison (compulsory program) and Wisdom in Your Life (facilitated over 3 consecutive days). There are other emotional wellbeing programs which are also delivered by unit/wing as they are noted as being beneficial to all young people. Specialised programs including cultural specific and programs which specifically address criminogenic factors are delivered to young people who have been identified as suitable for these specific programs.

An interim Education and Training Strategic Plan was developed in October 2017 to assist the continuous improvement of education and training to children (10-13), youth (14-16) and young adults (17-18) in detention, whilst the future state of education services is determined.

As a part of the rehabilitative focus of the MOC, education will continue to deliver a structured school day that is based upon the current Unit/Wing model. This model commenced mid-2017. This connection between unit custodial staff, teachers and detainees/students creates consistency across each school day and ensures improved communication between custodial staff and teachers in relation to the needs and risks associated with each detainee/wing class/unit.

The Principal position is currently being re-established and then will shortly progress to recruit a suitably qualified person.

Response to the announced inspection:
Banksia Hill Detention Centre

Security

There has been a significant focus on the three core components of Security Management. Intelligence is now at the forefront of operational decision making and there will be a continual focus on prevention and detection. The Security environment has improved significantly and will continue to do so. The strategic objective this year will be to enhance relational security.

Response to the announced inspection:
Banksia Hill Detention Centre

Response to Recommendations

1 Develop and implement an operational philosophy for Banksia Hill.

Response:

An operational philosophy has been developed based on the Model of Care which is a trauma informed approach to delivering services at Banksia Hill. The approach aims to address the young person's assessed needs as part of through-care, be culturally informed and support the young person to leave better equipped to live a law abiding lifestyle. Full implementation of the operational philosophy will take 3 years.

Responsible Person: Assistant Director IIOM

Proposed Completion Date: 31 December 2020

Level of Acceptance: Supported.

2 Implement a regular program of Youth Custodial Officer recruitment that accounts for known staff attrition rates.

Response:

The Department coordinates workforce planning and recruitment on an ongoing basis, and as the need arises facilitates entry level training. The next entry level school for Youth Custodial Officers has been scheduled for April / May 2018.

Responsible Person: Director Human Resources

Proposed Completion Date: 30 May 2018

Level of Acceptance: Supported – existing departmental initiative.

3 Deliver staff training without resorting to locking young people in cell.

Response:

The Department currently has a structured day that includes staff training, which includes an operational requirement at times to restrict routine operations to facilitate staff training. The Department will look at opportunities to increase activities for young people during these restricted routine periods.

Responsible Person: N/A

Proposed Completion Date: N/A

Level of Acceptance: Not Supported.

Response to the announced inspection:
Banksia Hill Detention Centre

4 Use the half-and-half procedure whenever a young person is strip searched at Banksia Hill.

Response:

Standing Order 17 currently provides guidance for youth custodial staff in searching. Staff are to show the highest regard for the dignity and respect of young people and their belongings at all times. The current standing order requires the use of the half and half strip search procedure with the exception of when a young person enters the facility and is required to shower and change clothing. The order will be amended to remove this exception during showering on admission.

The Department is currently reviewing new technologies and innovations to eliminate the need for strip searches for young people.

Responsible Person: Superintendent
Proposed Completion Date: 30 June 2018
Level of Acceptance: Supported

5 Build the new system for recording daily observations of young people into TOMS.

Response:

The Department has completed a business needs assessment and is currently identifying the system requirements for capturing observation information for young people into TOMS.

Responsible Person: Chief Information Officer
Proposed Completion Date: 31 December 2018
Level of Acceptance: Supported

6 Ensure that young people have regular opportunities to mix with their peers in other accommodation units.

Response:

The following established approaches already ensure young people have opportunities to mix with other peers in the centre; therapeutic and recreational programs and during religious services. A new inter-unit process is also currently being developed.

Responsible Person: Superintendent
Proposed Completion Date: 30 June 2018
Level of Acceptance: Supported - existing Departmental initiative.

Response to the announced inspection:
Banksia Hill Detention Centre

7 Revise the policy for managing girls to give them fairer access to self-care privileges.

Response:

There are typically low numbers of girls in custody. Individual golden cell privileges (extra privileges) are currently available within the Yeeda accommodation wing for girls. Banksia Hill will be reviewing all standing orders in 2018 and this will include a review of incentives and privileges.

Responsible Person: Assistant Superintendent Governance
Proposed Completion Date: 31 December 2018
Level of Acceptance: Supported in principle

8 Ensure proper information flow between community youth justice services and Banksia Hill.

Response:

Existing information flows are adequate and will continue regardless of any potential Machinery of Government changes.

Responsible Person: Deputy Commissioner
Proposed Completion Date: Completed
Level of Acceptance: Supported

9 Provide additional resources for the preparation of Detainee Management Reports.

Response:

The Department has proposed a new structure for the senior management team at Banksia Hill which includes a Manager - Case Planning position. The position will oversee day to day operations of case planning to ensure priorities are met including; case coordination and development of individualised and targeted case plans for young people, standardisation of practices and staff coaching. The Department will also explore ways to systemise this work.

