GOVERNMENT OF WESTERN AUSTRALIA

OFFICE OF THE INSPECTOR OF CUSTODIAL SERVICES

2021 INSPECTION OF THE INTENSIVE SUPPORT UNIT AT BANKSIA HILL DETENTION CENTRE

141

MARCH 2022

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2021 Inspection of the Intensive Support Unit at
Banksia Hill Detention Centre

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Inspector's Overview

BANKSIA HILL DETENTION CENTRE IS ONCE AGAIN IN CRISIS

We commenced this inspection in December 2021 because of our increasing concerns about the welfare of detainees and staff following a rise in the number of critical incidents, including detainee self-harm, suicide attempts, and staff assaults.

Because of the immediacy of our concerns we did not look at all operational areas across Banksia Hill Detention Centre (BHDC) and instead focussed on conditions and treatment of detainees in the Intensive Support Unit (ISU). But it is important to also recognise that the rise in the number and severity of critical incidents has had a significant impact on services available to detainees across all other areas of the centre due to frequent lockdowns, infrastructure damage, and the impacts of very high staff attrition rates.

The ISU performs several different functions at BHDC, including: crisis care; discipline and consequences; and management of the most challenging male detainees. It is also a good thermometer to gauge the overall temperature of the centre because, ultimately, it is where those involved in critical incidents end up. As the name suggests, it is where intensive support is supposed to be offered to detainees with the greatest needs.

As a starting point, we focussed attention on whether BHDC was meeting the minimum time out of cell requirements that are set by the *Young Offenders Act 1994*, the *Young Offenders Regulations 1995* and the relevant departmental policies and guidelines.

The normal daily regime at BHDC involves 11 hours and 15 minutes out of cell each day, during which detainees would be engaged in activities such as: education, training, programs, welfare support, socialisation, social and official visits, and recreation.

Under the relevant Western Australian legislation, policies and guidelines, on a normal day detainees would be entitled to a minimum one hour out of cell per day. This is less than the two hour minimum time out of cell set out in the relevant international human rights instruments. At the risk of stating the obvious, it is important to bear in mind that even when the minimum limits are met, detainees would still be held in their cell for 22 or 23 hours per day. There can be no doubt that such conditions, especially if prolonged, would be damaging to the health and wellbeing of young people.

To assist our analysis, we used four case studies to examine their individual out of cell times and our report sets out the detailed findings. We found a steady deterioration in average out of cell hours during 2021. And there were several days in November 2021 when the four young people did not receive the minimum time out of cell required by either the relevant legislation and policy, or the international instruments. We concluded that their human rights were being breached on those occasions.

These findings were so concerning that on 17 December 2021 we issued the Department with a show cause notice under section 33A of the *Inspector of Custodial Services Act 2003* (the Act) requiring a detailed response within six days. The Department's comprehensive response, received on 23 December 2021, acknowledged many of our concerns and set out the plans and strategies that were already underway, or were being put in place, to deal with

the issues facing BHDC. This included additional funding for infrastructure repairs and upgrades, strategies to recruit and train additional custodial staff, and the development of a trauma informed operational model of care.

It is also fair to acknowledge that, prior to this inspection, the problems and issues facing BHDC had been the subject of many discussions and briefings between my office and the Minister, the Director General, the acting Commissioner, and other senior staff.

On 21 January 2022, following consideration of the Department's response, pursuant to section 33A of the Act I referred the matter to the Minister for Corrective Services. In this referral I supported the Department's planned actions. However, I suggested that as an immediate non-custodial circuit breaker, a welfare focussed non-custodial workforce be embedded to supplement the custodial and security efforts being pursued by the Department. The Minister's response reiterated the commitment to the improvements that were outlined in the Department's response and advised that the Department was exploring options for an immediate circuit breaker initiative.

It is not possible to overstate the importance of the reforms currently underway around youth detention and how young people are treated once they are sent to BHDC. But the problem is far greater and the solutions broader than just focussing on BHDC. There needs to be better integration of support services, properly resourced support mechanisms, and effective diversions and interventions beyond BHDC. Consideration also needs to be given to having appropriate facilities for young female detainees, remandees, and young people from regional and remote communities.

Our report is critical of the conditions at BHDC and for many it will be difficult reading. BHDC is not fit for purpose as a youth detention centre. It looks like, and in many respects runs like, an adult prison. Even to the point where there are adult prison officers stationed there to assist in maintaining order and security. More recently, due to staff shortages, these staff have been required just to keep the facility running. Recent critical incidents have also regularly resulted in the deployment of response teams from the Department's Special Operations Group.

The Department's response to this report and the earlier show cause notice highlighted the difficulties faced by BHDC in managing a small cohort of detainees with complex and challenging needs who were behind most of the critical incidents. These young people had been involved in self-harm and suicide attempts, staff assaults, fence and roof ascents, and infrastructure damage. This may well be a fair assessment, but as also acknowledged in the responses many of these young people have significant impairments, traumatic backgrounds of abuse and neglect, and diagnosed complex neurological disorders. This tells us that the management and care of these children must be trauma informed and evidence based with at the very least an equal focus on welfare needs alongside custodial needs. For this reason, we consider that the most important reform currently underway is

the development of a trauma informed model of care. If successfully developed and implemented, this is the initiative that is most likely to have lasting impact and change.

All of this is detailed in our report along with two recommendations which were supported by the Department. I am encouraged that BHDC is finally getting attention and resourcing to address the many challenges they are now facing. But reforms have started and failed before and the current initiatives must be sustained through to successful implementation. We will continue to closely monitor progress and implementation.

In conclusion, it would be remiss of me to not mention the efforts and commitment of many staff who work at the BHDC. Most of them do an incredible job in very difficult and challenging circumstances. We often see and hear from staff who have endured because of their commitment to providing services to the young people and trying to make a difference.

ACKNOWLEDGMENTS

It is important to acknowledge the support and cooperation we received throughout the inspection from the Superintendent and staff at BHDC. I also acknowledge and thank the Director General and the acting Commissioner for their personal engagement and cooperation with us during this inspection.

I also want to recognise the detainees we spoke to and thank them for their time and sharing their experiences with us.

Finally, I would like to thank the members of the inspection team for their expertise and hard work throughout the inspection. I would particularly acknowledge and thank the Commissioner for Children and Young People for allowing Laura Jackman to take part in the fieldwork for this inspection. A special mention is also required for Ryan Quinn and Cliff Holdom for their hard work in planning and coordinating this inspection and for Ryan Quinn as principal drafter of this report.

Eamon Ryan
Inspector of Custodial Services

10 March 2022

ANNOUNCEMENT OF AN INSPECTION

On 1 December 2021 an inspection of conditions in the Intensive Support Unit (ISU) at Banksia Hill Detention Centre (BHDC) was announced in accordance with Section 21 of the *Inspector of Custodial Services Act 2003*. Under Section 21 the Inspector may inspect a facility at any other time outside the three yearly inspection cycle for that facility. The decision to commence this inspection was prompted by concerns about the deterioration of conditions at BHDC and the increasing number of critical incidents, including staff assaults, and detainee self-harm and suicide attempts. There were particular concerns about the conditions within the ISU.

The inspection sought to establish whether young people in the ISU were having their minimum entitlements met as established in the *Young Offenders Act 1994* (YOA) and within international human rights instruments. The inspection analysed available records, conducted onsite observations and undertook interviews with detainees, staff and other interested parties. Broad datasets were analysed, and then individual case studies were used for more in-depth analyses and to illustrate arguments. Pseudonyms have been used to protect the identity of individuals. [NB: The custodial status of these detainees may have changed in the period since the analysis was undertaken.]

The four case studies used in the report include:

Alex

Alex is a 15 year-old young person who was received into BHDC on 5 November 2021, nine days after being released from the facility. He has previously entered BHDC on 23 separate occasions since 2019. He was initially placed in Jasper Unit. Following a range of misconduct incidents, Alex was placed into the ISU where he has remained, except for a few nights. A Personal Support Plan – Change of Accommodation (CAPSP) was prepared for Alex on 23 November 2021 for behavioural and risk management.

Ben

Ben is a 15 year-old young person who was received into BHDC on 3 November 2021 after being sentenced. He has spent considerable time at BHDC since 2017. Ben was initially placed into Karakin Unit before moving to Jasper and Turner units. Ben was moved to the ISU for an ongoing period on 11 November 2021 where he remained until transitioning back into mainstream in January prior to his release. A CAPSP was prepared for Ben on 14 November for the purposes of risk and behaviour management following an out of bounds incident on 11 November 2021.

Chris

Chris is a 16 year-old young person who was received into BHDC on 15 July 2021 on remand status before being sentenced on 13 August 2021. Since reception, Chris has moved between several mainstream units and spent a considerable length of time in the ISU. Chris was moved to the ISU on 3 November for 20 days and later returned for most of December. A CAPSP was prepared for Chris on 8 November for risk and behavioural management following three staff assault incidents.

Daniel

Daniel is a 16 year-old young person who was remanded at BHDC on 15 March 2021 before he received a sentence on 24 March 2021. He has remained at BHDC until his release in early January 2022. Daniel has also spent a considerable amount of time at BHDC before 2021, with his first custody period occurring in 2018. Since March, Daniel has moved between several units with intermittent periods of stay in the ISU, including half of September and most of October. Daniel was admitted to Fiona Stanley Hospital in late October and later admitted to the East Metropolitan Youth Unit (EMyU). Upon return to BHDC on 2 December 2021 he was placed again in the ISU where he self-harmed and required further hospitalisation. Since returning to BHDC he has been placed under observation in Cue Unit.

