GOVERNMENT OF WESTERN AUSTRALIA

OFFICE OF THE INSPECTOR OF CUSTODIAL SERVICES

Use of force against prisoners in Western Australia

May 2021

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Inspector's Overview

We undertook this Review following publication in June 2020 of our report titled *Routine restraint of people in custody in Western Australia*. The routine restraint report found that there was a lack of reliable system level data recording the use of routine restraints and that there was some ambiguity in the relevant policy and procedures framework.

This review examining use of force has reached similar conclusions.

The major difficulty we found during this review was that data lacked clarity between the use of force and use of restraint. In simple terms, use of force is used in response to an incident, and use of restraint is used in response to potential risk.

Recent changes by the Department of Justice to relevant policies and the offender database have been positive and go some way towards addressing these concerns. However, we identified that confusion still exists, and further work and training is required before the benefits can be fully realised.

Accurate recording and reporting of incident data are critical first steps in ensuring accountability and effective oversight and governance. They form the foundation of the oversight mechanism and inform the review work undertaken by the internal Use of Force Committees, that have been put in place to assess use of force incidents. But it goes further than the internal review of individual incidents. Accurate incident data is also essential for systemic analysis and identification of good practice, emerging trends, and areas requiring improvement.

Our analysis of the data suggests that vulnerable prisoners are more often involved in use of force incidents compared to the remainder of the prison population. Vulnerable prisoners included remand prisoners, prisoners with mental health issues, prisoners with cognitive impairments, and Aboriginal prisoners.

But caution must be applied in interpreting this initial analysis. We have not undertaken a deep dive analysis of the data for each incident of use of force. This is a body of work that was beyond the scope of this review. This does, however, point to the need for more detailed research and data analysis to understand the drivers behind the data and whether there are learnings to be gained from a broader systemic analysis.

Consistent with our usual practice, we provided a draft copy of this report to the Department and Serco, the private operator of Acacia prison, for comment and response to the proposed recommendations. Both responses have been valuable in clarifying several areas covered in the draft and have been reflected in our final report. Both responses are also attached as appendices to this report.

One key point emphasised in both responses was the difference between use of force and use of restraint. At the risk of some repetition, we have clarified this in several areas of the final report.

The Department responded positively to all bar one recommendation (recommendation 6 was not supported), noting that several would require additional funding and/or prioritisation over other initiatives. We welcomed the positive response to recommendation 1 which relates to clarifying ambiguity and ensuring accurate and reliable reporting. This is the one recommendation that will have the greatest impact towards improving overall accountability and governance around use of force in prisons.

It is important to acknowledge the contribution and assistance we received in undertaking this review from key personnel in the Department and at the privately managed facility, Acacia Prison. It is important to also acknowledge the hard work and significant contribution of the team within our office in planning and undertaking this review. I would particularly acknowledge the work of Cherie O'Connor in leading this review and as principal drafter of this report.

Eamon Ryan
Inspector

14 May 2021

Executive Summary

Introduction

Our review examined use of force in Western Australian prisons for the five years from January 2016 to December 2020. For most of this period, policies and procedures had been in place for several years. However, in the middle of 2020, significant changes were made to the policy, reporting, and record keeping practices for use of force.

These were largely positive changes, but the change itself hindered some of our analysis. As such, we expect to conduct a follow up review into use of force in future years when the new policy and procedures have bedded down.

For the purpose of this review, 'use of force' refers to any physical intervention by staff towards a prisoner. This ranges from handcuffing a compliant prisoner who is being escorted within a prison to an active physical restraint to subdue a prisoner during a volatile incident.

Background

At times it will be necessary for staff to use force in prisons. But the use of force is a major area of risk for the Department of Justice (the Department). Both prisoners and staff are at risk of physical injury and psychological trauma when force is used. And unreasonable or inappropriate force also brings legal and reputational risks. As such, any application of force is strictly governed.

In Western Australia, the *Prisons Act 1981* (the Act) authorises prison officers to use reasonable force in a variety of circumstances. This includes, but is not limited to, when it is necessary to gain compliance with an order, to protect the safety of prisoners and staff, and to restrain a person in custody.

The Department has recently changed its policy governing the use of force in prisons. This new policy outlines use of force options for officers, the actions to be taken prior to and after a use of force incident, and the oversight mechanisms used to evaluate incidents where force was used. It aligns with the Act, outlining that use of force:

- must be the option of last resort
- must be justified based on the circumstances
- shall be no more than necessary to control the situation
- shall cease when the level of perceived threat has been managed
- shall never be used as a form of punishment.

The policy requires that where possible, compliance should be gained, and conflict resolved through non-physical de-escalation techniques. However, force can be used when all options have been exhausted or are reasonably considered impractical. Force can be applied empty handed or can involve the use of specialised equipment as set out in Table 1:

Table 1: Approved restraint equipment and use of force options

Approved restraint equipment		Approved use of force options
Ankle cuffs	Security chain link	Defence and control techniques
Ankle hobble	Spit hood	Batons
Handcuffs	Tape hobbles	Chemical agents
Passive restraint belt	Temporary restraints	Conducted energy weapon
Protective helmet	Velcro restraints	Firearms
Restraint bed	Waist transport belt	

Officers do not have access to all equipment at all times and special training is required for the use of some equipment. Only the Special Operations Group and the Albany Security Unit are authorised to use conducted energy weapons (commonly known as Tasers) and firearms. Restrictions are also placed on the circumstances when specific equipment can and cannot be used.

How regularly is force used in prisons?

The short answer is we really do not know and neither does the Department.

Between 2016 and 2020 there were 11,440 recorded incidences of force used in Western Australian prisons in 9,182 incidents. The difficulty we faced, which the Department acknowledged in their response, is the inability to differentiate between when force is used in response to an incident and when it is used as a routine precaution when moving prisoners.

An incident may involve multiple incidences of force such that a prisoner might be sprayed with chemical agent, physically restrained, and then put in handcuffs. This would equate to three incidences of force. Likewise, an incident involving a routine movement of a prisoner in handcuffs would equate to one incidence.

For much of this period, the Department's offender database could not accurately differentiate between use of force incidences (including the application of restraints) when they occurred:

- as part of a use of force incident
- when moving a prisoner after a use of force incident
- under a management regime
- or any other occasion of use.

As a result, the figures presented within this review include all such circumstances. Most use of force incidences involved handcuffs (96%).

Table 2: Type of instrument used, by year (2016–2020)

Instrument of force used	2016	2017	2018	2019	2020	Total (%)
Ankle Cuffs	5	7	3	5	2	22 (0.2)
Ankle Hobbles				5	6	11 (0.1)
Chemical Agent	7	6	5	47	19	84 (0.7)
Controlled Escort	6	3	2	3	3	17 (0.1)
Handcuffs	2,276	1,907	1,998	2,244	2,568	10,993 (96)
Leg Irons			4	43	23	70 (0.6)
Restraint Bed	1	2		3		6 (0.1)
Medical	3	1			1	5 (0.1)
Passive Restraint Belt	2		1	6	3	12 (0.1)
Physical Restraint	2		2	8	8	20 (0.2)
Plastic Cuffs/Flexi Cuffs	4	3	3	5		10 (0.1)
Security Chain Link	14	12	21	11	8	66 (0.6)
Spit Hood/Protective Spit Mask/Face Shield	5	5	7	21	22	60 (0.5)
Tape Hobbles	7	15	9	13		44 (0.5)
TASER				1		1 (0)
Total	2,332	1,961	2,055	2,415	2,677	11,440

The total equates to about six times per day or 44 times per week across all facilities in the context of an average of 6,692 prisoners in custody on any one day between 2016 and 2020. Over 75 per cent of these incidences of force occurred in the state's three biggest prisons; Acacia (31.9%), Hakea (30.7%) and Casuarina (14.8%).

Table 3: Number of use of force incidences in Western Australian prisons (2016–2020)

Facility	Total number of use of force incidences (%)	Facility average proportion of the total prison population (%)
Maximum-security		
Albany Regional Prison	291 (2.5)	6.5
Bandyup Women's Prison	685 (6)	4.1
Casuarina Prison	1,697 (14.8)	14
Hakea Prison	3,513 (30.7)	15.5
Melaleuca Remand and Reintegration Facility (Dec 2016 – April 2020)	135 (0.6)	3.2
Melaleuca Women's Prison (April – Dec 2020)	72 (1.2)	3.1
Medium-security		
Acacia Prison	3,648 (31.9)	21.3
Minimum-security		
Karnet Prison Farm	18 (0.2)	5.1
Pardelup Prison Farm	1 (0)	1.3
Wooroloo Prison Farm	22 (0.2)	5.8
Multipurpose-security		
Broome Regional Prison	26 (0.2)	1
Bunbury Regional Prison	315 (2.6)	5.5
Eastern Goldfields Regional Prison	328 (2.9)	3.4
Greenough Regional Prison	239 (2.1)	3.5
Roebourne Regional Prison	141 (1.2)	2.8
West Kimberley Regional Prison	309 (2.7)	3.0
Total	11,440	97.8*

* Does not include Boronia Pre-Release Centre, Wandoo Reintegration Facility, or Wandoo Rehabilitation Prison which did not record use of force incidents in the timeframe.

Casuarina Prison's proportion of the use of force incidences aligns to its proportion of the total prison population (14%). However, reported force incidences were overrepresented at Acacia Prison (31.9%), which makes up about 21 per cent of the total population, and at Hakea Prison (30.7%), which constitutes 15.5 per cent. Acacia Prison is a privately-operated facility with contractual reporting requirements which could mean more accurate recording, while those at Hakea Prison may be explained by its role as the state's leading remand facility for men (Corrective Services NSW, 2016; OICS, 2015).

Key findings

No clear definition of use of force

The Department's new policy streamlines requirements and clearly distinguishes between use of force and use of restraint. However, the policy does not adequately define use of force and this lack of clarity translates to confusion among staff on the ground. This has been compounded by the policy's introduction of 'routine restraint'. This has led to some practices being inappropriately recorded and consequently being missed by accountability measures.

Data analysis is hindered by poor record keeping practices, but improvements are emerging

Incidences of force are difficult to analyse due to poor record keeping practices and a clumsy database that perpetuated those poor practices.

The Department has taken important steps to address these issues. Recent changes to the database have improved how information is collected for use of force and use of restraints. The changes have also reduced the opportunity for collusion as identified by the Western Australian Corruption and Crime Commission (CCC, 2018a; CCC, 2018b). Our Office will continue to monitor the impact of these changes.

Force is used more often on vulnerable people

Some vulnerable groups of prisoners were frequently subject to use of force. Aboriginal prisoners, remand prisoners, and prisoners with cognitive impairments were disproportionately involved in use of force incidences. Conversely, female prisoners were less likely to be involved, although this did not extend to Aboriginal women who were also overrepresented.

Force was also often used to manage vulnerable prisoners in crisis who had made threats to self-harm or had self-harmed.

Internal oversight is structurally sound but not yet effective

The Department has five levels of internal oversight designed to objectively evaluate use of force incidents. Each of these levels are demonstrating varying degrees of effectiveness. While there are sound structures in place, the slow establishment of review committees, governance issues, and substandard CCTV have contributed to the ineffectiveness of the oversight structure.

Conclusion

The necessity to use force is not uncommon in Western Australian prisons and, therefore, it is critical for prison staff to know what it is and when it can be lawfully used. A new use of force policy, introduced in May 2020, clarifies some elements of confusion that previously existed. But it appears that the changes are yet to be fully understood and implemented by staff and that continuation of historical practice may be contributing to ongoing confusion. This points to a need for additional training to ensure the that the practices and processes required by the new policy become embedded in day to day operations.

The Department has established a sound internal oversight mechanism. This should help build better practice through post-incident review and learning. But the risks regarding the use of force are such that internal oversight should not be limited to reactive review. An ongoing process of operational review that looks at the tactics, techniques, and equipment being used, is needed to build public confidence, and ensure contemporary best practice is followed.

