GOVERNMENT OF WESTERN AUSTRALIA

OFFICE OF THE INSPECTOR OF CUSTODIAL SERVICES

The transport of regional and remote prisoners

February 2023

The Office of the Inspector of Custodial Services acknowledges Aboriginal and Torres Strait Islander people as the traditional custodians of this country, and their continuing connection to land, waters, and community throughout Australia. We pay our respects to them and their cultures, and to Elders, be they past, present, or emerging.

Reader advice: The following review contains the names of some Aboriginal and Torres Strait Islander peoples who have passed away. The review also contains discussions on self-harming and suicide. Some people may find the content of this report distressing.

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This report is available on the Office's website and will be made available, upon request in alternate formats.

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Inspector's Overview

Transport of prisoners across regional Western Australia is generally undertaken with a focus on prisoner welfare and managing risks

This review was prompted by a few recent incidents that raised questions for us about the conditions under which prisoners were being transported across regional Western Australia. It was also undertaken against a historical backdrop of the tragic case of Mr Ward who died during a prisoner transport in 2008. We set out to seek assurance that the gains made since 2008 have been sustained.

Almost two thirds of regional prisoner transports are undertaken by the contracted provider, Ventia. Most of the remainder are undertaken by staff from individual prisons or the Department's Special Operations Group.

It was reassuring that the broad findings of the review show that the transport of adult prisoners across Western Australia are generally of a high standard. We observed a strong focus on the welfare of prisoners with attention to risks and how best to mitigate them.

There was, however, some areas identified that need improvement. For example, we found some inconsistencies between the practices followed by the Department and those followed by Ventia. Also, on occasions documentation required to be completed under relevant policy had not been completed or, if it was, it was scant on detail. In other cases, we identified that there had been no formal risk assessments and/or documented justification for the use of additional restraints despite a policy requirement for the superintendent to document such decisions. At the risk of stating the obvious, inconsistencies such as these can become very significant if something goes wrong or if complaints or allegations are raised.

The transport fleet operated by Ventia was generally well maintained and there was good compliance monitoring by the Department's contract management team. But there were gaps evident in how the Department managed its own fleet of vehicles. For example, the Department only identified a fault in a vehicle's CCTV recording equipment after we called for copies of the recordings to examine the circumstances outlined in the case study in Chapter 4.

We have included the case study in Chapter 4 to illustrate some of the issues that can go wrong in undertaking regional transports. It also highlights how gaps in policy compliance, the absence of documented actions and decisions, and unclear practices can undermine the Department's stated intention of transporting prisoners in a safe, secure and humane manner.

It was pleasing that the Department supported our recommendation to review the findings arising from the case study to identify areas for improvement.

Acknowledgements

It is important to acknowledge the contribution and assistance we received in undertaking this review from key personnel in the Department, Ventia and Serco.

I acknowledge the contribution and hard work of the staff in our office who were involved in undertaking this review. I would particularly acknowledge and thank Ryan Quinn for his hard work in leading this review and as principal drafter of this report.

Eamon Ryan
Inspector of Custodial Services

20 February 2023

Executive Summary

Background

The death of Mr Ward led to an improved focus on welfare during prisoner transports

Mr Ward was a 46-year-old local Aboriginal Elder who died of heatstroke at Kalgoorlie District Hospital on 27 January 2008, after collapsing in the back of a custody transport vehicle.

The Coroner found that Mr Ward suffered heatstroke while being transported in the rear pod of a prisoner transport van where the air-conditioning was not working (Hope, 2009). The 360km journey from Laverton to Kalgoorlie occurred on a day where the outside temperature was over 40 degrees celsius. The temperature inside the rear pod was estimated to have reached 50 degrees. And, the body temperature of Mr Ward at Kalgoorlie Hospital following his death was 41.7 degrees, exceeding the normal range of 36 – 37 degrees (Hope, 2009).

In addition to heatstroke, a post-mortem examination found Mr Ward had suffered thermal burns to his body. The Coroner found these were caused prior to his death where he lost consciousness and fell to the metal-plated vehicle floor. The burn was considered significant enough to determine that the surface temperature of the van was extremely hot (Hope, 2009).