The Intensive Support Unit at Banksia Hill

The ISU is a four-wing unit used for acutely unwell young people requiring observation and for detainees demonstrating consistent poor behaviour. The Department describes the aim of the ISU as a place where targeted intervention and therapeutic care can be provided in a safe place (DOJ, 2021).

B-wing contains four multi-purpose cells and four observation cells. These are all monitored under CCTV. Detainees at-risk of self-harming or those presenting as a security risk may be placed in B-wing on short-term placements.

D-wing was initially a 12-bed wing to house arrestees overnight. However, more recently it has been used as part of the ISU for management purposes.

A- and C-wings are largely identical in design and size to wings in other accommodation units. Both wings have eight cells each. At times A-wing has been used as an orientation wing, or to accommodate youth with special care needs. However, recently it has been used with C-wing as part of the progression of detainees out of the ISU. These wings are intended for longer-term stays.

Recreation yards exist in three of the four wings. A medium-sized, enclosed outdoor yard with a telephone is available for use in B-wing. A- and C-wings have a larger shared yard with a half basketball court, and there is an additional caged outdoor area in between C- and D-wings. However, these yards are generally not in use following multiple detainees scaling the fence and absconding. Select youth from A- or C-wings may at times be able to use the smaller yard under close supervision.

Confinement is permissible under the Young Offenders Act and Regulations

Under the YOA and the *Young Offenders Regulations 1995* (the Regulations) there are two scenarios permitting the use of confinement:

- as a consequence for a detention offence, as per Section 173(2)(e) of the YOA and Regulations 75–77
- for the good order and security of the facility, as per Section 196(2)(e) and Regulations 74 and 78–80.

Confinement as a consequence for a detention offence can be ordered for up to 24 hours by a Superintendent or up to 48 hours by a Visiting Justice. Under this confinement regime, a detainee is entitled to fresh air, exercise, and staff company for a minimum of 30 minutes every three hours during the unlock period.

Confinement for the purposes of ensuring the good government, order and security of a detention centre can be ordered by the Superintendent for up to 24 hours. If the confinement exceeds 12 hours, the detainee is entitled to at least one hour of exercise every six hours during unlock hours. A typical day regime includes 11.25 hours of possible unlock time, which the Department claims makes an hour out of cell the minimum legislative requirement.

Under both scenarios, the detainee may be confined in their sleeping quarters or to a designated room. Regulation 76 requires a room being used for confinement to be appropriate in size, well ventilated, and lit to ensure the wellbeing of the young person.

Detainees could be 'segregated' under Standard Order 9a

Standing Order 9a (SO9a) allowed for the use of a CAPSP to manage detainees displaying ongoing inappropriate behaviour or those involved in a critical incident (DCS, 2016). SO9a articulates CAPSPs should be used as a last resort to manage risks by segregating detainees who may further negatively influence their peers. Detainees on a CAPSP are typically placed into the ISU. While they are not legally under confinement orders, the term 'segregation' is in effect interchangeable with the term 'confinement' and conditions are similar. However, CAPSPs are not intended to be punitive or used as a form of punishment. Rather, their intent is to assist in the management and moulding of a detainee's behaviour.

There are no specific timeframes that a detainee placed on a CAPSP can be expected to be transitioned back into mainstream. Operating as an incentive-based tool, management are required to discuss with detainees the standard of behaviour they are expecting to be displayed before they consider a re-entry into mainstream. The CAPSP is supposed to include defined milestones for behaviour expectations.

Under SO9a, detainees subject to a CAPSP are entitled to fresh air, exercise, and staff company for one hour of every six hours of unlock time, subject to their behaviour and the risk to staff and visitors.

During this inspection, the Department rescinded SO9a and replaced it with a suite of new policies, as part of a broader update of operational policies[1]. This is discussed further in the report. Given the detainees discussed in this report were held in the ISU under the provisions of SO9a, that policy remains the primary focus of this report.

YOA and SO9a inconsistent with international treaties

The provision of one hour of exercise and fresh air for detainees in confinement or segregation is contrary to the United Nations *Standard Minimum Rules for the Treatment of Prisoners* (Mandela Rules), which requires at least two hours of out of cell time in a 24-hour period (UNODC, 2015). These standards are also made applicable to youth detainees under Rule 27 of the United Nations *Standard Minimum Rules for the Administration of Juvenile Justice* (Beijing Rules) (UNODC, 1985).

Rule 67 of the United Nations *Rules for the Protection of Juveniles Deprived of their Liberty* (Havana Rules) also expressly prohibits cruel, inhuman or degrading disciplinary treatments including closed or solitary confinement (UNODC, 1990).

While Australia supports the Mandela Rules, they have not been enshrined in legislation in Western Australia and are therefore not legally enforceable. Despite this, they provide clear moral guidelines for the treatment of prisoners and detainees in custodial settings.

1 The policies released to replace SO9a were each considered prior to the preparation of this report.

LIST OF RECOMMENDATIONS

RECOMMENDATION 1

Re-introduce explicit minimum out of cell requirements for detainees in the ISU on a Personal Support Plan.

RECOMMENDATION 2

Embed an additional welfare focussed, non-custodial workforce to supplement the existing workforce in the ISU and Cue Unit at Banksia Hill Detention Centre.

FACT PAGE

NAME OF FACILITY

Banksia Hill Detention Centre

ROLE OF FACILITY

Banksia Hill is a maximum-security facility that holds sentenced and unsentenced boys and girls from all regions of Western Australia. Young people range in age from 10 to 18 (and beyond). It is the only juvenile detention centre in Western Australia.

LOCATION

Banksia Hill is on Noongar Whadjuk land in the suburb of Canning Vale, Perth, Western Australia.

BRIEF HISTORY

Banksia Hill opened in 1997. The centre underwent a major redevelopment from 2010 to 2012. Following this, the state's only other juvenile custodial facility, the Rangeview Remand Centre, was closed and converted into an adult prison. Since October 2012, all juvenile detainees in Western Australia have been housed at Banksia Hill.

This is our ninth report about Banksia Hill since 2012.

LAST INSPECTION

September 2020

THIS INSPECTION

December 2021

CAPACITY

215

NUMBER OF YOUNG PEOPLE IN CUSTODY AT THE TIME OF THE INSPECTION

121

Chapter 1

THE HUMAN RIGHTS OF DETAINEES IN THE ISU ARE BEING BREACHED

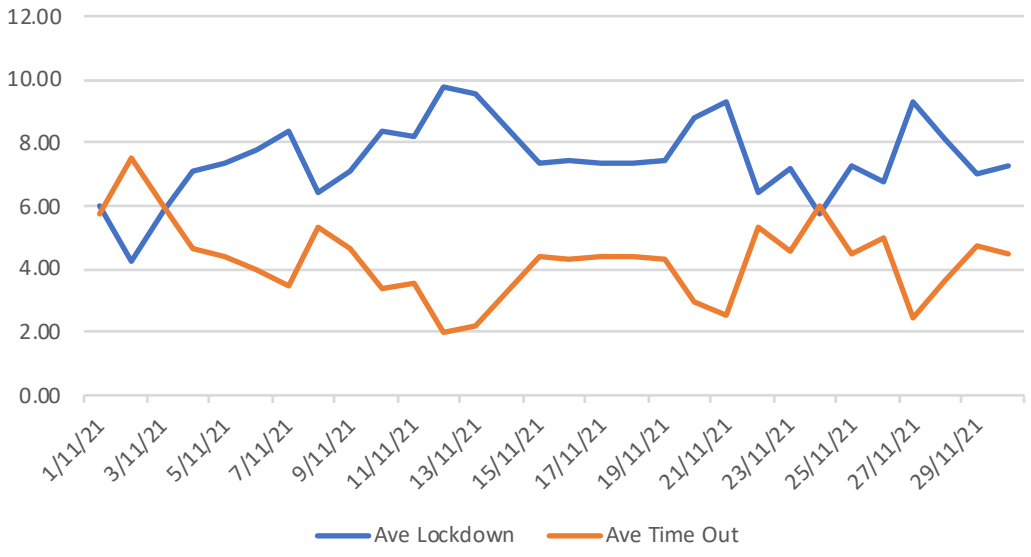
Detailed analysis of out of cell hours for detainees in the ISU demonstrate that, at times, their human rights have been breached. Throughout November 2021, analysis identified several days where three detainees did not receive their minimum out of cell time under both the Department's SO9a policy and international human rights agreements, such as the Mandela Rules (UNODC, 2015). These findings are consistent with our previous report on out of cell hours in 2018 (OICS, 2018).

1.1 OUT OF CELL HOURS OFTEN AKIN TO SOLITARY CONFINEMENT UNDER INTERNATIONAL HUMAN RIGHTS AGREEMENTS

The average time detainees within the ISU are spending out of cell is inconsistent with the provisions of S09a. Under the policy, detainees subject to a CAPSP are entitled to at least one hour of out of cell time for every six hours of unlock time (DCS, 2016). The daily routine in the ISU allows for a maximum 11.25 hours of unlock time on any given day, excluding staff lunch breaks, if unlock occurs at 7.45 am and lock-up concludes by 7.00 pm (DOJ, 2021a). As a result, detainees are only technically entitled to a minimum of one hour for exercise, fresh air, and staff interaction per day.