The purpose of independent review should not be a means of simply identifying abuse or excess, its primary purpose should be the objective review of incidents to identify and implement good practice and opportunities for improvement.

Recommendations

1 Unclear policy and reporting practices do not allow for force to be controlled effectively

Prison officers are, in certain circumstances, authorised by law to use force against people in custody. This is both a significant responsibility and risk. Prisons are closed environments and therefore, accountability and transparency are crucial to ensure the treatment of prisoners aligns with agreed standards and community expectations. Clear policies about practices and the reporting of use of force incidents are necessary to ensure that force is used lawfully and reasonably.

The *Prisons Act 1981* (the Act) outlines various circumstances when force may be lawfully used in Western Australian prisons. It authorises custodial staff to use reasonable force for: the preservation of the prison's good government, good order, and security; to ensure compliance with lawful orders; to search prisoners and visitors; and for other defined purposes. These powers are found in various parts of the Act.

1.1 There is no clear policy definition of use of force

The Department's current policy governing use of force came into effect in May 2020 (DoJ, 2020a). The policy does not contain a definition of 'use of force' but does require specific actions to be taken when force is used, including incident reporting requirements and oversight of those reports. These controls are necessary to ensure that use of force is both lawful and reasonable, and that lessons can be learned, and practices improved. The absence of a definition introduces an element of subjectivity in determining what is a use of force.

It is critical then that the policy provides a clear definition of what 'use of force' means so when force is used, it is recognised, reported, and reviewed.

Given the absence of a clear definition, there appears to be some confusion for staff resulting in some use of force incidents not being reported or adequately reviewed. In contrast, the previous policy defined 'use of force' as any situation where force was used with only two exceptions; escorts and management regimes. This policy, and therefore the definition, were in place for almost two decades. However, many staff including senior managers we spoke to during our review were unable to comprehensively and consistently define 'use of force'.

1.2 Some policy requirements are not being followed

Despite various requirements being present in both the current and former use of force policy, some were not adhered to, such as policy mandated registers. Current and former policies require the Superintendent of each prison to maintain a register detailing the circumstances of spit hood application (DoJ, 2020a; DCS, 2017a; DCS, 2012). Relevantly, the new policy (COPP 11.3 section 6.3.3, procedure 9) states 'maintain a register detailing the circumstances when a spit hood is used' (DoJ, 2020a). And the former policy required the Superintendent to keep a register of restraint bed use although the new policy does not. Despite the requirements, the registers were not consistently maintained between 2016 and 2020.

This meant that we could not accurately confirm the use of spit hoods or restraint beds and it also reduced our confidence that other aspects of the policy have been complied with.

> Roebourne Regional Prison advised us it had not used a spit hood since 2016. Yet in 2018, an incident report shows that a prisoner assaulted and spat at an officer. He was handcuffed and a spit hood was applied for four minutes.

The improper use and risks of spit hoods made global headlines in 2016 when footage emerged of a young person in the Northern Territory strapped to a restraints chair wearing a spit hood. In response, spit hoods were removed from use in Western Australia's youth detention centre. However, we found that, prior to their removal, there had been good governance processes around the use of spit hoods (OICS, 2017). In our analysis of the adult custodial estate, we found makeshift spit hoods being applied, including t-shirts and blankets, even though spit hoods are a restraint tool available. Good governance, such as a usage register, must be maintained. And while duplicating records may be cumbersome, their existence goes to ensuring transparency, accuracy in record keeping, and community confidence in the accountability of the corrections system.

1.3 The Department's introduction of 'routine restraint' creates confusion

The new policy clearly distinguishes between use of force and use of restraint. This is a significant change from the former policy and the distinction better reflects legislation.

Under s42(1) of the Act, subject to authorisation by the Superintendent, restraints can be applied:

- to prevent a prisoner injuring themselves or others
- upon advice from a medical officer or on medical grounds
- to prevent escape during prisoner movement outside the prison.

The Act also contains several provisions that permit the use of force in various circumstances. It is reasonable to assume that the intent was for there to be a difference between use of restraint and use of force. The former appears to be a response to risk while the latter appears to be a response to an incident.

The policy outlines these uses and the different requirements for the use of restraint. However, it also operationalises 'routine' and 'non-routine' restraint use. Routine restraint is permitted when:

1. moving a prisoner to or from another prison or during their temporary absence from a prison
2. as part of a prisoner management regime
3. in specified circumstances (set out in the prison standing order), where the Superintendent deems restraints necessary to prevent the prisoner injuring themselves, or others.

It is unclear where the authority to apply restraint 'as part of a prisoner management regime' is found, although the Department informed us that they had developed the policy based on the advice they had at the time.

Under the policy, any restraint use outside the above prescribed circumstances is considered 'non-routine' and constitutes a use of force (and therefore should be reported as such). According to the policy, routine restraints do not need to be recorded. This is where the potential for confusion arises for officers in determining what does and does not need to be recorded and reported.

Including routine restraint use within the policy is a positive move that allows for prior assessment of whether the restraint is necessary. But this relies on a good understanding of what is and is not considered a routine restraint. Despite the guidance, we found ourselves confused. And we were unsurprised that prison officers' understanding was muddied, and grey areas were leading to confusing reporting practices. This was particularly the case when applying restraints post-incident when a prisoner became compliant but required transfer to a management unit.

In clarifying whether this example was a routine use of restraint or a use of force, the Department advised us:

> This type of scenario would likely be considered a use of restraint. This is in accordance with [the policy] which aligns with section 42(1) of the *Prisons Act 1981* which details the circumstances where restraints should be used on prisoners which are: a) prevent injury; b) medical grounds; and c) prevent escape. It should be noted however that the management of all incidents is entirely dependent on the circumstances of that incident, so it is not possible to state with full certainty how the use of restraints would be classified in specific incidents, from a scenario as above without full details.

This response highlights the difficulty staff have consistently implementing the policy. There is no clear distinction between the use of a restraint where there are reporting requirements and a use of routine restraint where no reporting is required.

We are not attempting to dictate when restraints should be used. Rather we are concerned that there are several points in this scenario where officers could make different assumptions about whether restraints or subsequent reporting are necessary.

The policy requires force to be no more than is necessary to control the situation, and to cease when the level of perceived threat has been managed (DoJ, 2020a). Therefore, one interpretation is that if a prisoner is compliant following an incident, restraint is not required and ought to be removed. While it appears that the intention of the policy is to prevent excessive or prolonged use of force, there should not be any ambiguity.

Our office examined 336 reviews of use of force incidences that were conducted by prisons between 2016 and 2020. This included 67 reviews of incidences that occurred post the implementation of the new policy in May 2020. The 336 reviews looked at 272 separate incidents, involving 262 distinct prisoners. We identified numerous examples where officers were confused if an incident was considered a routine use of restraint or a use of force. Sometimes this occurred within the same incident. This means depending on individual interpretation of the policy, restraints can be underreported, overreported, or overused. At a minimum, the records have become inconsistent and the system lacks much needed transparency.

Recommendation 1 – Clarify the use of force and restraints policy to remove doubt and ensure accurate and reliable reporting

1.4 Data analysis is hindered by inaccurate record keeping practices

When an officer enters an incident description on the database, they are required to select which restraints have been used and what type of incident occurred. This results in at least three different types of data being captured:

- incident tags
- restraint tags
- incident report – free text.

We found little evidence these align. Key information is often only kept in free text which becomes 'dead data' that cannot be easily used for data extraction and analysis. This is particularly relevant as the level of force used in an incident indicates how much internal oversight the incident receives. The more accurate the data collection is, the more streamlined and effective the oversight system can be.

Physical force or restraint is frequent but rarely recorded

We found very few occasions where prisoners were recorded as having physical force used on them (20 times between 2016 and 2020). Yet, we found 269 of 336 incidences we examined involved physical force (80%). Only three of those accurately recorded the physical restraint, equating to less than one per cent accuracy (0.9%). By comparison, we also examined one week of incidents in June 2020 finding nine occasions of physical restraint, all inaccurately recorded.

Table 4: Physical restraint use, by year (2016–2020), compared to week 1 June 2020

Use of force option (Location)	2016	2017	2018	2019	2020	W1 June 2020
Physical restraint	2		2	8	8	9
Acacia Prison					1	
Albany Regional Prison				2	2	1
Bandyup Prison					2	1
Casuarina Prison						3
Hakea Prison	2			1	3	3
Melaleuca Remand and Reintegration Facility			2	5		
West Kimberly Regional Prison						1

The policy states that any physical force used to reduce a threat and/or gain control is a use of force (DoJ, 2020a). We read hundreds of incident reports where staff described grabbing prisoners, lowering prisoners to the ground, or holding prisoners against walls. These were not classified as a physical restraint. When we queried the considerable underreporting, we were advised that 'physical restraint' has only recently become an option for staff to select when documenting an incident. This is not consistent with the data as two of the 20 occasions were from 2016.

Firearms, tasers, and batons are rarely used, but are also poorly recorded

Firearms, with both lethal and non-lethal munitions, are the highest level of force intervention available for use in Western Australian prisons. In the last five years we found four incidents of firearm use. Once in 2018 at Albany Regional Prison and three times in 2020 (once each at Casuarina Prison, Hakea Prison, and again at Albany). The records of firearm use were only identified by manual trawling using

incident tags as a guide because they were not accurately recorded in the restraint data. This is not an accurate way to extract data, and therefore we cannot be sure we have identified all incidents.

Similarly, we found that conducted energy weapons (CEW), such as Tasers, and batons were poorly recorded. CEWs have only been used four times in the last five years with just two of these correctly recorded in the incident tags, restraint data, and free text.

Only three incidents of baton use were recorded (via incident tags) while another five occasions were identified while we were examining other use of force options. For this reason, these figures can only be considered a baseline. This is unacceptable, particularly as the current departmental policy states that the use of a baton is at the upper end of the use of force options (DoJ, 2020a). Baton use carries a high risk of injury so they are not to be used when lesser force options can resolve the incident. Furthermore, baton use not only includes striking, but also drawing of the implement (DoJ, 2020a).

Inaccurate reporting of incidents risks a lack of accountability because if they are not accurately recorded, they may not be subject to the internal oversight process.

A show of force is not easily identifiable or analysed

The very nature of a 'use' of force means departmental record keeping is based on when force is applied. A 'show of force', especially for higher-end tactical equipment can be wielded as a warning of potential action to elicit a deterrent response, without actual usage. This equipment can include CEWs and chemical agent (more commonly known as capsicum or pepper spray). The Department's draw and discharge policy is provided in Appendix C. It clearly states drawing an OC spray (chemical agent) or CEW is 'not considered a use of force' (DoJ, 2020a). Only when the chemical agent or CEW is discharged is this recorded as a use of force in the database and only then is it useful for analysis and tracking.

The Department's response noted that a 'show of force' is reviewable by its internal oversight mechanisms; its use of force committees. However, if 'draw only' instances are not recorded as incident tags or restraint data within the database, then how can the Department be certain all instances are reviewed. This includes instances of best practice that can provide learning opportunities for staff.

1.5 Reporting is improving

Changes to the offender database have improved incident reporting

Changes to the Department's database have reduced the opportunity for collusion. Previously, prison officers could view other officers' incident reports and could copy and paste sections or all of another officer's report into their own. This presented obvious risks relating to allegations of collusion and reduced the independence of officers' reports (CCC, 2018a; CCC, 2018b). In mid-2020, the Department amended the database preventing officers viewing other incident reports until the incident was finalised.

Further improvements were made on 1 October 2020 when the Department incorporated a 'wizard' into incident reporting. Previously, classifying an incident as a use of force using and cataloguing all the types of force used, was subjective. We found officers often only reported the most serious use of force. For example, if a person was sprayed with chemical agent and then put into handcuffs, only the chemical agent would be recorded.