The Coroner found that the vehicle used to transport Mr Ward was not suitable for the transportation of prisoners over lengthy journeys. The wear and tear of the vehicle over an eight-year period had contributed to it being unfit for use. The level of supervision by escorting officers, ability to communicate with Mr Ward, and CCTV coverage of the rear pod were also found to be inadequate (Hope, 2009).

The Coroner also noted both GSL, the transport contractor, and the Department had no written policies on conducting regular physical welfare checks of prisoners throughout journeys. There were also no written policies on the provision of food and water. The Coroner was also critical of the practice to provide prisoners empty bottles or jerry cans to urinate in, rather than pre-arranging comfort breaks at local police stations or fitting transport vehicles with on-board toilets. These issues led the Coroner to believe there had been a failure in the duty of care and concern for the dignity of Mr Ward (Hope, 2009).

At the conclusion of the inquest the Coroner recommended the Department replace its existing transport fleet, develop welfare policies for prisoner transportation, and conduct regular reviews of transport contractor services in regional locations.

Ventia are the current service provider for prisoner transports

Ventia, formerly Broadspectrum, are the current contracted service provider for court security and custodial services in Western Australia, as prescribed under the *Court Security and Custodial Services Act 1999* (CSCS Act). The Court Security and Custodial Services Contract (the CSCS Contract) outlines a range of transport-related obligations, which is summarised in Appendix A.

The CSCS Contract excludes the transportation of prisoners in certain circumstances. This includes all movements from West Kimberley Regional Prison, except for transfers to Broome Regional Prison. Pardelup Prison Farm also have limited service from Ventia. The Department is required to perform movements for these prisons, in addition to the following prisoners:

a) those assessed as a High Security Escort
b) those approved for external activities or work outside of a prison
c) those travelling to/from work camps
d) those travelling Interstate or overseas
e) those requiring emergency medical treatment
f) those who are accommodated at a prison and returned or handed over to the WA Police Force for operational purposes
g) those residing at Boronia Pre-Release Centre for Women, Karnet Prison Farm, Pardelup Prison Farm and Wooroloo Prison Farm requiring transport to medical appointments, hospital, or funeral visits, and
h) those participating in Re-Integration Leave (RIL) or Prisoner Employment Program (PEP) activities (DOJ, 2022a, p. 6).

Ventia, then Broadspectrum, was provided an initial five-year contract in 2016. At the time this report was being prepared, Ventia had been provided a one-year contract extension. In January 2023, Ventia was awarded a further four-year contract.

Ventia perform most movements

Two thirds of the regional transports completed between 2018 and 2021 were conducted by Ventia, or Broadspectrum before them. The Department conducted 29 per cent of transports, the WA Police Force conducted 2.5 per cent and the Special Operations Group (SOG) performed a small amount. Other transports utilised include family or employer arranged travel for re-integration leave or external employment activities.

Broadspectrum and Ventia performed most of the transports for inter-prison transfers, court appearances and scheduled medical appointments. The Department facilitated most unscheduled medical transports and most external activities such as community work, education and recreation.

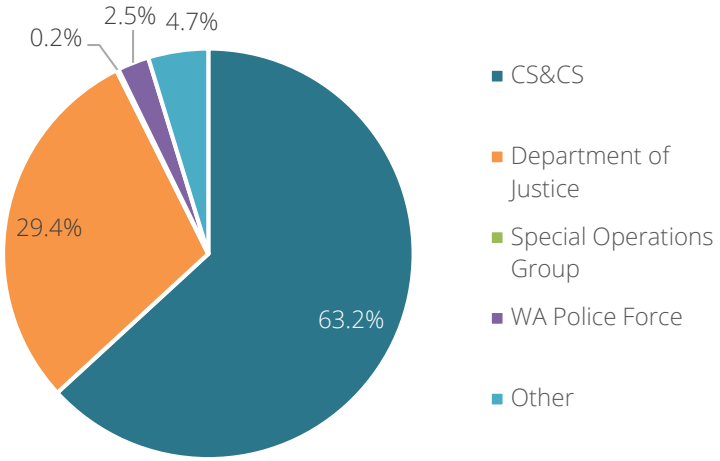


Figure 1: The CSCS contractor provided transport services for most regional movements between 2018 and 2021.