From January to November of 2021, detainees in the ISU were on average recording more time out of their cell than time locked up during the day. However, this has progressively decreased. By November 2021, detainees were on average spending 4.29 daytime hours out of cell compared to a high of 7.55 hours in February 2021. This average dropped to 1.99 hours of out of cell time for one day in November. However, this data includes all detainees who have spent time in the ISU. This includes those who may have only spent a few hours in a cell before moving to a different unit. As such, the data does not accurately reflect the average out of cell time for detainees spending entire days in the units.

Figure 1: The average hours locked in cell and time out of cell for detainees in the ISU during November 2021.



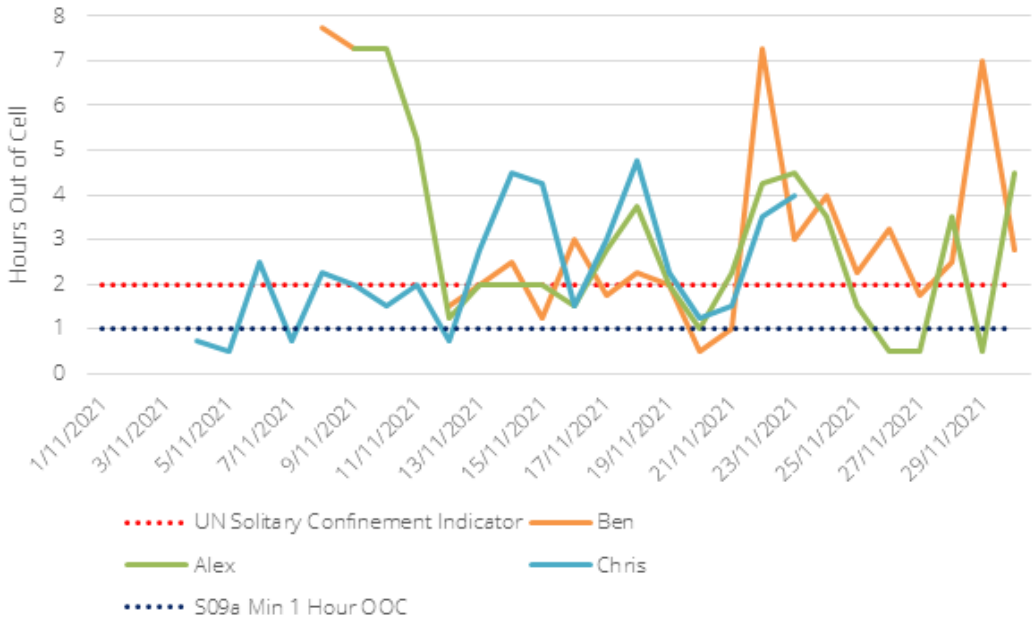
THE HUMAN RIGHTS OF DETAINEES IN THE ISU ARE BEING BREACHED

Detailed analysis of detainees spending full days in the ISU confirms that some are often being held in conditions akin to solitary confinement as defined under the Mandela Rules (UNODC, 2015). We analysed the out of cell hours for detainees Alex, Ben, and Chris who featured prominently in critical incidents and spent considerable time in the ISU in November 2021. On average, the three detainees spent 8.78 daytime hours in their cell and 2.97 hours out of cell. However, the three detainees had between 8 and 11 days with less than two hours out of cell time. And each detainee had at least one day where they received less than one hour out of cell. One detainee had as little as 30 minutes of out of cell time on three out of four consecutive days.

These experiences are also not limited to the three case studies examined. Another detainee spent 15 out of 27 days in the ISU in November 2021 with fewer than two daytime hours out of their cell. This included one period of five continuous days and a second period of six continuous days.

The confinement of detainees in this manner contradicts Rule 44 of the Mandela Rules, which stipulates solitary confinement within a cell should not exceed 22 hours in a day (UNODC, 2015). Solitary confinement of children constitutes 'cruel, inhuman or degrading treatment' and is 'strictly prohibited' under the Havana Rules (UNODC, 1990).

Figure 2: The time spent out of cell during the day was often less than the minimum required by the United Nations' Mandela Rules.



Further, often the personal monitoring forms of these detainees identify inconsistencies with the out of cell data extracted through the Department's offender database, which was used for the above analysis. For instance, the Department's data states Alex as having 30 minutes of out of cell time on 26 November. However, his personal monitoring form shows only one 15-minute period out of cell, with the comment:

> *1735hrs Code amber Forced his way out of cell, standoff with Staff*

On 27 November the notes state Alex had 12 minutes out of cell to shower and receive clean clothes. The Department's data shows this as 30 minutes out of cell. The recording of out of cell time in 15-minute blocks does not paint an accurate picture, and likely inflates actual out of cell time.

The Department has acknowledged there are data inconsistencies between the personal monitoring forms and out of cell data in the offender database. They argue the personal monitoring form is primarily a quick reference point, and not the sole reference for time out of cell reporting.

1.2 INSUFFICIENT STAFFING IN ISU INCREASING LOCKDOWNS

Staff we spoke to lament the impact staffing shortages were having on detainees. They were highly conscious of the lack of out of cell time detainees were receiving, which often resulted in legislative requirements not being met. This was often acknowledged in the personal monitoring forms of detainees in the ISU, such as:

> Staff shortages resulting in rolling lockdowns and extended periods in cell for all ISU detainees. Staff reassignment to conduct, psych consults, AWO consults, OICS consults, video links, official visits and security investigations. Unable to meet legislative requirements.

Throughout November, the ISU was understaffed on 17 out of 30 days. When fully staffed, the ISU has 10 officers, including a senior officer, unit manager and two officers for each of the four wings. However, the B-wing officers are fixed to desks for their shift to undertake monitoring. The remaining staff are then required to facilitate out of cell hours, meals, showering and movements for official and family visits. On one day in November, the ISU was short six out of the required 10 staff members. When short-staffed, officers are focussed on moving detainees around to attend their appointments. This often comes at the expense of out of cell hours and recreation time.

Since January 2021, there have been 49 staff members depart BHDC. Four of these were retirements, one had been released under workers' compensation, and the remaining 44 had resigned. This attrition rate has created a significant resourcing issue for the facility. Recently, prison officers from the adult custodial estate have been brought in to assist with staffing shortages. However, skills deficits in youth custody limit their usefulness. Anecdotally, we heard from staff that the working conditions and environment have led to many of these resignations.

1.3 FEMALES IN CUE UNIT EXPERIENCE SIMILAR LEVELS OF CONFINEMENT

Analysis of monitoring data for female detainees placed into observation in Cue Unit demonstrate similar levels of confinement to that experienced in the ISU. Monitoring data suggests there are limited opportunities for female detainees to engage in education and activities, or associate with peers. Typically, out of cell time is used for cleaning their cell, attending official visits or meeting with psychologists. However, Cue Unit is smaller, less volatile, and often has the benefit of a 1:1 staff to detainee ratio. This allows for better management of escalating behaviour and the opportunity to develop more meaningful and therapeutic relationships with staff.

1.4 'SEGREGATION' OF DETAINEES NOT TECHNICALLY IN CONTRAVENTION OF THE CONFINEMENT PROVISIONS IN YOA

The segregation of the detainees and the denial of their minimum out of cell entitlements is not in contravention of the confinement provisions under the YOA. From a legislative perspective, Alex, Ben and Chris were not residing in the ISU because they were serving confinement orders under Section 173 or Section 196 of the YOA. Rather, they were placed in the ISU as a management option under SO9a using a CAPSP or for the purposes of medical observation. As such, from a legal perspective they were being 'segregated' and not 'confined'. Therefore, the parameters of their segregation are not legally comparable to the confinement provisions under the YOA. We are therefore unable to argue that the Department has unlawfully *confined* these detainees in contravention of the YOA. However, the recorded out of cell hours is, at times, in contravention of the minimum entitlements listed under SO9a and breaches international human rights agreements, including the Mandela Rules, Beijing Rules and Havana Rules.

As we noted previously on this issue, we are not a court of law (OICS, 2018). If allegations are tested in court, the court may view the evidence differently or adopt a different interpretation of the law and its applicability to detainees in the ISU on CAPSPs. However, as it appears, it might be argued that the Department has created a regime equivalent to confinement, as defined under the YOA, but without the protections and limitations set out in the YOA. If this is the case, it could expose the Department to a potential legal challenge. We noted similar concerns with regards to the Department's disruptive prisoner policy (OICS, 2020a).

Similar findings in relation to out of cell hours in the ISU at BHDC were previously reported by OICS (OICS, 2018). The two detainees subject of that review were also being managed under CAPSPs and were similarly found to have been held in conditions that were in breach of the Mandela Rules and Havana Rules. OICS recommended legislative amendments to the confinement provisions under the YOA and the Regulations including:

- repealing the provisions governing 'confinement'
- enacting a framework for managing special regimes such as the ISU, including adequate protections for young people

- ensuring that all young people are entitled to a minimum of two hours out of cell each day.

The Department supported the recommendation in principle, acknowledging a review of the legislation was timely. No changes have been made to the YOA or Regulations to date. The Department has informed us that work on legislative reforms is ongoing.