The new 'wizard' removes this subjectivity by asking officers a series of questions to auto-classify incidents. Officers must enter the details, including the type of force or restraints used. Officers cannot bypass these questions. This allows the system to determine the type of incident, and correctly apply analytical information.

The rate of chemical agent use has increased

Chemical agent usage has increased over the last five years. There was a considerable rise in 2019, which continued in 2020. It was primarily used at Casuarina and Hakea prisons and Albany Regional Prison. However, it is not just the frequency of chemical agent use which has increased. The rate of use per 100 prisoners rose sharply in 2019 and again in 2020.

Table 5: Combined recorded use of chemical agent, and rate of use per 100 prisoners (2016–2020)

Use of force option (Location)	2016	2017	2018	2019	2020
Chemical agent	51	44	56	70	96
Acacia Prison	1		3	5	1
Albany Regional Prison	7	9	11	12	3
Bandyup Women's Prison	6			1	5
Bunbury Regional Prison	1				
Casuarina Prison	7	11	9	26	26
Eastern Goldfields Regional Prison	1	3	2	1	
Greenough Regional Prison	1		1		
Hakea Prison	27	21	25	22	47
Roebourne Regional Prison			5	2	11
West Kimberley Regional Prison				1	3
Rate of chemical agent use per 100 prisoners	0.83	0.66	0.81	1.01	1.41
Daily average population	6,181	6,674	6,873	6,910	6,820

These increases are, in part, explained by better reporting. We confirmed this by comparing the different types of data. This showed increased use of chemical agent, but also indicated increasing accuracy in reporting. The yearly totals show that correct recording improved considerably in 2019; up to 67 per cent accurate from less than nine per cent accuracy in 2018. However, this accuracy rate dropped considerably in 2020 to 20 per cent. Some of this was due to multiple large-scale incidents, in which many prisoners were collectively sprayed with chemical agent. Yet, overall, we see improvement. Further gains are required, particularly as the Department has no way to capture incidents where neither a restraint or incident tag is used. But the improvements indicate the departmental focus on data integrity (DoJ, 2017b) is beginning to succeed.

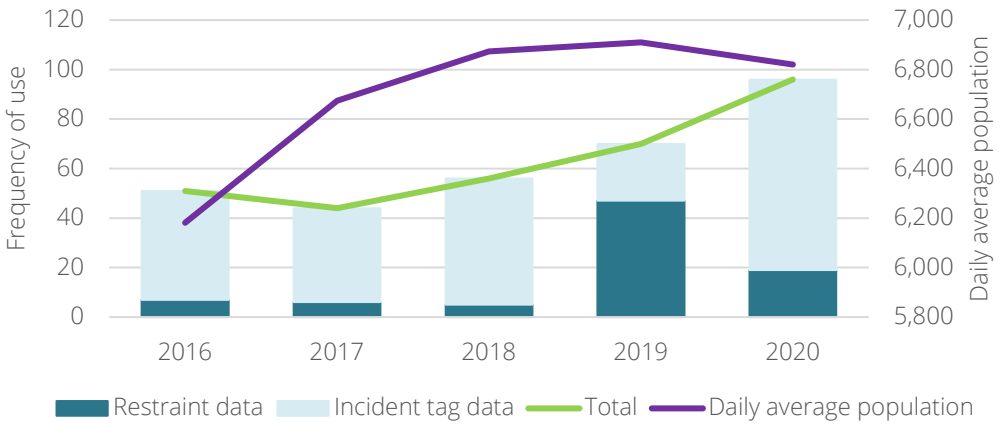

Figure 1: Combined recorded use of chemical agent (2016–2020)

Access to chemical agent by prison officers has increased. Hakea Prison previously only permitted access to two staff per accommodation unit. This increased to four, and now every officer is permitted to wear chemical agent on their belt if they choose. A similar change in access occurred at Albany Regional Prison.

At some prisons, chemical agent is more readily accessible to general duty prison officers now than previously. This may also explain the increased usage and it is likely linked to staff perception of effectiveness. Throughout this review, many staff told us that chemical agent was the most effective method of rapidly incapacitating a person with the least chance of physical injury to staff and others. There may be some merit in this argument as physical intervention can result in injuries such as bruises, cuts and abrasions, and soft tissue damage. However, this does not acknowledge the real risks associated with using chemical agent. Common side effects for prisoners and staff who are inadvertently exposed include:

- swelling of the mucous membranes in the eyes, nose and throat causing irritation and burning sensations
- nasal and sinus discharge
- coughing
- shortness of breath
- hyperventilation
- psychological effects like fear, anxiety, and panic (Yeung & Tang, 2015).

Policy states that chemical agent should not be authorised for use against any prisoner who has or is suspected of having a heart or respiratory problem, or is pregnant, unless it is impracticable not to do so (DoJ, 2020a). This may be unrealistic in practice. Prisoner medical information is subject to confidentiality, and staff are not always equipped with sufficient information to ensure compliance.

The use of spit hoods has increased

Spit hoods, face shields and/or protective spit masks were used 60 times between 2016 and 2020[1]. Like chemical agent use, there was a sharp increase seen in recent years.

Table 6: Spit hood, face shield, and protective spit mask usage, by prison (2016–2020)

Facility	2016	2017	2018	2019	2020
Albany Regional Prison				2	
Bandyup Women's Prison	1		1	3	1
Bunbury Regional Prison				1	1
Casuarina Prison		1		4	9
Eastern Goldfields Regional Prison		2			
Greenough Regional Prison			1	1	1
Hakea Prison	4	2	4	10	9
Roebourne Regional Prison			1		
Total	5	5	7	21	22

There was no corresponding change in practice, policy, or an event that provides an explanation for the increase in 2019. It is also unclear whether this reflects an increase in use or simply an improvement in reporting. Spit hoods can cause serious injury or death (DoJ, 2020b). As such, the policy requires staff to carefully consider the necessity of use prior to application and constant supervision once a spit hood has been put on. Each use, and the reason the equipment was needed, should be recorded.

The COVID-19 pandemic may have impacted on the use of spit hoods in 2020.

1 In its response to the report, the Department agreed that a spit hood, face shield or protective spit mask was used 43 times (a total of 38 distinct prisoners) between January 2019 and 31 December 2020. The Department also stated 'Of the 38 prisoners, 97% had behavioural issues (including mental health issues, mental disability, history of self- harm or history of violence)'.

2 Force is used more on vulnerable people

Some prisoner cohorts, particularly those who were more vulnerable or minorities, were more likely to be involved in use of force incidents. This included prisoners with cognitive impairments, prisoners who self-harm, Aboriginal prisoners, and people on remand[2]. In contrast, female prisoners were less likely to be involved in use of force incidents.

2.1 Almost a third of prisoners involved in use of force incidences had a cognitive impairment

Prisoners with cognitive impairments face additional challenges while in custody. They may struggle to understand and comply with instructions. If officers are not aware of their challenges, behavioural issues may be interpreted as disrespect, 'acting out,' or deliberate non-compliance. This can be compounded by comorbid conditions such as mental illness and substance misuse.

A female prisoner in custody between 2019–2020 was involved in 15 use of force incidents. She has a severe intellectual disability and is a DSU client. She is under a guardianship order and is the recipient of support from the National Disability Insurance Scheme. The offender database states she is unlikely to live independently without support and she has a significant history of self-harm and suicide attempts. Her incidents were related to the management or prevention of self-harm attempts (8 incidents) and non-compliance (7 incidents). Staff were assaulted in half the incidents, with the woman spitting and scratching officers.

During this review, we found 30 per cent of prisoners involved in use of force incidents were marked with a Disability Services Unit (DSU) alert and 22 per cent of those were involved in two or more incidents.

Health professionals from the DSU identify prisoners who have a cognitive impairment through intake information, psychological reports, and staff referrals. The DSU does not employ its own screening tools, nor undertake psychological assessments, and alerts are only added if there is evidence of a verified cognitive impairment. This means that the number of prisoners with a DSU alert is likely to be an underrepresentation of people in custody with a cognitive impairment. In 2019, 7.5 per cent of the prison population had a DSU alert. However, estimates indicate that up to 15 per cent of prisoners have an intellectual disability, generally characterised as an IQ score of under 70 (AIC, 2017).

Once a prisoner is identified as having a cognitive impairment, the DSU adds an alert to the database stating the prisoner's disability and strategies to manage their behaviour. While DSU alerts are visible to all staff, they can only be added by DSU staff.

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2 In its response, the Department stated 'There are a large number of vulnerable prisoners in the custodial estate. As at 8 April 2021, there were 33% of prisoners with active alerts from the 'behavioural issues'. A significant number are those with cognitive impairment and mental health issues. In the review of '*Prisoner access to secure mental health treatment*' undertaken by OICS in 2018 (page iv), OICS has acknowledged that half the prisoner population in WA have some form of mental health disorder and there are some prisoners who are so unwell that they need to be in a forensic mental health facility, not a prison. Prisoners with serious psychiatric conditions often have behavioural issues and difficulty regulating behaviour. In these circumstances, attempts at de-escalating behaviour and/or reasoning may prove ineffective and use of force is often required for the prisoner's own safety and for the safety of others,'

There has been a steady increase in the number of prisoners in custody with a DSU alert.

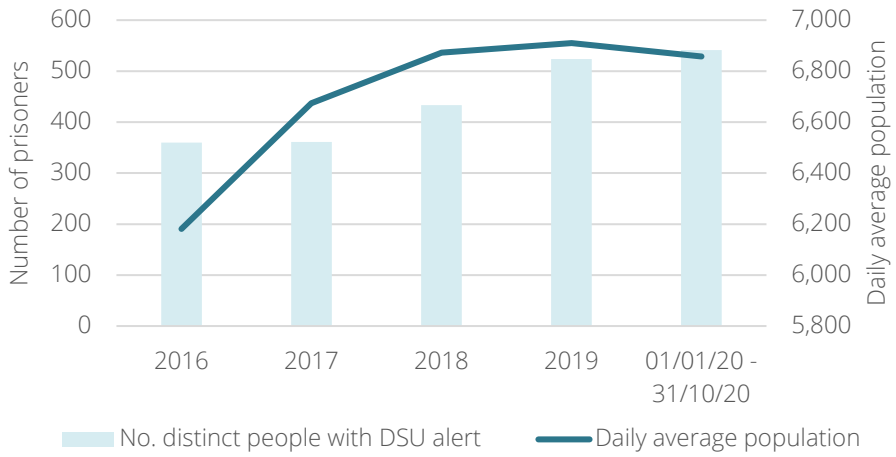

Figure 2: Number of prisoners with DSU alerts compared to daily average population (2016-Oct 2019) (Source: Department of Justice)

Officers are required to manage an increasing number of complex prisoners despite having limited training and expertise to do so. This is likely contributing to the overrepresentation of people with cognitive impairments in use of force incidents.

2.2 Force was often used to manage threats of and actual self-harm

We identified limited de-escalation in circumstances where force was used on prisoners who were self-harming or threatening self-harm. In many incidents, force was used almost immediately, including high level force, such as chemical agent spray.

Prison staff have limited options for managing people who self-harm or make threats of self-harm, incident response often amounts to the removal of the tools of self-harm. Options that are available are often short-term solutions and, in some circumstances, may worsen the person's mental health. For example, following an incident of self-harm, or an attempt at self-harm, prisoners are often moved to an observation cell and on occasions placed in rip-proof clothing made of canvass.

There will be occasions when a rip-proof gown may be necessary. However, we identified several times it was used without apparent need. On some occasions, the gown was issued when the person's mode of self-harm would not be affected by using a gown, for example banging their head against the wall or biting themselves.

On other occasions when a gown was issued, prisoners would spend a brief time in crisis care observation (which was usually accompanied by a mandatory strip search and monitoring through the prison's at-risk management processes) before returning to mainstream. Rip-proof gowns are used to prevent prisoners engaging in self-harm and suicidal behaviour. If their mental health deteriorates such that they require a rip-proof gown, then logically they need a professional mental health assessment. This is not clear within the current policy.