Occasionally, the SOG will undertake movements of high-risk and designated high-security prisoners. All prisoners with an

active high-security escort alert[1] are required to be moved by the SOG, regardless of their location or the movement reason (DOJ, 2022). Additionally, prisons may also request the SOG assist moving a prisoner considered high-risk, such as those who are difficult to manage. Using the SOG for these escorts helps ensure the movement is safe and secure for all involved.

Between 2018 and 2021, the SOG only completed 104 movements, or 0.2 per cent of all movements to or from a regional prison. Most of these were inter-prison transfers. The SOG uses air transportation where it is available, but also has a small vehicle fleet it can use for road journeys.

Inter-prison transfers the most common movement reason in regional Western Australia

Twenty-six per cent of the 65,191 prisoner transports to or from regional prisons were for inter-prison transfers. Albany Regional Prison recorded the highest volume of inter-prison transfers, mostly between Hakea and Casuarina Prisons. However, the most common route was between Broome Regional Prison and West Kimberley Regional Prison.

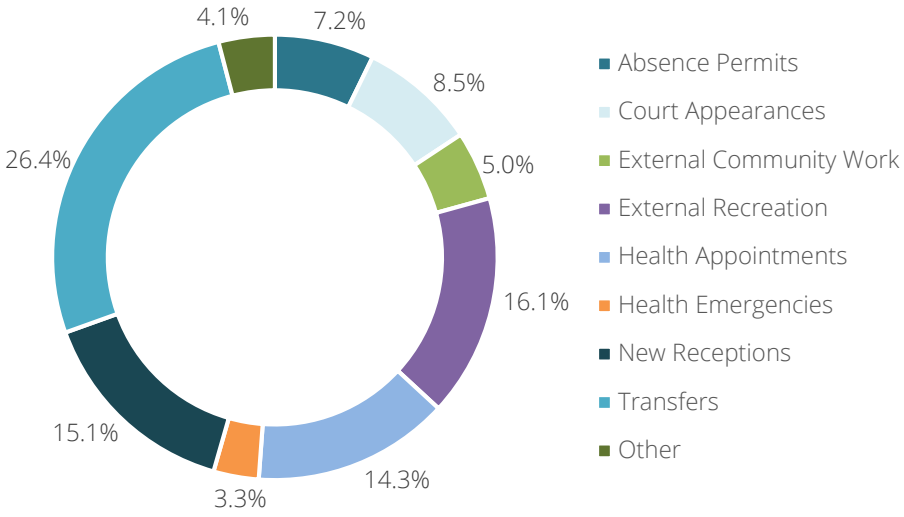


Figure 2: Inter-prison transfers were the most common regional transport movement reason between 2018 and 2021.

Prisoners travelling locally for external recreation (16%), those being received into prison from a police lock-up or local court custody centre (15%) and those being transported to a health appointment (14%) were the other most common reasons prisoners were transported to or from a regional prison in Western Australia.

1 A high-security escort alert is assigned to a prisoner if information or intelligence suggests there is an identified risk to an escort. This may include evidence to suggest a prisoner may be an escape risk, be violent towards others, be notorious or high-profile, or possess other factors that heighten the risks involved with their movement (DOJ, 2022).