1.5 NEW POLICIES HAVE SINCE REMOVED REFERENCES TO MINIMUM OUT OF CELL REQUIREMENTS FOR DETAINEES ON PSPS

Shortly after our inspection, SO9a was rescinded and replaced by three new policies as part of a broader update to the Department's operational policy suite. This includes:

- 6.1 Behaviour Management (DOJ, 2021b) – effective from 28 December 2021
- 6.4 Offences and Charges (DOJ, 2021c) – effective from 22 January 2021
- 7.6 Personal Support Plans (DOJ, 2021d) – effective from 3 May 2021

A review of the policies identified that any reference to minimum out of cell requirements for detainees held in the ISU under a PSP had been omitted. SO9a had previously included a provision requiring detainees on CAPSPs to have at least one hour out of cell for every six hours. This requirement mirrored the entitlements under Regulation 79(4) for detainees ordered into confinement by the Superintendent under the YOA. As detainees on CAPSPs are not serving confinement orders under the YOA, the out of cell requirements under the Regulations are not technically applicable.

In the Department's policy on supervision levels and privileges it states that all detainees are entitled to an opportunity to exercise at least one hour a day (DOJ, 2021e). But that same policy also provides management the ability to regulate a detainee's access to their entitlements in order to 'promote improvements in [the] detainee's behaviour' for those on a PSP (DOJ, 2021e, p. 12). With the out of cell requirements under SO9a now revoked, it is concerning that there is no explicit policy or legislative guidance guaranteeing a minimum number of hours out of a cell a detainee on a CAPSP is permitted.

Without such guidance, there is no explicit standard to hold the Department accountable to.

The Department also provided a draft copy of a new policy on detainees placed into the ISU and Cue Unit. The draft policy did not contain references to minimum out of cell requirements or other entitlements.

Recommendation 1
Re-introduce explicit minimum out of cell requirements for detainees in the ISU on a Personal Support Plan.

Chapter 2

DETAINEES HAVE A POOR QUALITY OF LIFE IN THE ISU

Detainees residing in the ISU are living in conditions that do not support physical and mental wellbeing or encourage positive behaviour. Due to staffing shortages, detainees are often locked into their cells for most of the day, preventing meaningful social interaction with peers and staff. Detainees face long periods of alone time in cells that are often in a poor state and are small. This typically leads detainees to act out and increasingly there are more detainees self-harming.

2.1 DETAINEES ARE NOT PROVIDED WITH MEANINGFUL TIME OUT OF CELL

Detainees do not appear to be receiving quality time out of their cells. Analysis of Alex, Ben, and Chris' monitoring data shows that time listed as out of cell often coincides with time showering, cleaning their cells, and speaking with psychologists or other official visitors.

On many occasions time out of cell does not include having meaningful social interaction with their peers or exercise in the yard. Access to the yard varied and was often dependent on staff numbers or the volatility of the unit at the time. Following previous out of bounds incidents, currently only B-wing yard is being used, further limiting access. The Department has acknowledged that B-wing yard, a caged concreted area, is unable to meet the exercise and recreation needs of the young people (DOJ, 2021). Throughout November, Ben was provided yard time on only a third of the days he spent in the ISU. Chris received access on eight of 20 days in the ISU and Alex received access on 13 out of 23 days. The average length of time per yard visit varied from a low of 34 minutes for Ben to a high of 77 minutes for Alex.

Most meals appear to be provided to detainees in their cell, further limiting their social interactions with others. Detainees in B- and D-wing are typically served four slices of toast each and a bladder of milk for breakfast. When staff are able or available, those in A- and C-wing are allowed up to make their own breakfast.

The detailed logs of the three detainees show there were also limited opportunities to engage in education, activities or programs when out of cell. The Department acknowledged that throughout November the three detainees received little education, as a result of the volatility and staff shortages in the unit. Education packs were at times provided as an alternative. It is unclear to us how effective these packs would be in such an unsettled environment. Activities and peer-to-peer interactions are also provided where possible and where safe to do so.

Table 1: Recorded incidences of activities undertaken during out of cell time in November 2021 in the ISU.

Detainee	Days in ISU	Shower	Education	Programs	Activities	Phone Calls
Alex	23	14	0	0	2	5
Ben	22	13	1	0	1	7
Chris	20	5	2	0	1	2

Family and other social visits are also often restricted under the regimes of detainees on a CAPSP. Phone calls are often limited as a result of damaged or broken handsets. The Department advised that visits are considered on an individual basis and were accommodated where possible, but this often led to other detainees being locked down due to staff shortages and the need to escort detainees to their visits.

Staff were also required to navigate movements of detainees so they could attend official visits, psychology appointments and meet with other welfare supports, such as Aboriginal Welfare Officers. These are important meetings and visits for the detainees. We acknowledge the challenges involved in coordinating these movements in a volatile environment and while short staffed. However, they should not be included in an assessment of meaningful time out of cell as they are not enriching or enhancing the detainee's experience or enabling socialisation with peers.

Table 2: Recorded official visits in November 2021 in the ISU, as provided by the Department.

Detainee	Psychology services	Medical appointment	Case planning	Aboriginal Welfare Officers	Aboriginal Visitors Scheme	Visits - Social	Visits - Official
Alex	11 successful, 5 unsuccessful	17	5	13	4	3	21
Ben	7 successful, 2 unsuccessful	5	6	4	4	3	14
Chris	5 successful, 4 unsuccessful	7	0	5	4	0	5

2.2 OBSERVATION CELLS ARE IN A VERY POOR STATE

The observation cells in B-wing of the ISU are damaged, graffitied, and not suitable for acutely unwell young people. The four observation cells have a clear glass-like panel to enable direct observation from officers at the control desk. Over the years, these panels have become heavily scratched and graffitied, impeding the view of officers. Cameras are also used but are often covered by materials such as wet toilet paper. Shutters on the outside are controlled by officers. Some detainees request these be closed during the day. The shutter on one observation cell was broken, which meant the detainee had no option but to remain in a dimly lit cell during the day. Failure to provide cells with enough ventilation and natural light to prevent ill-health may constitute a breach of the Mandela Rules (UNODC, 2015).

Observation cells are also small, contributing to their unsuitability for unwell detainees. In our previous report, we confirmed that the cells in A, C, and D-wings of the ISU are the same size as those in standard accommodation units, and typically larger than most cells in adult prisons (OICS, 2018). Cells at BHDC are also not commonly double-bunked, which is often the case in the adult estate. However, B-wing cells are smaller and non-compliant with the *Standard Guidelines for Prison Facilities in Australia and New Zealand*, which requires cells with wet facilities to be at least 8.75 square metres in area (Victorian Office of Corrections, 1990). B-wing includes the four available observation cells within the ISU for the acutely unwell.

In successive previous reports, we have raised our concerns about the state of the observation cells and the need for a standalone crisis care unit (OICS, 2020; OICS, 2018a; OICS, 2015). In their response to our preliminary report, the Department recognised that the environment in the ISU was not therapeutic, and there was a lack of exercise yards with space and resources for detainees to engage in exercise (DOJ, 2021). The Department informs us they are working with Government to secure funding for a range of works to improve the infrastructure and conditions of the ISU. The Department also confirmed that a remediation program to address the immediate requirements of the ISU, including repairs to observation cells, were underway.

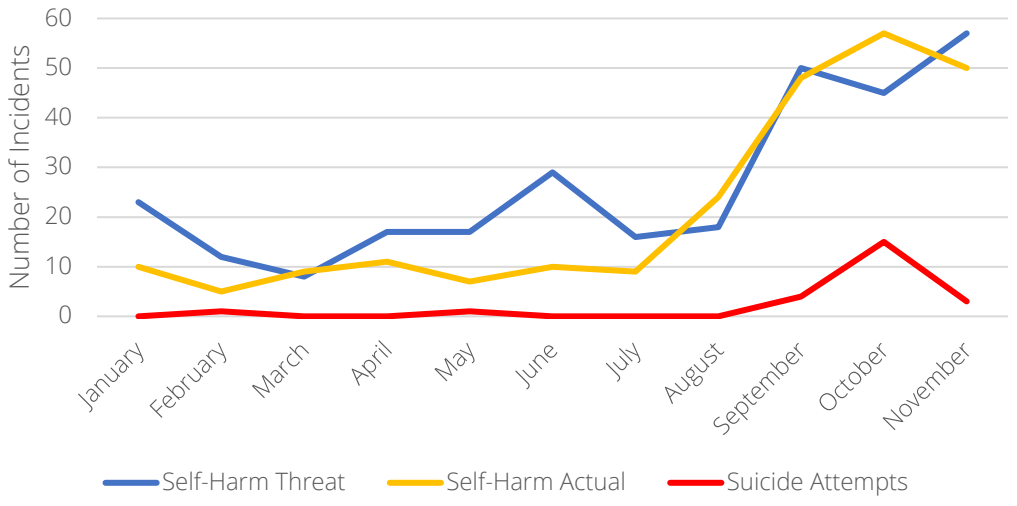
2.3 SELF-HARM MORE FREQUENT IN ISU AND OFTEN ALIGNED TO TIME OUT OF CELL

Threats of self-harm and actual incidents of self-harm in the ISU have increased to its highest levels in October and November of 2021. Between January and July, actual incidences of self-harm were recorded between six and 11 times per month across BHDC, while threats occurred between 10 to 30 times per month. However, by September 2021 there were twice the number of incidents of actual self-harm and more than double the threats compared to a month earlier. In October there were more actual self-harm events than there were threats. This increasing trend continued into November. Across the entire year, 63 per cent of self-harm threats and 71 per cent of self-harming incidents occurred in the ISU.

There were also 24 attempted suicides at BHDC between January and November of 2021. Most of these occurred in September (4), October (15) and November (3) and 83 per cent of these occurred in the ISU. Most of these were from a select group of detainees who formed a self-described 'suicide squad'. Attempts at suicide have been a relatively rare occurrence at BHDC with only one occasion recorded in 2020, and one incident occurring in February 2021 and May 2021.