Recommendation 2 – Change policy so prisoners placed in a rip proof gown are only returned to mainstream following an assessment by a mental health professional

The limited options for dealing with prisoners with mental health issues are also highlighted by the use of restraint beds. Restraint beds are a mattress and bedframe that permit a prisoner's arms and legs to be secured. They are an instrument of last resort and are only to be used in 'extreme circumstances' for prisoners 'at extreme risk of immediate and/or ongoing self-harm behaviour' (DoJ, 2020a). Its use requires the approval of the Superintendent. It is not an option for the management of a prisoner's behaviour.

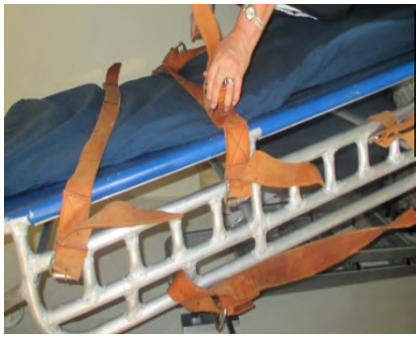

Image 1: Restraint bed

Owing to its purpose, and that most prisons in the state are not equipped with restraint beds, use is minimal. They have only been used 13 times in the last five years.

Table 7: Restraint bed usage, by prison (2016–2020)

Facility	2016	2017	2018	2019	2020
Bandyup Women's Prison	3				
Casuarina Prison	1	3		3	
Eastern Goldfields Regional Prison		1			
Hakea Prison	1	1			
Total	5	5	0	3	0

The policy appropriately notes the negative effects placement on a restraint bed can have on prisoners. This includes increasing the risk of self-harm behaviours that a restraint bed is expressly trying to prevent (DoJ, 2020a). The policy also requires prisoners who have been placed on the restraint bed to be managed according to the Department's At Risk Management System manual. This is because placing a prisoner, especially one in an acute mental health crisis, in isolation, without appropriate mental health intervention, can increase their risk.

The use of a restraint bed requires a 'balance between security, safety, and decent and humane treatment' (DoJ, 2020a). The policy and procedures provide good governance ensuring the prisoner is always monitored by physical presence or via CCTV. And that physical checks of the harness are made and recorded every 15 minutes.

Self-harm incidents are placing pressure on staff

Force was often used by officers to stop prisoners from engaging in self-harm. Of the 336 local reviews we examined, 44 incidents involved a prisoner threatening or attempting self-harm. Of these incidents, 20 per cent involved the same distinct prisoners.

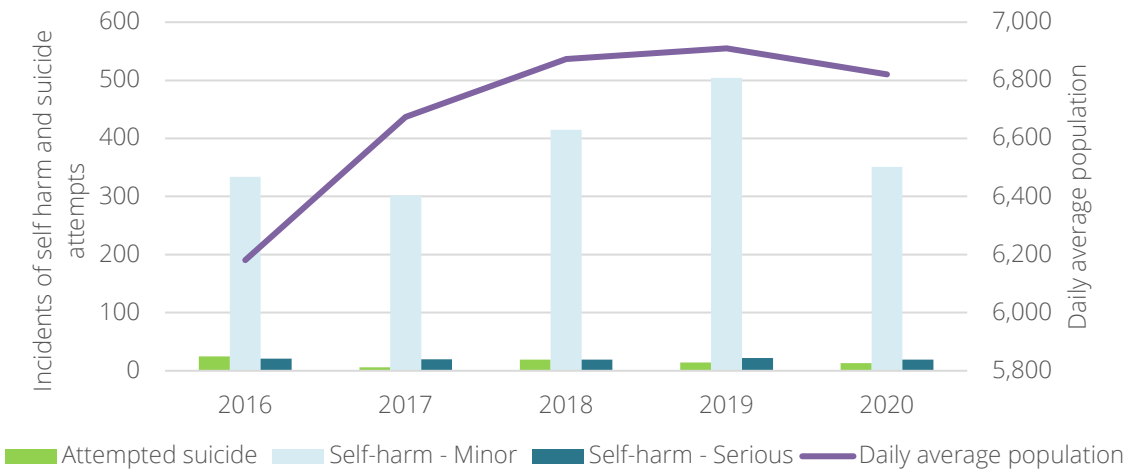

Figure 3: Incidents of self-harm and suicide attempts across all adult custodial facilities (2016-2020)

There has been an increase in minor self-harm incidents between 2016 and 2019, however these incidents saw a downward trend in 2020. Officers remain the primary responders to mental health crises of prisoners even though some staff may have a poor understanding of, or lack of training in, how to deal with mental health issues. In our 2018 review into access to mental health treatment (OICS, 2018a), we found that staff largely have high tolerance for prisoners with mental health concerns, but this was not universal. Mandatory online training on mental health awareness is provided, but this provides a broad overview of mental health issues and not necessarily the tools to manage severe mental health needs or a self-harm incident.

A lack of understanding was evident in our review of several incidents where officers attempted to 'counsel' prisoners about self-harming behaviours. While this was framed as talking to prisoners, it appeared to be simply reprimanding them. On one occasion a prisoner being managed for mental health concerns, was spoken to by an officer 'in regards to him self-harming'. He was informed his 'attitude and behaviour [were] unacceptable'. This escalated to a staff assault and use of force.

The reliance on officers to immediately respond to mental health issues is probably understandable given their proximity. In most, if not all prisons, mental health professionals are isolated from the units. This often means a delay between when prisoners need acute mental health support and when they receive it. Depending on the time of the day or the day of the week, this support could be delayed by hours or days following an incident. Establishing trained mental health first aid responder teams to attend mental health related incidents could address this delay. A team of clinical staff, supported by specially trained officers, could support prisoners during and immediately after a self-harm threat or need. Extending this team beyond business hours would also address the known problem of having few, if any, health or mental staff on site after hours.

Recommendation 3 – Investigate the use of trained mental health first responders

There were 4,767 distinct prisoners involved in use of force and use of restraints incidents since 2016, with just under half 2,225 (47%) recorded in two or more incidences. Twenty prisoners were involved in 20 or more incidences over the five-year period. Of those 20, 70 per cent (14) had alerts for self-harm.

Table 8: Number and frequency of prisoners involved in use of force occasions (2016–2020)

Number of incidences of force	Number of prisoners involved	Number of incidences of force
Once	2,542	2,542
2-9 times	2,098	7,000
10-19 times	107	1,339
20-29 times	15	340
30-39 times	2	61
40-49 times	1	43
50-59 times	1	50
60+ times	1	65
Total	4,767	11,440

2.3 Force is used more often on Aboriginal prisoners

On average 39 per cent of the prison population in Western Australia is Aboriginal, however more than half of all use of force incidences involved Aboriginal prisoners (55%).

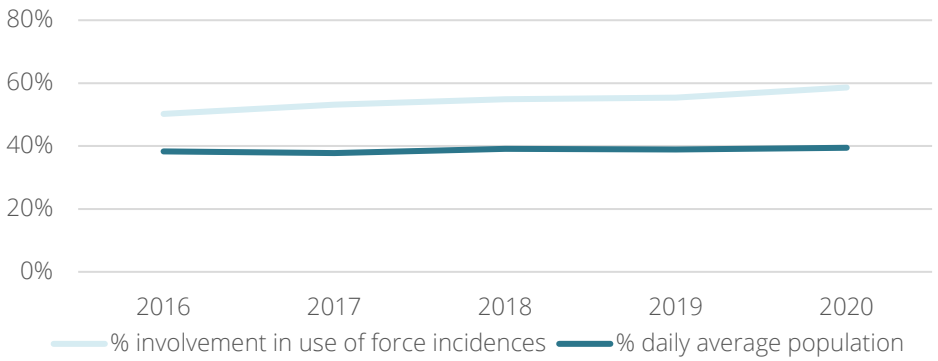

Figure 4: Proportion of Aboriginal prisoners involved in use of force incidences (2016–2020)

The overrepresentation is apparent at almost every prison in Western Australia, with Broome Regional Prison, Pardelup Prison Farm, and Melaleuca Women's Prison/Melaleuca Remand and Reintegration Facility as exceptions.

Table 9: Proportion of population that is Aboriginal compared to incidents where force was used (2016–2020)

Facility	Proportion of population that is Aboriginal (%)	Aboriginal prisoners - use of force (%)	Percentage point difference
Acacia Prison	33.6	52.9	19
Albany Regional Prison	43.2	62.2	19
Bandyup Women's Prison	45	68.3	23
Broome Regional Prison	85.5	80.8	-5
Bunbury Regional Prison	22.9	41.6	19
Casuarina Prison	35.6	51.8	16
Eastern Goldfields Regional Prison	69.9	80.2	10
Greenough Regional Prison	71.7	79.9	8
Hakea Prison	36.2	47.1	11
Karnet Prison Farm	12.5	27.5	15
Melaleuca Women's Prison/Melaleuca Remand and Reintegration Facility	50.2	48.65	-2
Pardelup Prison Farm	10.2	0	-10
Roebourne Regional Prison	83.8	90.1	6
West Kimberley Regional Prison	89.5	94	5
Wooroloo Prison Farm	13.3	23	10

As noted previously, until October 2020 the Department's database could not accurately differentiate between the circumstances in which use of force incidences occurred (whether it was use of force or use of restraint). Consequently, the Department maintained during our review that, given the uncertainty with the data, it could not accurately be used to ascertain that Aboriginal prisoners were overrepresented in use of force incidences because this included post incident restraint use and routine restraint use. However, if we removed handcuff use from our analysis, the data still demonstrated that Aboriginal prisoners were overrepresented in use of force incidences (51%).

Table 10 Comparison of total incidences of force and those not including handcuffs, by Aboriginality (2016–2020)

	Number involving Aboriginal prisoners (%)	Number involving non-Aboriginal prisoners (%)	Total
All incidences of force	6,247 (55%)	5,193 (45%)	11,440
Incidences of force excluding handcuff use	230 (51%)	217 (49%)	447

2.4 Force is used more often on remand prisoners

Remand prisoners were also overrepresented in use of force incidences compared to their proportion of the daily average population. People on remand make up approximately 28 per cent of the total prisoner population. Yet for the last five years, remand prisoners were involved in 41 per cent of all use of force incidences. The overrepresentation appears to support research indicating people on remand are likely to be more volatile than their sentenced counterparts (Corrective Services NSW, 2016; OICS, 2015). For many people, being placed on remand is an unsettling and stressful time. It can sometimes result in unpredictable behaviours, particularly for people newly received into custody and those withdrawing from drugs or alcohol. As these behaviours escalate, it is likely force is being used to ensure compliance.

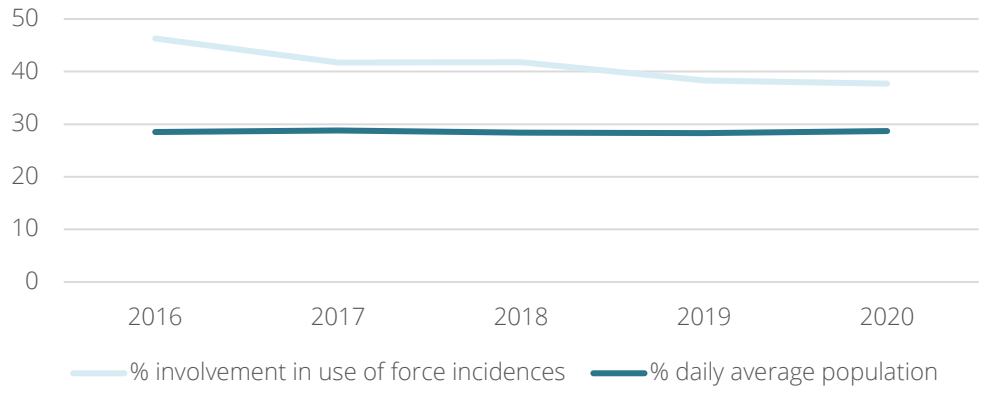

Figure 5: Proportion of remand prisoners involved in use of force incidences (2016–2020)

Although there has been a downward trend in the involvement of remand prisoners in use of force incidents since a high in 2016, it is still disproportionate.