Responsible Person: Superintendent
Proposed Completion Date: 31 December 2018
Level of Acceptance: Supported in principle

10 Ensure that program delivery to young people is based on risk and need.

Response:

The Department provides a range of programs to young people in custody; the programs aim to address health, rehabilitative, recreational, cultural and educational needs. Programs are delivered either by Departmental staff or external providers.

Response to the announced inspection:
Banksia Hill Detention Centre

For all sentenced young people their suitability for programs is assessed and according to their YLS/CMI (risk/needs assessment tool) they are referred to programs based on risk and need. Remanded young people are referred to life skills programs including; Hope Services (budgeting), Beyond YJS (positive communication and Be Solid which raises awareness in MH). Case planning are currently reviewing their approach to completing the YLS/CMI for YP who are on remand for more than 30 days to ensure the reprioritisation of the assessment and the implementation of programs.

Responsible Person: Assistant Director IOM
Proposed Completion Date: 31 December 2018
Level of Acceptance: Supported in principle

11 Implement a strategic plan for education services at Banksia Hill.

Response:

An interim education and training strategic plan was developed in October 2017 to assist with the continuous improvement of education and training to young people at Banksia Hill. The plan is based on five key principles; quality teaching, safety and inclusiveness of the learning environment, efficiency with which resources are allocated, quality professional leadership, effective internal and external relationships and partnerships.

Responsible Person: Director Education, Training and Employment
Proposed Completion Date: 31 December 2019
Level of Acceptance: Supported

12 Re-establish the Principal position and recruit a Principal to lead education services at Banksia Hill.

Response:

A new position of Principal will be established and filled in due course. As of January 2018, an acting Principal is in place at Banksia Hill.

Responsible Person: Director Education, Training and Employment
Proposed Completion Date: 31 December 2018
Level of Acceptance: Supported

Response to the announced inspection:
Banksia Hill Detention Centre

13 Introduce a Protective Behaviours program as part of the school curriculum.

Response:

The Department has made contact with the Department of Education's School of Special Education Needs – Behaviour and Engagement and School Drug Education and Road for professional development on resilience education courses for staff to teach students how to cope and thrive in the face of negative events, challenges and adversity.

Responsible Person: Director Education, Training and Employment
Proposed Completion Date: 31 December 2018
Level of Acceptance: Supported – existing Departmental initiative

14 Provide a separate education budget managed by the Principal.

Response:

Education has a separate budget and this will be managed by the Principal, once established. Additionally, the Department currently has an MOU with the Department of Education which outlines an agreed funding model to support three qualified teacher positions and a quota of resources per student calculated at an agreed census date.

Responsible Person: Director Education, Training and Employment
Proposed Completion Date: 31 December 2018
Level of Acceptance: Supported

15 Review health service provision at Banksia Hill based on an analysis of the health needs of young people in detention.

Response:

The Justice Health Project is currently underway. This is an interagency project (Justice, Health, Mental Health Commission) reviewing the governance of Prison Health Services considering whether improved health and mental health outcomes for offenders and efficiencies can be achieved through transferring governance to the Department of Health. The Justice Health Report is due to be submitted to Cabinet in June 2018.

In addition, the Department of Justice, Corrective Services Health Services are reviewing the current model of care provided at each of the health sites, including Banksia Hill. The aim is to transition to an evidence-based nurse led model of primary care that ensures better health outcomes for patients and a supportive structure for staff.

Responsible Person: Director Health Services
Proposed Completion Date: 31 July 2018
Level of Acceptance: Supported

Response to the announced inspection:
Banksia Hill Detention Centre

16 Prioritise the development of a purpose-built crisis care unit at Banksia Hill.

Response:

Improvements have already been made and additional measures proposed within existing capital works funding and resources at Banksia Hill. The Department recognises the need for a crisis care unit and will include this requirement in the Department's future capital works program. This will be subject to funding and prioritisation of the works program.

Responsible Person: Superintendent
Proposed Completion Date: 31 December 2018
Level of Acceptance: Supported in principle

Appendix 4

INSPECTION TEAM

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Andrew Harvey	Deputy Inspector
Natalie Gibson	Director Operations
Lauren Netto	Principal Inspections and Research Officer
Kieran Artelaris	Inspections and Research Officer
Jim Bryden	Inspections and Research Officer
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Christine Wyatt	Review and Research Officer
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Appendix 5

KEY INSPECTION DATES

Formal notification of announced inspection	20 March 2017
Pre-inspection community consultation	30 May 2017
Start of on-site phase	19 July 2017
Completion of on-site phase	26 July 2017
Inspection exit debrief	9 August 2017
Draft Report sent to the Department of Justice	15 December 2017
Draft report returned by the Department of Justice	17 January 2018
Declaration of Prepared Report	26 February 2018

*Inspection of prisons, court custody centres, prescribed lock-ups,
juvenile detention centres, and review of custodial services in Western Australia*



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