DETAINEES HAVE A POOR QUALITY OF LIFE IN THE ISU

Figure 3: Incidents of self-harm and attempted suicides have increased significantly since September 2021.



Analysis of Alex, Chris, and Ben's records illustrate they were more likely to threaten or actually harm themselves on days where they were locked down. Both Chris and Ben were listed as threatening to self-harm on two and three occasions respectively. The average out of cell time on these days was 0.63 hours for Chris and 2.25 for Ben. Alex threatened self-harm on 11 occasions throughout November 2021. He received an average of 2.07 hours out of cell on these days. This included seven days where he was provided less than two hours out of cell. He self-harmed on three separate days where he received 2.75, 2.25 and 0.5 hours out of cell. One young person we spoke to explicitly linked their self-harming behaviour with the time they spent locked down:

> They say at Banksia Hill you get to go out for an hour... I see everyone else... like, Friday last week, um... I was out for 20 minutes to see my psych and then I came back in and they said, no we have to (inaudible) everyone... and I said it's still my time and I haven't finished my time. I should be allowed to finish my time in the yard. And that's when they said no and I got angry and threatened them ... you know, that's when... I get angry and start cutting myself up ... and get real angry...

Many detainees in the ISU enter with complex combinations of pre-existing mental health conditions, trauma and cognitive impairments. We found that following extensive periods of lockdown in the ISU, detainees experienced further deterioration in their behaviour and mental health. This deterioration is well known and documented in research (Nunez & A, 2017; Mackay & Naleemudeen, 2021). The Australian Children's Commissioners and Guardians have also noted:

> Isolation practices have no recognised therapeutic value and often retraumatise children and young people in youth justice detention and exacerbate medical, psychological and social problems… For children and young people with mental health problems or past experiences of trauma, isolation practices can have severely damaging psychological effects. Where children and young people are at risk of suicide or self-harm, isolation is likely to increase their distress and suicidal ideation and rumination (ACCG, 2017, p. 21).

Further, Rule 45(2) of the Mandela Rules prohibits the use of solitary confinement for those with mental or physical disabilities, if that confinement would exacerbate their conditions (UNODC, 2015). Where confinement or separation is used, Rule 38(2) also requires facilities to take steps to minimise the negative effects of that confinement on the prisoner. The exacerbation of mental ill-health evident in some detainees in the ISU may therefore constitute further breaches of human rights.

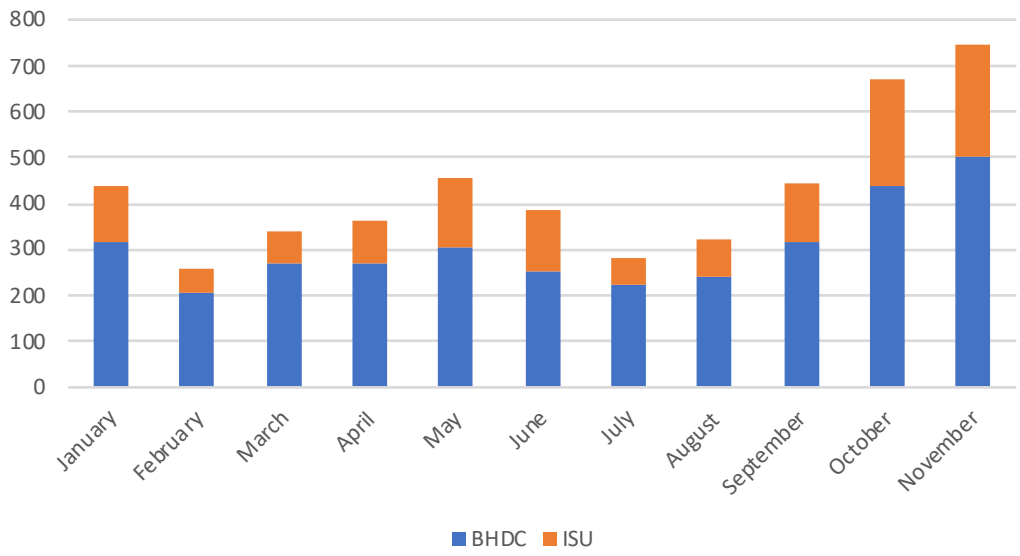
Such deterioration in mental health was clear in one young offender with several diagnosed mental health conditions. Since his most recent receival into BHDC in early November 2021, he had spent most of his time in the ISU due to behavioural issues, abuse to staff, and threats of self-harm. However, reports from his psychologist argue that his placement in the ISU was likely exacerbating his behaviour and decline in mental health. They note that he was likely triggered by long periods of time in his cell away from his coping strategies, which include access to distractions such as education, sports, and engagement with peers. Continued placement of Alex in the ISU is likely to result in a further decline in his mental health and a breach of his human rights.

It is fortunate that Banksia Hill has never had a death in custody or suicide. However, the likelihood of this remaining the case is diminishing as the conditions in the ISU aggravate the mental health of detainees and incidents of attempted suicide continue to increase.

2.4 THE ISU IS PROGRESSIVELY BECOMING A MORE VOLATILE SPACE

The number of incidents occurring in the ISU progressively increased throughout 2021, escalating in October and November. Of the 3,339 incidents recorded at BHDC in 2021, 41 per cent occurred in the ISU. Forty-nine per cent of the 254 critical incidents recorded were also located in the ISU. In October 2021, 23 of the 25 incidents involving a threat to staff or an actual staff assault were within the ISU. And threats of self-harm, actual incidents of self-harm and suicide attempts within the ISU also increased to its highest levels. Across BHDC there have also been an increased number of roof ascents and out of bounds incidents, and assaults against staff.

Figure 4: Incidents across BHDC and within the ISU have escalated in recent months.



The volatility experienced at BHDC throughout 2021 is intensified within the ISU, where detainees involved in critical incidents are held under behaviour management plans. Poor infrastructure, a lack of staff and, at times, inhumane living conditions fuel this volatility. This was expressed to us by one young person who said:

> It's terrible. Every day we are locked down all day, like 24/7. When I was moved out to A-wing I come up to the unit and that's when… like every day was just rolling lockdowns… and I was just getting angry, you know? And I smashed up my TV, you know? And that's when I come back here and threatened to kill myself and self-harming. And I've just been in here for like two weeks… yeah, I've been in that cell for like two weeks. And every day is just stressful, you know?

During a recent visit we observed a young person acting out by secreting a paper clip following an official visit. Staff were required to restrain the detainee on the floor after he refused to hand over the item. The incident took at least 40 minutes to resolve. At the same time, a monitoring officer saw three young people requiring attention. This included one who was hiding behind his mattress, one who had covered the camera in their cell with wet toilet paper, and a third who had tied clothing around his neck as a potential ligature.

This level of volatility impedes the ability of officers to provide detainees with yard time or opportunities to shower. This results in detainees becoming more frustrated, acting out and then being locked in cell. One detainee expressed to us that they 'make them [staff] do it harder' in response to the 'hard' conditions the young people experience in the ISU. Psychology reports for Alex state he has admitted to acting out and threatening self-harm in the ISU so he can have interactions with staff and feel less isolated, even if those interactions are negative. This cycle of volatility is not sustainable and is doing harm to both the detainees and the officers.

2.5 PSPS DO NOT OFFER A CLEAR PATHWAY OUT OF THE ISU

The PSPs of detainees in the ISU often do not provide specific, measurable goals for detainees to achieve and provide no clear timelines for their progression back into mainstream units. We reviewed the PSPs for Alex, Ben and Chris and found that the behaviour expectations were often lacking in specificity, were not measurable, and failed to provide clear timelines for detainees to work towards. Behaviour expectations often appeared to be the same across PSPs, with no clear tailoring of goals for individual detainees and their personal circumstances.

Further, PSPs appear to be used to hold some detainees indefinitely in the ISU with only vague behaviour adaptation expectations. As per the Department's policy, a PSP is not intended to be disciplinary in nature (DOJ, 2021d). However, when considering the complex cognitive impairments and mental health conditions many of the detainees in the ISU have, in addition to the stressors of the ISU environment, many detainees struggle to achieve, or even comprehend, the behaviour expectations required of them. As a result, some detainees are spending excessive periods of time in the ISU, failing to progress through their PSP milestones. In this way, PSPs appear to often be used as a disciplinary tool to continue a detainee's indefinite confinement in the ISU.

2.6 THERE IS A NEED FOR ADDITIONAL WELFARE SUPPORT INSIDE THE ISU

There is an urgent need for additional welfare support within the ISU and Cue Unit to act as a circuit breaker between custodial staff and young people. These supports should be embedded within and dedicated to these units. Without intervention the cycle of volatility within the ISU will continue, resulting in further harm to young people and more staff resigning.

We recognise the toll that this volatility – the abuse, threatening behaviour, and assaults – has on the custodial staff within the ISU. Staff have a right to feel safe in their workplace. The level of staff attrition, which we were told included some recent graduates, is concerning

and is reflective of the challenging environment staff are required to work within. The use of additional welfare-focused, non-custodial staff on the ground, working alongside custodial staff, may help deliver a trauma-informed model of care, de-escalate volatile situations, alleviate the emotional burden on staff, and reduce distress in young people.