2.5 The Women's Standard may contribute to fewer uses of force against women

Female prisoners' average involvement in use of force incidences in the last five years (8.9%) has been lower than their proportion of the daily average population (10.4%). The yearly breakdown

demonstrates this was not always as favourable with a much higher average of almost 12 per cent occurring in 2016. While overall there has been a drop since that time, it rose again in 2020 (10.3%).

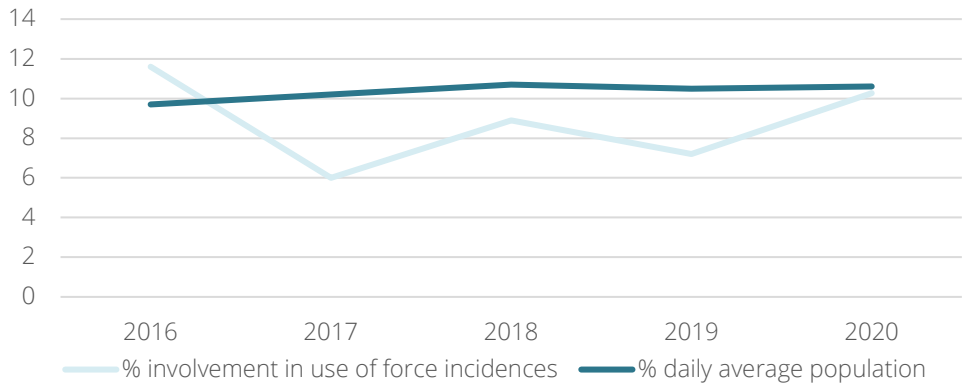

Figure 6: Proportion of female prisoners involved in use of force incidences (2016–2020)

The overall drop may be, in part, explained by the introduction of the Department's Women in Prison, Prisons Standard (DCS, 2016). The standard, like the policy, states that staff responses to incidents should be aimed at de-escalating conflict without resorting to force. But it goes further noting chemical agents and batons should never be used on women. Staff are to deploy trauma-informed de-escalation techniques, based on appropriate training. The training focuses on the different needs of women, particularly pregnant women, women with disability, and women with mental illness.

The underrepresentation of women generally was not replicated for Aboriginal women who were considerably overrepresented compared to their proportion of the population. Since 2016, Aboriginal women have made up between 45 and 47 per cent of the female prisoner population. Yet, they have been involved in upwards of 65 per cent of recorded use of force incidences involving women. Like the trend for Aboriginal prisoners generally, we found no explanation for this during our review.

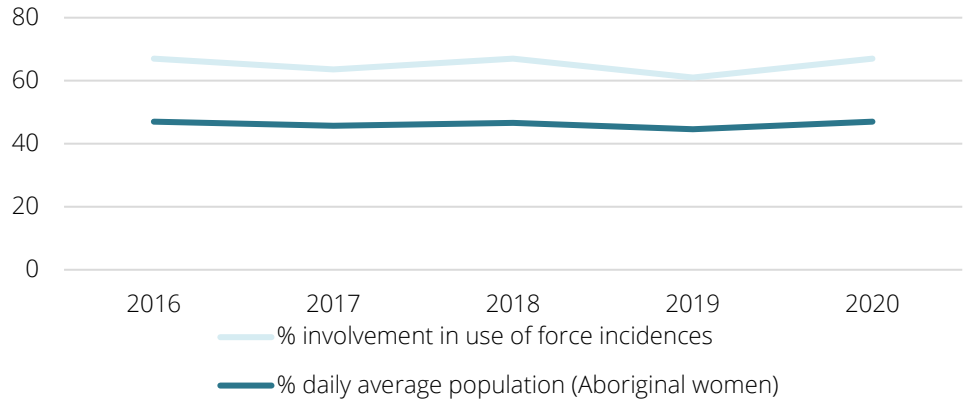

Figure 7: Proportion of female Aboriginal prisoners involved in use of force incidences (2016–2020)

3 Internal oversight is structurally sound but not yet effective

Up to five levels of internal oversight objectively evaluate incidents of force ensuring they are reasonable, lawful, appropriate, and consistent with policy and training. Initially, each incident is reviewed by a Senior or Principal Officer from the prison where the incident occurred. This involves making sure that incident reporting is accurate, thorough, and timely, and includes a quality assurance assessment of the descriptions and data. For example, where an officer reports using handcuffs in text, the quality assurance process should confirm that handcuffs are recorded as a restraint tag.

From that first level, there are additional levels of oversight depending on how an incident is classified. Those deemed the lowest level, where the force used may cause temporary discomfort but does not cause injury, are reviewed by two extra levels of oversight. Incidents where the force used might cause injury greater than temporary pain, or where certain weapons and techniques are used, are reviewed by at least three levels. To determine the level of oversight, each application of force is classified as either level 1, 2 or 3 (see Appendix C).

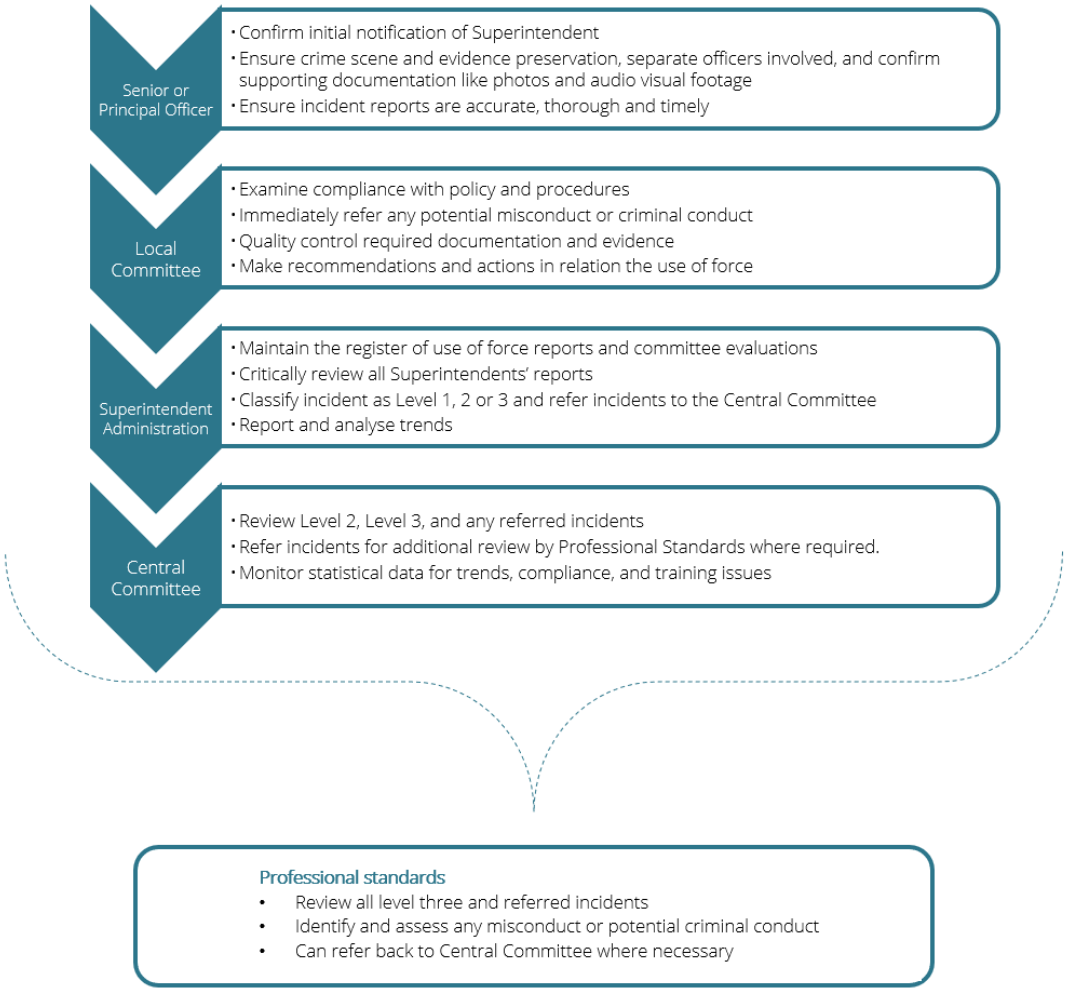

Figure 8: Review agent and responsibilities

After each use of force incident, a local review committee, chaired by the prison's Superintendent, thoroughly examines the incident. The local committee provides a second level check to ensure all

required documentation and associated evidence is accurate and complete. It then makes any recommendations and actions where necessary. The local committee must immediately refer any potential misconduct or criminal conduct to the appropriate authority.

All local committee reports are then reviewed at head office by the Superintendent Administration who maintains a register of all use of force reports and committee evaluations. The role critically reviews all local reports and classifies them to determine if they will be referred to the central committee for further review (it is not mandatory for level 1 reports to be referred on, but they can be where deemed necessary). The role also has a responsibility to report and analyse trends.

The central committee reviews all level 2 and 3 use of force incidents and any that have been directly referred from the prison. The central committee is also responsible for monitoring data to identify trends, compliance, or training issues. Where necessary, the central committee can refer an incident for additional assessment by Professional Standards. Similarly, if any of the local committees have concerns about staff conduct, they can refer the matter to Professional Standards. Where this occurs prior to any of the lower level reviews, Professional Standards can refer an incident back to the central committee for further learnings. However, Professional Standards are required to review all Level 3 use of force incidents regardless of the referral pathway.

3.1 Local review processes are still developing but are hampered by old technology

Local use of force reviews are expected to occur following every incident involving force. Substantial variation in the maturity and effectiveness of the local committees was apparent to us with some prisons' local committees well established and actively addressing identified issues such as:

- Albany Regional Prison – identifying that the forcible strip search of a prisoner prior to their placement under observation was potentially likely to increase the volatility of a situation
- Bandyup Women's Prison – identified and rectified an issue with prison officers not obtaining a medical assessment after each use of force incident
- Bunbury Regional Prison – implemented a Use of Force training guide, de-escalation techniques, report writing and an overview of the use of force review process.

However, other facilities have been slower to establish these committees and so they remain in their infancy. Despite the Department calling for the creation of local use of force committees in November 2016, many have only been established since 2019. Hakea Prison did not commence consistently reviewing use of force incidents until 2020. This created a significant backlog of incidents to be reviewed given the frequency of force incidences at Hakea (3,513). Additional resources were consequently allocated in early 2020. Eventually, when those resources were increased, the backlog was also able to be addressed. By August 2020, we were advised that only 80 reviews (out of approximately 180) were outstanding, and the prison was up to date with current incidents. At the time of this review, Hakea was seeking to extend resourcing until the backlog was resolved.

Local committee membership also varies with policy proposing multidisciplinary membership where practicable. This is to ensure various perspectives provide a balanced review and assist in identifying areas for improvement. Some local committees are including health services staff, occupational health, safety, and risk representatives, and satellite trainers to meet this need. Others are not.

Reviews focus more on whether force was legal rather than whether it was reasonable or necessary

The quality of local reviews and the ability to identify issues, varied between facilities. Often there was no assessment as to whether force could have been avoided and whether there was enough emphasis placed on de-escalation. Policy states that the local committee reviews should provide independent levels of assurance that:

- actions prior to the actual use of force did not directly contribute to the need to use force
- the use of force was lawful (necessary, reasonable, and proportionate to the circumstances)
- the use of force was performed consistent with policy and training
- correct and appropriate actions were taken afterwards (DoJ, 2020a).

However, the template to review these incidents is largely focused on whether the use of force was legal, rather than whether it was reasonable, necessary, and proportionate in the first place.