Currently support attend the ISU and Cue Unit on an occasional basis for short periods of time. This includes Aboriginal Welfare Officers, case planning officers, mental health nurses, psychologists, educators, recreation officers and chaplains. However, youth in the ISU are often competing for attention from support staff with other youth across the centre. Providing dedicated welfare support staff to the ISU and Cue Unit will ensure youth are appropriately supported, particularly in times of crisis.

Failure to radically shift the operations of the ISU will risk a continued deterioration of conditions for both detainees and staff, creating an environment not conducive to rehabilitation. In 2020/21 it cost $1,387 a day to detain a young person at BHDC (DOJ, 2022). This equates to $506,255 per year, which is nearly quadruple the $129,210 a year it cost to imprison an adult. In 2008, the cost of managing 250 of the State's young offenders throughout their juvenile years, in detention and out in the community, was estimated to cost in excess of $100 million (OAG, 2008). There is a great investment being made in the detention and rehabilitation of these young people. There is a real risk that, for those being confined in the ISU, the trauma associated with their treatment and the conditions within the facility will nullify any positive rehabilitation undertaken and the risk of recidivism will be heightened.

Recommendation 2
Embed an additional welfare focussed, non-custodial workforce to supplement the existing workforce in the ISU and Cue Unit at Banksia Hill Detention Centre.

Chapter 3

DANIEL: A CASE STUDY

Daniel's experience illustrates many of the challenges of the ISU discussed earlier in this report. Daniel experienced a significant deterioration in his mental health while confined. The seriousness of Daniel's situation led to the facility taking steps to manage him in an alternative way, utilising an observation cell in the female precinct. This decision was reactive, following multiple self-harm and suicide attempts, and a stay at an external mental health facility. Nonetheless, this was a positive, trauma-informed management decision that led to Daniel becoming more settled in his final weeks at BHDC.

Readers are advised that the following chapter discusses instances of self-harm and attempted suicide.

3.1 DANIEL ENTERED THE ISU ON 14 SEPTEMBER 2021

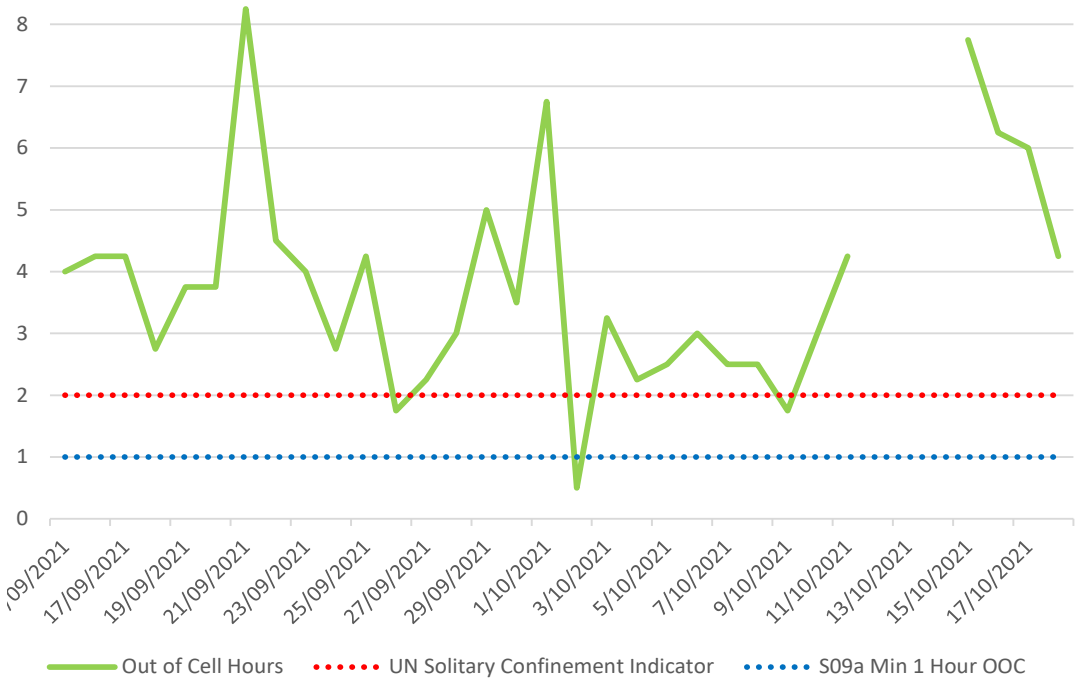
Daniel was received into BHDC on 15 March 2021, before being sentenced on 24 March. He has spent a considerable amount of time at BHDC since 2018. While detained, he has regularly spent time in the ISU as a result of poor behaviour. His most recent placement into the ISU commenced on 14 September 2021 for approximately one month.

3.2 DANIEL'S EXPERIENCE IN THE ISU WAS TYPICAL

Daniel's time in the ISU was similar to the experiences of Alex, Chris and Ben discussed earlier. There were some days where Daniel received a considerable amount of time out of cell, where he was able to participate in education, activities with other detainees, make phone calls, and spend time in the yard. There were also days where he received less than two hours out of cell, or time spent out of cell was not meaningful.

His time out of cell began to deteriorate by his fourth week in the ISU. In the first three weeks, Daniel received on average 3.8, 4 and 3.5 hours out of cell, respectively. In the seven days prior to Daniel's suicide attempt on 12 October, the average time out of cell time reduced to just 2.8 hours each day.

Figure 5: Daniel progressively received less time out of cell prior to his first suicide attempt. The gaps in data from 12 October – 14 October represent time Daniel spent in hospital.



3.3 DANIEL EXPERIENCED A CLEAR DECLINE IN MENTAL HEALTH

Daniel experienced a clear decline in his mental health during his most recent placement in the ISU. Prior to this, Daniel did have a self-harm history but there had been no recorded incidents since 2020 where he had made threats to harm himself. On 2 October 2021, during his third week in the ISU, Daniel was involved in multiple incidents of threatening to assault staff and actual staff assaults. At the time, he was also observed placing ligatures around his neck and, along with another detainee, made suicide threats. In the days after these incidents, he appeared to settle down.

On 11 October 2021 Daniel was moved to an observation cell after an officer observed him stressing out in his cell. He was provided with a stress ball. Apart from this, there are no notes on Daniel's personal monitoring form the week prior to the attempted suicide that suggested he was experiencing a serious decline in mental health.

On the evening of 11 October three detainees in observation cells began simultaneously threatening self-harm and suicide. This included Daniel, along with Alex and another detainee. All three were observed with ligatures around their neck. Daniel was observed collapsing onto the floor and appeared unresponsive. Officers entered the cell and placed him into the recovery position. He was later taken to Fiona Stanley Hospital. He later returned to BHDC and was placed back into observation in the ISU.

The following morning, Daniel was observed by an officer in his cell with a bloody nose and a ligature around his neck. The incident notes state Daniel was observed to be losing consciousness. A defibrillator was used and chest compressions were commenced by medical staff onsite. Ambulance staff took over and he was soon after taken to hospital. He returned after a day. BHDC were advised he did not qualify for admission under the Mental Health Act.

Following intervention of the Director General of the Department and executive staff, Daniel was returned to hospital on 13 October for a mental health assessment. He returned to BHDC the following day before attempting suicide again on 17 October.

In the days prior to the attempt on 18 October 2021, Daniel was averaging 6 hours out of cell per day. His days were spent meeting with psychologists, official and social visitors, and spending time in the yard. On the afternoon of 18 October 2021, a series of incidents unfolded involving four detainees, including Daniel. Officers initially responded to Daniel who was in the yard damaging the telephone. The incident report notes:

> The detainee smashed the phone into several pieces and then appeared to drop to his knees and scream in frustration.

From this description, it is evident that Daniel had become agitated. At the same time, officers were dealing with three other detainees including Alex who had blocked his camera and was slumped against his door with a ligature around his neck. Eventually Daniel was counselled and escorted back to his cell.

Later that evening, Daniel was observed in his cell with a ligature around his neck. Officers described Daniel as non-responsive and with a dark red discolouration to his face and blood coming from his nose. The cell was entered, and the ligature removed. The incident notes state Alex was heard yelling:

> *"Suicide squad, yeah we are the suicide squad".*

While waiting for an escort to hospital, an officer noted in his report that Daniel stated he had planned the incident with the other detainees to get out of BHDC and be taken to hospital. Daniel spent a further two days at Fiona Stanley Hospital, before transferring to the EMyU for mental health treatment.

Daniel returned to BHDC on 9 November 2021 and was placed in Turner Unit. After one-week Daniel deteriorated and on 16 November he ascended the roof and began threatening to self-harm. After some time, Daniel descended the roof and was placed in observation in the ISU. The following day Daniel again attempted suicide. Officers observed him slumped in his cell with a pool of blood between his legs and a ligature around his neck. Daniel was unresponsive. Officers entered the cell and observed that his face and lips were blue, and his body appeared lifeless. The ligature was removed, and ambulance staff arrived and commenced resuscitation and defibrillation. He was transferred to Fiona Stanley Hospital and on 19 November 2021 transferred back to EMyU. Daniel spent just over two weeks at EMyU before returning to BHDC.

On arrival to BHDC on 2 December 2021, Daniel was placed in the ISU where he immediately began to self-harm. Daniel was transferred back to Fiona Stanley Hospital for treatment to his injuries. He returned to BHDC the following day and was placed in one of two observation cells in Cue Unit. He remained relatively settled throughout the remainder of our inspection process. However, we understand that Daniel's circumstances have changed significantly since our inspection was completed.

3.4 PLACEMENT IN CUE UNIT HAS BENEFITTED DANIEL

Since 3 December 2021, Daniel has been placed in an observation cell in Cue Unit. When returning from Fiona Stanley Hospital, Daniel expressed that the ISU was triggering for him. His At Risk Management System (ARMS) minutes on 3 December note this, and further states that when placed in the ISU the day before Daniel began hearing voices and was receiving flashbacks to past negative experiences. Staff made the decision to place Daniel in Cue Unit, despite it being within the female precinct. Daniel has no prior negative experiences with the unit, and it is also much quieter and calmer than the ISU.

Since his placement in Cue Unit, Daniel has been more settled. The unit only has four cells, which means there is often a better staff to detainee ratio and he is able to receive more attention and observation than in the ISU. He has also been able to spend more time out of cell for recreation in the small caged yard, participating in education and meeting with psychologists. ARMS reports state that Daniel was in a better place mentally and emotionally, and that Daniel also recognised this.

The ARMS reports note that the low stimulus environment of Cue Unit has generally benefited Daniel's recovery. The reports also noted that the primary intervention for mitigating Daniel's risk-to-self is providing an environment that is supportive, with daily engagement in recreation and meaningful activities, with minimal time alone in cell. Arguably, those requirements should apply universally to all at-risk detainees and those placed in the ISU. However, the infrastructure, staffing levels and environment of the ISU simply do not make this possible, to the detriment of detainees.

It should not take several attempted suicides for a detainee to be provided with an environment that supports their emotional wellbeing.

3.5 OTHER MEMBERS OF THE 'SUICIDE PACT' REMAIN AT BHDC

Alex and another detainee with the pseudonym Ethan are two other detainees who we are aware of that formed part of the 'suicide pact' with Daniel. Ethan was released from BHDC in November 2021 but was remanded in custody again on 8 December. He spent a week in the ISU but on 14 December was relocated to a mainstream unit. His ARMS supervision log notes that he was stressed about extended lockdown time and negative peers when residing in the ISU. He remains on ARMS.

Alex remains in the ISU at BHDC, where he has been placed for most of October, November, and December 2021. In that time, he has been involved in numerous abusive, threatening and assault incidents against staff. He has also been involved in several self-harm and attempted suicide incidents. In a discussion with us, Alex acknowledged the 'suicide pact' and how his time in the ISU was affecting his mental health:

Table 3: Transcript of interview with Alex in December 2021.

Interviewer:	And have you tried to kill yourself in here, Alex?
Alex:	Yeah.
Interviewer:	And did you have a plan with those other boys?
Alex:	Yeah like... they were stressing out...
Interviewer:	How did they plan it?
Alex:	They were like... just... ripping up their sheets and just tie it around their neck until they pass out and die. Like... one boy he died ... they came in and he stopped breathing and his heart had stopped... and they had to use the oxygen tank to bring him back and then he went straight ... they done that like four times... yeah. They took him to the mental hospital. And he came back on Friday night from the mental ward and he's just drugged... just drugged. He looks like a zombie. I tried to talk to him and he didn't talk back he just started smashing his face on the wall... and blood... and he's in the cell next to me and there's just blood all on the floor.
Interviewer:	So you were in that cell there and he's right next to you there?
Alex:	Yeah and then he went back to hospital... ... I'm depressed too... I'm doing it too, you know?
Interviewer:	What do you mean when you say I'm doing it too?
Alex:	Like I was doing it too. I was on that phase too.
Interviewer:	You mean self-harming and...
Alex:	Yeah self-harming...
Interviewer:	... and attempting to kill yourself?
Alex:	Yeah.
Interviewer:	Do you actually want to die or do you just want this to stop? Which one is it?
Alex:	Bit of both. Like when I'm really angry... or when I'm really sad... I just really want to die.

Chapter 4

A 'SHOW CAUSE NOTICE' WAS ISSUED

4.1 A 'SHOW CAUSE NOTICE' WAS ISSUED FOLLOWING THE INSPECTION

Considering the preliminary findings of this inspection, the Inspector of Custodial Services (the Inspector) formed a reasonable suspicion that:

1. There was a serious risk to the care or welfare of detainees held in the ISU at BHDC.
2. That detainees were being subjected to cruel, inhuman or degrading treatment in the ISU at BHDC.

It was also noted that many of the same factors affecting service delivery at the centre were similar to those that existed prior to the January 2013 riot (OICS, 2013), and the significant disturbances on 4 and 5 May 2017 (OICS, 2018).

As a result, on 17 December 2021 the Inspector provided a copy of a preliminary draft inspection report to the Department and issued the Director General a 'Show Cause Notice' (the Notice) under Section 33A of the *Inspector of Custodial Services Act 2003* (the ICS Act).

The Notice highlighted the Inspector's concerns and provided the Department an opportunity to provide a formal response.

4.2 THE DEPARTMENT'S RESPONSE TO THE NOTICE

In response to the Notice and our preliminary draft inspection report, the Department provided a detailed submission outlining plans already underway which would also address the concerns raised. This included providing longer term plans for the centre generally, and the ISU specifically. Some of the proposed changes and infrastructure upgrades follow recommendations made by OICS in previous inspection reports (OICS, 2015; OICS, 2018a; OICS, 2020). Other proposed upgrades continue the project of target hardening the centre that has been ongoing since the 2013 riot. The submission also highlighted measures the Department is taking in order to address custodial staff shortages, attrition, and workers' compensation claims at BHDC, and work being undertaken to reset the centre's operating philosophy and model of care.

The Department recognised the importance of providing as much productive out of cell time for detainees as possible, beyond the minimum statutory entitlements. The Department anticipated increased staff numbers, infrastructure changes and upgrades, and providing greater supports to reduce stress and the number of critical incidents, would assist in facilitating more meaningful time out of cell. Specific details of the additional supports being proposed were not included.

The Department also reaffirmed their support for legislative amendments to the confinement provisions under the YOA and Regulations, as per our previous recommendations (OICS, 2018).

A 'SHOW CAUSE NOTICE' WAS ISSUED

4.3 THE MATTER WAS REFERRED TO THE MINISTER

Following consideration of the Department's response, the Inspector referred the matter to the Minister for Corrective Services (the Minister) in accordance with Section 33A(7) of the ICS Act. The Inspector advised the Minister that the plans outlined in the Department's submission were supported.

However, the Inspector concluded that there was an overreliance on security mechanisms, physical and personnel, to address the concerns highlighted in the preliminary draft inspection report. There appeared to be a limited focus on the social, emotional, and welfare needs of the young people despite the Department's referral to their trauma informed model of care. For example, in reflecting on time out of cell, the Department concentrated on the physical amount of time a young person was spending out of cell rather than whether that time was meaningful, and socially and emotionally enriching.

The Inspector advised the Minister that an appropriate balance between security and welfare responses ought to be achieved. While the safety of staff and detainees is paramount, there are opportunities to considerably improve the Department's welfare response at Banksia Hill. This may include supplementing the custodial workforce with a non-custodial service provider to assist the facility in meeting the minimum statutory entitlements of the young people detained.

4.4 THE MINISTER'S RESPONSE TO THE NOTICE

The Minister responded to the Notice and acknowledged the issues raised. The Minister recognised the infrastructure deficiencies at the facility and the impact of staffing shortages, and noted the works being taken by the Department to address these issues.

The Minister noted that the Department continues to investigate ways to improve the operation of the facility and enhance the quality of life for detainees.

Appendix 1

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Appendix 2

ABBREVIATIONS

ACCG	Australian Children's Commissioners and Guardians
ARMS	At Risk Management System
Beijing Rules	Standard Minimum Rules for the Administration of Juvenile Justice (UNODC, 1985)
BHDC	Banksia Hill Detention Centre
CAPSP	Personal Support Plan – Change of Accommodation
COPP	Commissioner's Operating Policies and Procedures
Department	Department of Justice
EMyU	East Metropolitan Youth Unit
Havana Rules	Rules for the Protection of Juveniles Deprived of their Liberty (UNODC, 1990)
ICS Act	Inspector of Custodial Services Act 2003
ISU	Intensive Support Unit
Mandela Rules	Standard Minimum Rules for the Treatment of Prisoners (UNODC, 2015)
the Minister	Minister for Corrective Services
OAG	Office of the Auditor General
OICS	Office of the Inspector of Custodial Services
PHS	Psychological Health Services
PRAG	Prisoner Risk Assessment Group
the Regulations	Young Offender Regulations 1995
SO9a	Standing Order 9a
UNODC	United Nations Office on Drugs and Crime
YOA	Young Offenders Act 1994

Appendix 3

DEPARTMENT OF JUSTICE RESPONSE

Government of Western Australia
Department of Justice
Corrective Services

Response to Inspection:

Inspection of the Intensive Support Unit at Banksia Hill Detention Centre

February 2022

Version 1.0

Response to Inspection:
Inspection of the Intensive Support Unit at Banksia Hill Detention Centre

Response Overview

Introduction

The Inspection of the Intensive Support Unit (ISU) at Banksia Hill Detention Centre (Banksia Hill) was announced by the Office of the Inspector of Custodial Services (OICS) on 1 December 2021.

Being an occasional inspection under section 21 of the *Inspector of Custodial Services Act 2003* (the ICS Act), the methodology for the gathering of documents and information for this inspection occurred primarily on site at Banksia Hill.