We found reviews that delved into the preceding factors provided valuable information and identified learnings which could prevent similar situations in the future. Conversely, those that did not look at preceding factors tended to have similar situations reoccur. At one facility every local review stated that the situation was spontaneous which prevented de-escalation techniques being used. It seems improbable that de-escalation was not possible for every incident, and that the only documented learnings from this prison related to better record keeping.

The response to the practice of forcibly removing a prisoner's clothing shows the variation between facilities. We found two instances at Albany Regional Prison which were examined by local review. On both occasions they found the removal of clothing was premature, despite in one instance officers negotiated with the prisoner for over 20 minutes. It is clear from the local review that the policy of forcefully removing a prisoner's clothes is an extraordinary use of power and should be rarely used.

In contrast, the local review of an incident at Acacia Prison acknowledged that the prisoner's clothing was forcibly removed but did not raise any concerns about the practice being reasonable. The prisoner was in an observation cell because he had self-reported suicidal ideations earlier that day due to a death in the family. He was strip searched as per policy on arrival to the observation cell. Four minutes later, staff smelled cigarette smoke coming from the cell. They entered the cell and asked him to hand over the lighter and comply with a second strip search. He refused. After a six-minute negotiation, staff entered the cell, throwing a blanket over his face to prevent him spitting (Acacia has not approved the use of spit hoods; staff are supposed to put on personal protective equipment to manage the risks associated with spitting). They forcibly cut off his clothing and found a lighter.

The review deemed the action necessary as the prisoner had been 'spoken to by the Officers for an extended period of time exceeding six minutes'. The review stated he was 'issued a rip proof gown due to him being on [the At Risk Management System]'. This was despite the strip search four minutes earlier and no further self-harm risk being identified between the two searches. The forcible removing of clothing occurred on nine further occasions at Acacia.

The current policy acknowledges the potential for the practice of forcibly removing clothing to have a traumatic effect on prisoners. It instructs that force may be only used to perform a search provided:

- the search is delayed while the prisoner is monitored by an officer or CCTV and attempts to de-escalate the situation occur; and
- if the need to remove the person's clothing remains, it is to be conducted as a planned use of force following specific procedures, including seeking authorisation from the Superintendent or Office in Charge.

As a planned use of force, practice should improve as officers must first seek approval and necessarily set out the rationale for the decision. This may result in officers, reconsidering the need to use force and instead persist with de-escalation techniques.

No effective training for quality assurance role

Senior Officers play an integral early role in the quality assurance of incident reports. They are responsible for:

- ensuring all staff who are involved or witness an incident complete an accurate report
- reviewing all incident reports
- writing minutes
- finalising incidents
- providing feedback to officers.

However, Senior Officer training is not mandatory, leaving many to simply learn on the job from other Senior Officers. This is difficult if new Senior Officers are learning from others who have not been trained themselves. Therefore, despite taking on the additional quality assurance function, Senior Officers are left to their own prior training and knowledge to fulfil this role.

Our Office identified several incidents where prison officers did not correctly code information onto the offender database and the Senior Officers did not identify the error or correct it. While the purpose of this review was not to assess the Senior Officer role, these re-occurring errors suggest that on the job learning is not effective.

Recommendation 4 – Provide mandatory training for Senior Officers including for their quality assurance role in incident reporting

Local reviews rely on sub-standard CCTV

Local reviews examine all available evidence when conducting their assessments, including CCTV footage. However, CCTV coverage in many prisons is aging, poor quality, and does not provide audio evidence. This means reviews of use of force incidents cannot always adequately identify whether de-escalation and tactical communication were employed prior to a use of force. Body worn cameras fill an obvious gap providing numerous benefits which increase safety, security, and transparency within the prison system. These benefits include, but are not limited to:

- de-escalating heightened situations

- increasing the transparency and accountability of use of force reporting
- recording evidence from incidents, prisoner interviews, and cell searches
- offering staff protection against allegations of misconduct and complaints
- using footage for training purposes and identifying trends.

Despite these benefits, body worn cameras are not consistently used in Western Australian prisons. Acacia Prison and Melaleuca Remand and Reintegration Facility (as it was known at the time), and the youth detention centre, Banksia Hill, have all introduced these devices in recent years (although Melaleuca has removed them since returning to State Government hands as a publicly run prison). Acacia originally rolled out body worn cameras in 2015 and upgraded their model in 2018 (OICS, 2019a), while Melaleuca introduced them in 2018 (OICS, 2018b). Over the course of this review other prisons, and the Special Operations Group, highlighted the usefulness of body worn cameras and their keenness to implement them.

We have previously recommended introducing body worn cameras, particularly in high-risk maximum-security prisons throughout the state (OICS, 2016; OICS, 2019b). In our most recent inspection of Hakea Prison, the departmental response to this recommendation noted its relevance but stated it was subject to funding (OICS, 2019b). Recently, the Ombudsman of South Australia recommended Correctional Services take steps to implement body worn cameras within all its prisons after the death of an Aboriginal prisoner (Ombudsman SA, 2020). The Coroner also recommended that the South Australian State Government consider allocating funds to enable that implementation. Budgetary constraints should not prevail over the real risks that present when failing to have meaningful footage of an incident, particularly use of force. Nor do they override the other ancillary benefits.

Recommendation 5 – Review the potential for investment in both body worn cameras and high quality CCTV

3.2 The central committee is reasonably effective

Initially poor structure and governance occurred, but it is improving

The Commissioner for Corrective Services is responsible for appointing a central use of force committee. It is governed by documented terms of reference that are regularly reviewed. Despite being established in November 2016, implementing basic governance for the central committee has been slow. Record keeping, including taking attendance and minutes, only started in May 2019. Some representatives told us they were unaware they were members until discussions with us as part of this review.

Recent departmental appointments have seen major improvements in the governance of the central committee. For example:

- all members are required to adequately and appropriately prepare beforehand including reviewing the documentation and audio/visual footage
- the Superintendent Administration Adult Male Prisons and the Director Women's Operations (depending on which prisoner/s are involved) are required to provide a brief snapshot of the incident at the meeting.

While the central committee had previously fallen behind, in October 2020, we were advised that they were up to date with only one incident on the agenda for the next meeting. This had been a goal of the central committee due to the known backlog at Hakea Prison, some of which was expected to make its way to the central committee.

Despite the early governance limitations, the central committee is reasonably effective. It has met 34 times, eight of which were in 2019 when it conducted 25 reviews. Based on their reviews that year, around 14 per cent of all incidents reviewed locally were then reviewed by the central committee. Most made recommendations either back to the prison where the incident occurred, or to divisions within the Department for more systemic application. Nine were referred through to Professional Standards for assessment.

Table 11: Number of Central Committee meetings, incidents reviewed and recommendations (2016–June 2020)

Number	2016–2018	2019	Jan-Jun 2020
Meetings conducted	16	8	5
Incidents reviewed	Unknown	25	13
Recommendations made		54	25
To prison		48	17
To departmental division		6	8

There was limited duplication of the recommendations issued to departmental divisions. Although the same recommendation to improve reporting and the reporting structure was made twice to the policy division for incidents at court custody centres.

Recommendations back to the local committees, while still unique to the incident, reflected some consistent themes. There were:

- 32 recommendations for staff training
- 13 recommendations relating to reporting and review of the incident
- 13 recommendation regarding policy and procedure
- 7 recommendations for continuous improvement.

Some prison administrators perceived that there were missed opportunities to learn from the central committee. They advised us that they mostly received feedback about data entry errors, while they expressed a desire for more analysis and feedback about systemic issues.

Process for analysing trends is still developing

The central committee is responsible for monitoring 'statistical data related to use of force incidents, identifying trends, compliance or training issues requiring further examination by the relevant business areas' (DoJ, 2020c). This has yet to happen. However, as of August 2020 resources were being directed to fill this gap by recruiting a security analyst who will be responsible for collating these trend reports. Improvements to incident reporting means less manual manipulation will be required to analyse use of force incidents.

Refresher training is a burden to staffing levels that could be minimised

One of the most common outcomes of a use of force review was a requirement for additional or refresher staff training. Officers must be trained prior to any application of force and they must regularly complete refresher training to maintain their competency. It is a joint responsibility of the officer, the Superintendent, and the Corrective Services Training Academy to ensure training is current (DoJ, 2020a).

Some facilities are very good at ensuring compliance with refresher training, but this is not true for all facilities. The Department provided us the following scorecard:

Table 12: Refresher training compliance scorecard (August 2020)

Location	Cell Extraction (%)	Chemical Agents (%)	Defence and Control (%)	Restraint (%)	Batons (%)	Use of Force theory (%)
Albany Regional Prison	63	80	26	69	71	82
Bandyup Women's Prison	78	86	86	86	81	90
Boronia Pre Release Centre	87	67	80	83	7	93
Broome Regional Prison	95	79	100	81	100	91
Bunbury Regional Prison	85	71	74	82	73	76
Casuarina Prison	85	71	46	67	73	83
Eastern Goldfields Regional Prison	83	74	52	69	64	73
Greenough Regional Prison	63	90	88	94	89	70
Hakea Prison	81	69	50	69	45	45
Karnet Prison Farm	89	70	41	75	55	72
Melaleuca Women's Prison	12	94	14	16	69	17
Pardelup Prison Farm	76	60	4	64	56	68
Roebourne Regional Prison	83	64	54	64	49	60
Wandoo Rehabilitation Prison	88	46	29	44	52	50
West Kimberly Regional Prison	79	94	90	94	92	80
Wooroloo Prison Farm	41	93	59	88	91	96
Average completed training	74.3	75.5	54.8	71.6	66.7	71.6

*excludes Acacia Prison

The difficulty with the approach of standardised training is all facilities and staff have equal training responsibilities, despite the different needs in different facilities. Some facilities do not use higher level force options, such as batons. Therefore, it is understandable that some minimum-security facilities, like Boronia Pre Release Centre and Pardelup Prison Farm, have low levels of compliance in these areas.

Training is critical. But it takes valuable time, effects staffing levels, and may not be an imperative for an experienced officer, particularly if the training is in a technique they perform regularly. Assessment testing, where officers demonstrate their competency in the required skill, could be used instead to reduce the burden. Where competency is demonstrated, the officer would then re-qualify. If they cannot demonstrate the required skill, they would be required to complete the refresher course. This means training can be prioritised to what is needed and who needs it.

Recommendation 6 – Investigate assessment testing in place of mandatory refresher training

3.3 Limited evidence of reviews of tactics, techniques, and equipment

One aspect to the committees' reviewing use of force incidents is to assess the appropriateness of tactics, techniques, and equipment used. However, the Department generally does not regularly review these various options and techniques. We initially asked for any evidence that tactics, techniques, or equipment had been assessed or reviewed, over a five-year time-frame. Unhappy with the response, we expanded the timeframe seeking documentation of any assessment or review ever conducted by the Department. We were provided with eight reviews since 2011.

Five of these were Operational Testing and Evaluation (OTE) reviews which focussed on the testing of use of force equipment to determine if it met operational need. For example, an OTE review into shields in 2019 arose from a supply change issue. We expected to see more reviews, and some that were gap driven, particularly as our analysis of the local and central committee reports found recommendations to review:

- chemical agent usage
- baton use and techniques
- Hoffman knife use to forcibly removal prisoners' clothing.

Of these, our Office was only provided with a copy of a review into chemical agent which was completed prior to the recommendation and looked at the mode of dispensing chemical agent not its usage.

Suggestions regarding new equipment or changes to current practices are to be first forwarded to the Special Operations Group for OTE. Testing outcomes and any recommendations are to be forwarded to the central committee. If endorsed, it is then submitted for backing by the Security and Intelligence Committee, and then finally for approval by the Commissioner of Corrective Services.

While the Department has a sound system in place, we found it was limited in both quality and quantity of output. A properly implemented review process would ensure that lessons learned are adopted on a systemic level and that current practice remains consistent with industry best practice.