On 17 December 2021, OICS provided the Department of Justice (the Department) a preliminary report of the Inspection, which highlighted concerns for the treatment and care of young people in the ISU at Banksia Hill. As a result, OICS issued the Director General a Show Cause Notice under the *Inspector of Custodial Services Act 2003* and requested the Department provide a response and evidence demonstrating how the Department intends to address or alleviate the concerns raised by OICS. The Department provided a response to the preliminary report and Show Cause Notice on 23 December 2021.

On 15 February 2022, the Department received the completed draft report on the Inspection. The draft report reiterated the findings made in the preliminary report received by the Department on 17 December 2021 and made two recommendations. The Department has reviewed the draft report and provides comments and responses to the recommendations as outlined below.

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

Review Comments

The Department is aware of the vulnerabilities of the young people in its care at Banksia Hill and a major priority is the safety, health and welfare of these young people. Many of the young people received at Banksia Hill come from highly dysfunctional and challenging backgrounds, suffer from complex neurological disorders, trauma abuse and have a long-term criminal offending history.

Since mid-2021, Banksia Hill has been experiencing considerable challenges, particularly with a small number of detainees who continue to behave in a highly disruptive manner impacting on the rest of the centre. These young people have consistently been involved in incidents of significant damage to infrastructure, fence and roof ascents, assaults to staff and self-harm and suicide attempts.

Although the critical incidents have been driven by a small number of young people, their actions have widespread consequences and have resulted in extensive damage to infrastructure and assaults on staff. That has led to an increase in workers compensation claims and high staff attrition, increased time in cells for young people and more frequent centre-wide lockdowns, impacting access to services for all other young people.

Some of these young people would be more appropriately accommodated in a forensic mental health facility. This however is rarely possible due to a dearth of youth forensic beds in the Perth metropolitan region and regional areas. These young people are placed in the ISU for the purposes of managing their behaviour and for the good order and security of Banksia Hill.

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The ISU is a multifunctional unit that provides a safer environment for the management of young people with unique and complex needs, requiring a greater level of supervision. These young people include those who are self-harming or at risk of self-harm, or who are harming others.

The ISU may be utilised for short periods to interrupt a cycle of behaviour and provide the opportunity for young people to reflect and receive support. Like other detainees, the Department seeks to engage these young people in education, recreation and programs, unless there are significant security or safety reasons not to do so.

The Department acknowledges that Banksia Hill has inherent infrastructure issues and was not designed as a fit-for-purpose youth detention centre for both remanded and sentenced youth. Similarly, the ISU infrastructure is less than optimal, and the architecture is not conducive to providing the best therapeutic response that benefits the detainees who are accommodated within the unit.

Given the lack of other suitable enhanced security units at Banksia Hill, the ISU must be used for multiple, disparate purposes. This involves the shared housing and mixing of various cohorts for the purpose of post-incident management, security placement and to better manage vulnerable or at-risk youth. Staff within the ISU manage the young people to their best of their ability, with the safety of the young people being paramount.

As a consequence, the operational capacity to provide a stable environment and structured daily routine within available infrastructure for all young people (including young people with trauma or mental illness, complex and challenging behaviours, or those at acute risk of self-harm or suicide) is impacted. Further, the current infrastructure does not allow for adequate separation and targeted responses to each cohort's particular needs. These issues are more evident when the unit is full and holds cohorts of individuals who have very complex needs. Infrastructure damage and repairs as a result of incidents that have occurred in the ISU as well as in transitional units have also limited placement options for young people.

The Department has initiated a number of strategies to address the issues at Banksia Hill, including the service delivery model, infrastructure, staff attrition and the complex needs of the young people at Banksia Hill and more specifically, the ISU. The Department is continuing a program of work to address these issues

A bulk recruitment campaign has been undertaken with sufficient candidates identified to fill future Entry Level Training Programs (ELTP). Two training schools have commenced and expect to graduate in April 2022 with approximately 40 extra staff for Banksia Hill.

A more-appropriate model of care for the young people at Banksia Hill is under development. This will include a new operating philosophy and model of care based on best practice. The model of care will be a way of working with young people using trauma-informed principles across the system. The Department has committed resources to develop and implement the model of care and improve services for the young people at Banksia Hill.

The Department has also committed funds to address some urgent infrastructure needs. In addition, a number of submissions have been made for additional infrastructure project funding which are pending Government approval.

It should be acknowledged that, although the inspection report highlights cases of a small number of young people causing disruption at Banksia Hill, the majority of the

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young people are compliant and are effectively managed within available infrastructure / facilities without incident. Banksia Hill continues to balance the welfare needs of the young people with the security of the facility and the safety of staff who work at the facility. Cells in poor condition and damaged telephones referenced in the report are caused by detainees and repaired as soon as possible

The inspection report also claims the Department is not complying with the minimum entitlements of young people in relation to time spent out of cell as established in international human rights instruments. To this effect, the Department has reviewed and amended related policies to provide clarity around the minimum entitlements for young people and provide operational guidance for staff in the application of the minimum requirements in accordance with legislation.

While maximising a detainee's time out of cell is a priority for Banksia Hill, this is dependent on the young person's behaviour and is impacted by Centre constraints – reduced staffing numbers and the management of critical incidents – which often result in Centre-wide lockdowns.

It should also be noted that in each of the cases cited in the inspection report, in addition to recreational time out of cells, the young people left their ISU cells for such purposes as health and psychological consultations and social visits.

While the Department is ultimately bound by the *Young Offenders Act 1994* (YOA), it does recognise the importance of providing as much productive out-of-cell time for the young people as possible, beyond the minimum requirements set out in legislation. The Department is working to increase out-of-cell hours by increasing staff numbers, infrastructure changes and provision of a greater number of supports to disturbed detainees to assist with reducing stress and the number of critical incidents which reduce time out of cell.

The Department supports the two recommendations made by the Inspector as they align to current practice and projects that have been initiated by the Department.

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Response to Recommendations

1 Re-introduce explicit minimum out of cell requirements for detainees in the ISU on a Personal Support Plan.

Level of Acceptance: Supported - Current Practice / Project
Responsible Division: Corrective Services
Responsible Directorate: Women and Young People
Proposed Completion Date: N/A

Response:

Current policies for Banksia Hill Detention Centre, namely *COPP 6.2 Supervision Levels and Privileges* and *COPP 5.2 Intensive Supervision and Cue Units* identify the minimum out of cell hours for young people, including those on Personal Support Plans in the Intensive Support Unit (ISU).

The Department maintains that all young people are afforded participation in the normal daily routine program unless in circumstances where the good order, safety and security to young people and staff does not permit. Where the circumstances do not permit, COPP 6.2, particularly sections 3 (*Entitlements*) and 4 (*Privileges*), operationalises the minimum standards applicable to all young people.

The minimum standards apply to all young people irrespective of their accommodation placements and are detailed within individual Personal Support Plan – Change of Accommodation (CAPSP).

Additionally, and in line with the Young Offenders Act 1994 and Young Offender Regulations, COPP 5.2 reinforces the minimum requirement of one hour exercise per day for each young person in the ISU and Cue Unit.

COPP 5.2 has been reviewed and amendments made to provide clarity around the minimum requirements and to ensure that the minimum out of cell hours is provided to a young person on a CAPSP. The revised COPP is scheduled for implementation in April 2022.

2 Embed an additional welfare focused, non-custodial workforce to supplement the existing workforce in the ISU and Cue Unit at Banksia Hill Detention Centre.

Level of Acceptance: Supported - Current Practice / Project
Responsible Division: Corrective Services
Responsible Directorate: Women and Young People
Proposed Completion Date: N/A

Response:

The Department recognises that contemporary best practice for the effective rehabilitation and reintegration of young people requires a multi-disciplinary and trauma informed approach to address the underlying reasons for their offending and behaviour.

Actions are underway to develop a more-appropriate model of care for the young people at Banksia Hill Detention Centre. A new operating philosophy and model of

care based on best practice is being developed. The model of care will be a way of working with young people using trauma-informed principles across the system.

The model of care will be supported by providing staff from all business areas with appropriate training. Staff will actively engage in the case management of the young people and will have detailed knowledge and understanding of the specific role they play in effective case management and how their contribution fits into the overall aims of the facility and the individual case plan.

Appendix 4

INSPECTION DETAILS

Data sets for this inspection were obtained from the Department of Justice's (the Department) 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 between January and November 2021.

We examined Western Australian legislation and departmental documentation including policy. As part of the inspection we conducted site visits to Banksia Hill Detention Centre across several days, where we spoke with staff and young people.

A preliminary findings report was presented to the Department in December 2021, accompanied with the 'Show Cause Notice'.

INSPECTION TEAM

Eamon Ryan	Inspector
Darian Ferguson	Deputy Inspector
Christine Wyatt	Director Review
Natalie Gibson	Director Operations
Ryan Quinn	Research and Review Officer
Cliff Holdom	Inspections and Research Officer
Kieran Artelaris	Inspections and Research Officer
Laura Jackman	Senior Policy Officer, Commissioner for Children and Young People

KEY DATES

Formal announcement of inspection	1 December 2021
Start of on-site phase	7 December 2021
Completion of on-site phase	10 December 2021
Preliminary report and 'Show Cause' Notice sent to the Department of Justice	17 December 2021
Response to 'Show Cause' Notice received from Department of Justice	23 December 2021
Letter to the Minister for Corrective Services sent	21 January 2022
Draft report sent to the Department of Justice	15 February 2022
Draft report returned by the Department of Justice	3 March 2022
Declaration of prepared report	10 March 2022

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

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