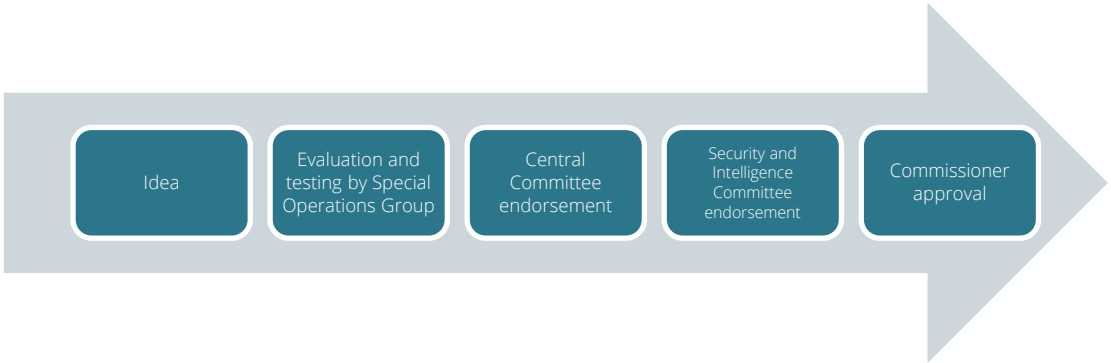

Figure 9: Process to review changes to, or implement new, equipment, tactics, and techniques

Recommendation 7 – Operationally review all use of force and restraint tactics, techniques, and equipment every two years

3.4 Few complaints have been reported about use of force

Since 2016, there have only been eight complaints about use of force received by the Department's ACCESS team which monitors complaints, compliments, and suggestions. Half of these complaints related to prisoners at Hakea Prison. Another two were for prisoners at Casuarina Prison, while one complaint was received for Eastern Goldfields Regional Prison, and Melaleuca Remand and Reintegration Facility (as it was known at the time). All complaints were resolved except one which had insufficient information to progress.

The information we received can only be considered the minimum number as it was provided to us via a search term methodology for the phrases 'use of force', 'excessive', and 'excessive force'. The limited parameters mean a complaint like 'I was restrained long after I was compliant' would not be identified. Given there were 11,440 recorded incidences of force over the same timeframe, it seems unlikely more people did not take issue with their treatment.

There are genuine reasons why few complaints might be received from prisoners or their families about use of force. This includes not having faith in the system generally, believing complaints open individuals up to retribution, and requiring complaints to be in writing which can be daunting. The small numbers may also indicate that prisoners made complaints to external agencies like the Ombudsman or the CCC.

We have commented on the limited usefulness of complaints data in the past (OICS, 2019c). The functionality of the system means extracting, analysing, and using the compiled information is cumbersome manual work. In 2019, we recommended the Department improve the system so it could effectively interrogate its data. This was supported by the Department with an expected completion date of April 2019. However, in calling for this data in July 2020, we were faced with the same issues.

Recommendation 8 – Improve the prisoner complaints management system to provide the ability to effectively interrogate the data

Appendix A The Department's response to draft report

Response overview

Review undertaken by the Office of the Inspector of Custodial Services - 2020-21

Introduction

The Department welcomes all reviews and inspections undertaken by the Office of the Inspector of Custodial Services (OICS) and is open to comments and recommendations that allow the Department and its contractors to initiate improvements and provide a better service to those being cared for by the Department.

The review *Use of force against prisoners in Western Australia* (the 'use of force' review) was announced on 29 May 2020. As per usual process, a wide range of documentation and access to systems, policies, processes, custodial facilities, staff, prisoners and contractors were made available to OICS upon request for the purposes of the review.

On 9 March 2021, the Department received a draft report from OICS for review and comment. The draft report has highlighted key findings and made eight recommendations. The Department has reviewed the draft report and provides comments and responses to the recommendations as below.

Appendix A contains further comments linked to sections in the report for your attention and consideration.

Review Comments

- **Restraints data used to undertake 'use of force' review**

The Review is based on statistical data provided by the Department on the number of 'use of force' incidences in Western Australia (WA) prisons (Table 2 of the draft report). The table shows a total of 11,440 recorded incidences of force used in WA prisons between 2016 and 2020 (five years).

The Department would like to clarify that the figure of 11,440 incidences is a combination of routine and non-routine use of restraints. All use of restraints are authorised by the Superintendent of each prison, however only the non-routine use of restraints constitute a 'use of force' and are to be reported as such. The 11,440 incidences therefore would not all be classified as 'use of force'. The data extracted is from the Corrective Services Reporting Framework 'Reporting Data Mart' which OICS has access to, and represents a single instance of the application of an approved restraint type on a prisoner. A single incident therefore can have multiple counts or incidences of restraints and includes scenarios such as:

- One incident where a prisoner is sprayed with chemical agent, physically restrained and then put in handcuffs to be escorted to a unit/cell – this is recorded as a total of three counts of restraints;
- One incident where three prisoners are put in handcuffs – this is recorded as a total of three counts of restraints;
- A prisoner is escorted or being moved from one area of the prison to another and is handcuffed according to policy – this is recorded as a total of one count of routine restraint (does not constitute a 'use of force').

The total of 11,440 'use of force' incidences in WA prisons between 1 January 2016 and 31 December 2020 includes the scenarios mentioned above. A further analysis of the data shows 96% of the 11,440 restraint occurrences represents restraint type "handcuffs".

Whilst the Department is confident that the figure 11,440 is undoubtedly an inaccurate representation of 'use of force' in WA prisons, the Reporting Data Mart is unable to, at this stage, accurately identify from the 96% occurrences of restraint type 'handcuffs', the number / percentage that would be classified as non-routine occurrences and hence actual 'use of force' incidences. A manual interrogation of the data suggests that 77% of the 96% were from routine escort purposes and not during use of force incidents.

Corrective Services has been aware of the reporting issues, including policy gaps and system shortfalls. Significant changes have been made and continue to progress towards reviewing and revising Departmental policies, including the development of a data capture methodology for 'use of force' with the ability to record and disseminate the data for accurate monitoring and reporting.

- **Related review - '*Routine restraint of people in custody in Western Australia*'**

OICS undertook a review into '*Routine restraint of people in custody in Western Australia*'. The review was announced in February 2019 and concluded in May 2020. The review into '*Use of force against prisoners in Western Australia'* was announced in May 2020, immediately following the completion of the 'routine restraints' review. Reference is being made to the 'routine restraints' review in the context of the 'use of force' review as they are both derived from a review of restraint type data and information and share the same policy platform.

In the final report of the 'routine restraints' review, OICS *accepted that the routine use of restraints is a reasonable and understandable strategy to maintain community safety and the security and good order of prisons*; however did highlight the '*lack of reliable system level data recording instances and frequency of routine restraint use across the prison estate'* and *'elements of ambiguity in existing Department policies and procedures'*. The 'routine restraints' review made three recommendations.

In its response, the Department supported the Inspector's comments that '*good records support good decision-making, effective business practice, and improve accountability and efficiency'*. The Department advised of a Departmental review of relevant policies as part of the Custodial Operational Policy and Procedures Project (COPP) being undertaken. The revised policy, COPP 11.3 – Use of Force and Restraints, had been approved for implementation in October 2019 and the implementation phase had commenced. This includes improved processes around the use of restraints and system changes to support improved record-keeping and reporting practices.

- **Department's internal review – 'Use and recording of routine restraints'**

In response to the recommendations made in the 'routine restraints' review and parallel to the implementation of COPP 11. 3, the Department undertook an internal review of the use and recording of routine restraints in WA prisons. The internal review identified specific problem areas linked to the recommendations and proposed further policy and system changes to address the issues.

- **Policy and system changes**

Significant work has been undertaken to date to change policy and amend the Department's Total Offender Management Solution (TOMS) to address the intent of the recommendations made in the 'routine restraints' review and to ensure officers accurately record the use of restraints. This work is ongoing and expected to tie in with the review of COPP 11.3 scheduled to commence in May 2021.

Improvements in the recording of restraints has started to show in the total restraint numbers in TOMS, which is positive. Changes however are also required to the Reporting Data Mart to incorporate the changes made to policy and restraints recording which will enable the separation of routine and non-routine restraints and report on use of force data as a separate report. This can only occur once policy and system changes are completed.

Conclusion

The Department acknowledges the operational policies and procedures that govern the custodial operations in WA have been fragmented and unclear for some time causing a level of confusion amongst staff and contractors. This has been highlighted in both back to back reviews, 'routine restraints' and 'use of force' undertaken by OICS during 2019-20 and 2020-21.

In 2018 the Department undertook to review and update all operational policies and procedures as part of the Custodial Operational Policy and Procedures Project (COPP). To date 60 of 128 COPPs (25 prison related and 35 youth related -Banksia Hill) have been implemented, revoking 71 existing corporate operational policies. 176 Standing Orders have been developed and implemented. The project is due to be completed in December 2021.

The Department's offender management system TOMS is an old legacy system which is also known to have some serious shortfalls and the Department has progressively over the years implemented, and continues to implement patches and system changes to address the shortfalls.

At the time of the 'routine restraints' review and the 'use of force' review, the policy that governs both reviews, COPP 11.3 – Use of Force and Restraints, was undergoing a Departmental review as part of the COPP project and progressed through to implementation in 2020. This was combined with some gradual changes to TOMS to support the new policy. Work on refining the policy and TOMS continues as the Department approaches a scheduled follow up review of the new COPP 11.3 expected to commence in May 2021.

Although the 'use of force' review is based on the restraints data and recommendations from the 'restraints review' continue to be addressed, the Department acknowledges the findings from the 'use of force' review and will constructively use the findings to further inform and refine COPP 11.3 and enhance TOMS to maintain good records that will support good decision-making, drive effective business practices and improve accountability and efficiency.

Response to Recommendations

1. Clarify the use of force and restraints policy to remove doubt and ensure accurate and reliable reporting.

Level of Acceptance: Supported
Responsible Division: Corrective Services
Responsible Business Area: Operational Support
Proposed Completion Date: 31 December 2021

Response:

COPP11.3 – Use of Force and Restraints (COPP11.3) outlines the different legislative requirements, circumstances and authority required when using force and restraints on prisoners. Further to this, COPP11.3 outlines the different types of force and restraint options available to prison officers.

A review of COPP11.3 is scheduled to commence in May 2021 and will consider the intent of this recommendation and feedback within the review report to ensure the policy provides clear guidance to staff when using and recording the use of force and restraints.

Corrective Services is also implementing changes to COPP11.3 and TOMS to improve record keeping regarding the use of 'routine restraints'. These changes are in response to the recommendations from the OICS Report "*Routine restraint of people in custody in Western Australia*" which was released in May 2020.

2. Change policy so prisoners placed in a rip proof gown are only returned to mainstream following an assessment by a mental health professional.

Level of Acceptance: Supported
Responsible Division: Corrective Services
Responsible Business Area: Offender Services
Proposed Completion Date: Completed

Response:

Prisoners placed in rip proof gown are generally identified as prisoners At-risk. When a prisoner is identified and assessed as At-risk and placed in the Crisis Care Unit (CCU) as part of the At-RIsk Management System (ARMS) process, the prisoner is seen by a member of the Mental Health Alcohol and Other Drugs (MHAOD) team prior to the prisoner's ARMS rating being reduced and being transferred back to mainstream population or another part of the prison.

A prisoner's transfer out of the CCU is generally coordinated through the Prisoner Risk Assessment Group (PRAG) via their PRAG meeting where members from the MHAOD team are in attendance at all times.

3. Investigate the use of trained mental health first responders.

Level of Acceptance: Supported subject to funding
Responsible Division: Corrective Services
Responsible Business Area: Offender Services
Proposed Completion Date: Completed

Response:

The Department supports the intent of the recommendation however, it would be resource intensive for the MHAOD branch to establish a mental health first aid responder team. It should be noted that the MHAOD team has expanded over recent years with an additional 50 FTE providing greater MHAOD services as a whole. This includes an additional 18 permanent Aboriginal Visitors positions which hold an essential role in providing cultural support and interventions to Aboriginal Prisoners.

The MHAOD branch continues to evolve and improve service development in accordance with evidence based best practice and is working towards increasing capacity, through planned dedicated mental health units to support those who require intensive mental health care and management.

Prison officers are also provided mental health training to enable them to appropriately interact with prisoners with mental health issues and call upon the mental health professionals during mental health related incidents.

The Department is cognisant of the increasing prisoner population with mental health issues over the years and has committed to the following new initiatives to accommodate and care for these prisoners in the custodial estate. These are dedicated units that will have dedicated mental health staff who will be able to provide greater response and flexibility for prisoners with mental health related illness. This however does not replace the need for transfers to the Frankland Unit under the *Mental Health Act 2014* when necessary.

- Bandyup Women's Prison (BWP), the first prison in WA where a dedicated Mental Health Unit including 26 sub-acute mental health beds and six bed high dependency will be in operation mid-2021.
- A 30 bed Mental Health unit for male prisoners is being built as part of the current infrastructure program at Casuarina Prison with an expected completion date of 2023.

4. Provide mandatory training for Senior Officers including for their quality assurance role in incident reporting.

Level of Acceptance: Supported
Responsible Division: Corrective Services
Responsible Business Area: Operational Support
Proposed Completion Date: Completed

Response:

Learning and professional development for current (acting) and future Senior Officers is provided through the Assistant Senior Officer Program (ASOP) delivered by the Academy. The ASOP is a two year developmental position where selected Officers are provided the opportunity through on and off the job learning to develop the essential skills and knowledge for Senior Prison Officer roles within the custodial environment. The program includes learning experiences, mentoring, and professional development. Included in the three weeks off the job component delivered by subject matter experts at the Academy is eight hours training on Use of Force Reviews and Incident Reports Assessment Standards and Quality.

The Department has recently introduced the new Custodial Operating Policy and Procedures (COPPs) to provide a clearer and more streamlined operational policy framework. This includes the following COPP's related to use of force and incident reporting:

- COPP 11.3 - Use of Force and Restraint
- COPP 13.1 - Incident Reporting and Notifications

These COPPs are explicit in the requirements related to the reporting of incidents and the role Senior Officers play in providing regular assurance that the prison is accurately reporting incidents. The online completion rates for information and familiarisation for these COPPs by uniformed staff (including Principal and Senior Officers) is 95%.

Governance structures are in place and maintained with respect to the reporting, review and assessment of all incidents, including those resulting in use of force. This occurs at both the local prison level, by the Superintendent and local review committees, and through the Corrective Services Use of Force Review Committee for more serious incidents. These structures ensure accountability for any force used through an ability to impartially and independently report and review each incident to determine whether actions taken were reasonable and necessary in the circumstances.

5. Review the potential for investment in both body worn cameras and high quality CCTV.

Level of Acceptance: Supported subject to funding and prioritisation of capital expenditure
Responsible Division: Corrective Services
Responsible Business Area: Operational Support
Proposed Completion Date: 30 June 2022

Response:

The Department is supportive of enhancing CCTV capability throughout the custodial estate. A budget submission is currently being drafted to enhance the CCTV capability at Hakea Prison (Hakea). The plan is to upgrade CCTV at Hakea as part of a pilot project before expanding the program to other facilities. The Department expects to be advised of a decision from the Expenditure Review Committee in June 2021.

The Department acknowledges the additional investment in Body Worn Cameras (BWC) would significantly complement CCTV capability throughout the custodial estate. BWC footage is particularly beneficial in the review of Use of Force incidents to identify opportunities for continuous improvement. The feasibility of a new BWC trial, utilising cloud technology to manage digital evidence, is currently being explored noting that the investment of BWC and cloud storage would be a significant cost.

6. Investigate assessment testing in place of mandatory refresher training.

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Business Area: Operational Support
Proposed Completion Date: N/A

Response:

All new Prison Officers (PO's) are trained and assessed to the minimum standard in knowledge and skills related to custodial operations during the Entry Level Training Program (ELTP). The ELTP consists of 11 weeks 'off the job' training completed at the Corrective Services Academy (The Academy), followed by a further six months 'on the job' completed at the PO's parent prison. Due to operational risk, there is a need for PO's to preserve their knowledge and practical skills for work in accordance with their defined job requirements through ongoing refresher training. Refresher training includes refreshing previously acquired skills and knowledge and providing assistance, advice and feedback at the point of need.

An assessment only pathway does not provide for the delivery of critical information required to support the technical application of the skill within the operational environment, including underpinning legislation, policy and procedures.

The Academy is currently developing an up-to-date online Use of Force Theory Training Module to reduce the overall training impost. In line with continuous improvement, the current delivery model will also be examined to identify possible improvements and delivery efficiencies.

7. Operationally review all use of force and restraint tactics, techniques, and equipment every two years.

Level of Acceptance:	Supported
Responsible Division:	Corrective Services
Responsible Business Area:	Operational Support
Proposed Completion Date:	Completed

Response:

The Department is committed to a continuous improvement cycle, rather than introducing a scheduled review cycle for all use of force and restraint tactics, techniques and equipment. The Department currently undertakes reviews as follows:

- After Action Reviews (AAR) to identify gaps and risks following an incident or operation;
- Proactive industry and jurisdictional scanning;
- Reported issues or faults with the current techniques and tactics and/or in-service equipment;
- Supply issues triggering the need to identify replacement equipment from an alternate supplier; and
- Improvement actions identified as a result of the tiered Use of Force incident review process.

8. Improve the prisoner complaints management system to provide the ability to effectively interrogate the data.

Level of Acceptance:	Supported subject to funding and prioritisation of capital expenditure
Responsible Division:	Corrective Services
Responsible Business Area:	Operational Support
Proposed Completion Date:	Completed

Response:

Reporting from the prisoner complaints management system was improved following a recommendation made by OICS in 2019. The reporting will continue to be monitored and reporting refine as part of continuous improvement.

The current complaints management system includes the ability for staff receiving and recording complaints to categorise these into category and subcategory (116 subcategories in total). The system allows for reports to be generated against these and other criterion, effectively filtering the complaints data. Free text word search reports are used as secondary reporting in order to provide an additional layer of assurance that all relevant complaints have been captured.

Appendix B Serco Acacia response to draft report

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28 April 2021

Office of the Inspector of Custodial Services
Level 5 Albert Facey House
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Perth WA 6000

Dear Mr Ryan

Acacia Prison – Use of Force Review

The Director of Acacia prison wishes to acknowledge the Office of the Inspector of Custodial Services (OICS) and researches for the opportunity to discuss the use of force report and provide feedback to the report.

Acacia acknowledges the parameters and research definition undertaken with regards to the OICS use of force review and thus the figures that are provided in use of this definition. This includes –

1. Use of Force; which can be applied in the more serious cases with staff utilising physical force on a non-compliant prisoner, and;
2. Use of Restraints; which can be applied without any use of physical force in collaboration of a compliant prisoner, for security reasons.

Whilst we acknowledge the report is not aimed at distinguishing between the two, the later does however provide context to the figures in table 2. (page 5) of the report. This table is one area the Director feels shows Acacia Prison in poor light without the added context to the figures. For example, the same period that it is identified in the report that Acacia Prison has a recorded 3,648 use of force applications, the site has a recorded 236 physical use of force on a non-compliant prisoner.

The definition utilised in the report, more predominantly relating to the use of restraints without physical force utilised (on a compliant prisoner), does not take into consideration environmental factors across different prisons. For example, Acacia Prison being an open campus medium security prison, provides movement of prisoners between units for investigation or disciplinary reasons, this will almost certainly be undertaken in restraints. This is done to reduce risk of escalation in behaviours, reduction of risk to site and in consideration that free movement of other prisoners across site generally will still be in progress.

Acacia wishes to acknowledge the statement under table 2, page 5, of Acacia being a "privately-run facility with contractual reporting requirements. This may, in part, account for its high figures".

In closing I wish to provide that Acacia prides itself on the review mechanism for every Use of Force (not routine restraint) undertaken within the guidelines of Department of Justice Policy and Procedure. We also take our responsibility to report, investigate and action any identified –

1. Misuse of force,
2. Misuse of authority to undertake force, or
3. Breach in not following de-escalation protocols.

I again would like to thank the OICS for allowing Acacia to review the report and provide feedback.

Yours Sincerely

Brenton Williams
Director
Acacia Prison

Appendix C Department's Draw and Discharge policy

The Department's use of force policy defines the difference between drawing and discharging as (DoJ, 2020a):

Term	Definition
Draw and Cover – OC Spray, CEW and Firearm	The spray/CEW/firearm was drawn by an officer and pointed in the direction of a prisoner or other person to reduce a threat and gain control.
Draw and Discharge – CEW	The CEW device was drawn with the officer discharging it in the 'Probe Deployment' and/or 'Drive Stun' modes in the direction of and/or on a prisoner or other person to reduce a threat and gain control.
Draw and Discharge – Firearm	The firearm was drawn, and a projectile discharged in the direction of a prisoner or other person to reduce a threat and gain control.
Draw and Discharge – OC Spray	The spray was drawn with the officer discharging the spray in the direction of a prisoner or other person to reduce a threat and gain control.

Appendix D Classification levels of use of force

Classification levels based on the use of force type sourced from the Department's use of force and restraints policy (DoJ, 2020a).

<table>
<tr><th>Level</th><th colspan="5">Use of force type</th></tr>
<tr><td>1</td><td colspan="5">Techniques which cause temporary discomfort, pain, or disorientation as a means of defending, gaining control or compliance. It is not reasonably expected that this level of force will cause bodily injury. Types include:
defence and control tactics like pushing, redirecting, hand control or escort holds
takedown techniques that do not result in actual injury or complaint of injury
draw and cover using chemical agent spray
drawing a baton.</td></tr>
<tr><td>2</td><td colspan="5">Force that causes or could reasonably be expected to cause injury greater than temporary pain. Or the use of weapons or techniques (as below) provided they do not rise to Level 3:
defence and control techniques including, but not limited to, elbow or open/closed fist strikes and kicks
any force option involving impacts to the head, neck, sternum, spine, groin, or kidney area
baton strikes
use of restraints bed
planned cell extraction.</td></tr>
<tr><td></td><td></td><td>Chemical agent spray</td><td>CEW</td><td>Less-lethal launcher/munitions</td><td>Firearm</td></tr>
<tr><td></td><td>Draw only</td><td>-</td><td>-</td><td>-</td><td>Yes</td></tr>
<tr><td></td><td>Drawn and cover</td><td>Level 1</td><td>Yes</td><td>Yes</td><td>Yes</td></tr>
<tr><td></td><td>Draw and discharge</td><td>Yes</td><td>Yes</td><td>Yes</td><td>Level 3</td></tr>
<tr><td>3</td><td colspan="5">Applying more than three CEW cycles in a single encounter, regardless of mode or duration, or of whether the applications is by the same or different officers
applying a CEW for longer than 15 seconds, regardless of whether it is a single continuous application or from multiple applications
firearm discharges, including unintentional discharges
use of force resulting in loss of consciousness, or bodily injury requiring external (to the prison) medical treatment and/or overnight hospitalisation
uses of lethal force.</td></tr>
</table>

Appendix E Methodology

Data sets for this review were obtained from the Department's offender database through a series of extractions using SQL Server Management Studio. We also used a series of pre-constructed reports from the Department's Reporting Framework and from the offender database. We examined data for the five years between 2016 and 2020.

We interpreted Western Australian legislation and analysed departmental documentation including policy, registers, and use of force local and central reviews. As part of this review, we also conducted site visits to Acacia Prison, Albany Regional Prison, Bandyup Women's Prison, Bunbury Regional Prison, Casuarina Prison, Eastern Goldfields Regional Prison, and Hakea Prison.

A key findings briefing was presented to the Department in March 2021.

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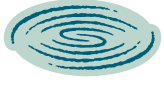

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