REGIONAL PRISONER MOVEMENTS
2018 - 2021

65,191
movements to / from regional prisons

17,210
prisoners transferred to / from regional prisons

2,142
health emergencies

9,321
health appointments

961
visits to funerals or ill relatives

4,859
prisoners moved by plane

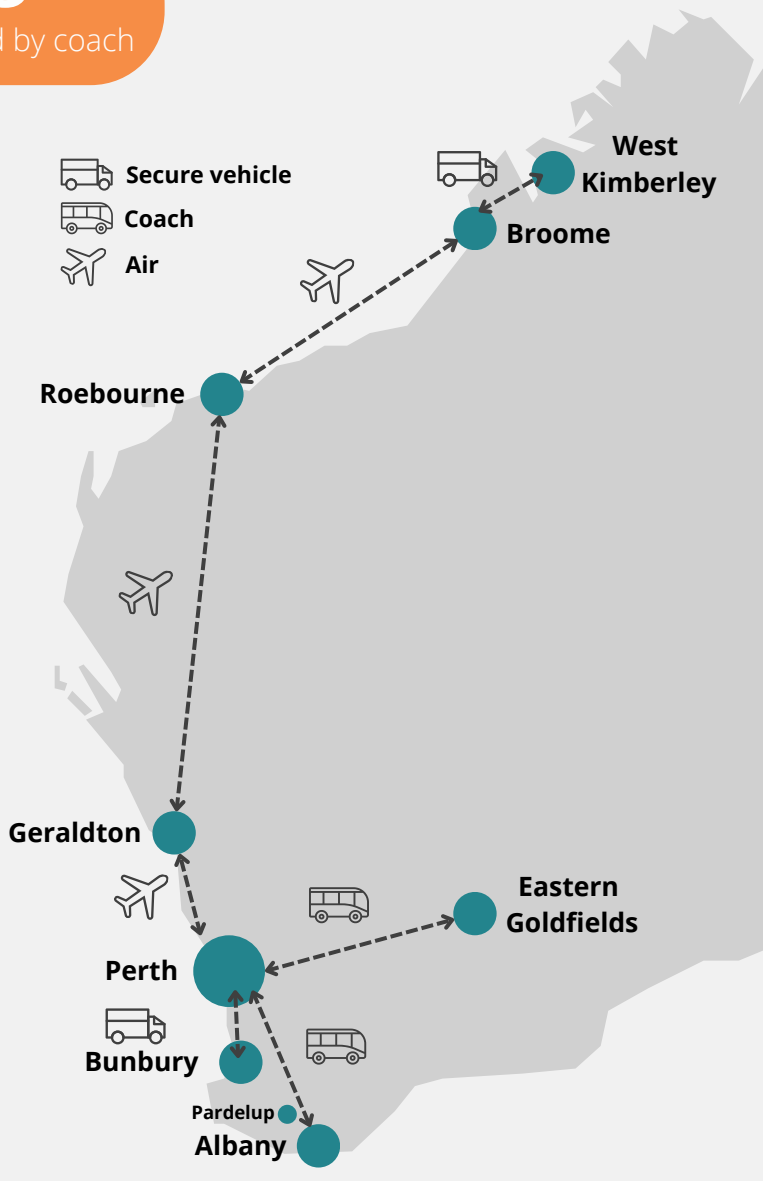
5,899
prisoners moved by coach

4,863
prisoner movement risk assessments completed

3,459
police lock-up clearances

21
vehicle/plane faults, accidents or breakdowns

1
escape from custody



Key findings

Clear focus on prisoner welfare, but gaps exist

Since the death of Mr Ward, the Department has implemented a clear focus on welfare during prisoner transports. This focus is present through policy and practice throughout the various stages of a prisoner movement and demonstrates the Department's commitment to preventing mistreatment. However, we identified some areas where practices are not clearly aligning with the policy intent, or where improvements could benefit both staff and prisoners. We also found some discrepancies in practice between Ventia and Department-led movements, which could be aligned.

Risk mitigation is prioritised

Both the Department and Ventia have processes in place to assess and mitigate risks prior to undertaking a prisoner movement. However, we found the Department's Prisoner Movement Risk Assessments were often lacking in detail and External Movement Risk Assessments were not always completed when required.

Generally, we found prisoners were restrained in accordance with policy, but identified some areas of non-compliance. This included the Department at times placing prisoners in hand cuffs and leg restraints while secured in a vehicle, without completing a risk assessment that justified the need for additional restraints. We also found an inconsistent approach to the use of leg restraints for prisoners travelling on planes.

Despite Ventia operating an ageing fleet, we found vehicles were being maintained to a high standard. This was aided by a relatively rigorous compliance and monitoring framework undertaken by the Department to ensure that safety, security and prisoner welfare was not compromised.

Good governance, but oversight and transparency are poor in some areas

Both the Department and Ventia have developed comprehensive policy and procedural frameworks for the delivery of prisoner transports. These frameworks reiterate a priority on safety, security and welfare. However, transparency issues and limited oversight hamper the Department's ability to assure Department-led movements are conducted in accordance with policy.

Ensuring dignified travel: Anna's experience

The case study outlined in this chapter demonstrates how the actions of staff, a range of procedural errors and a lack of transparency can undermine the Department's intention of transporting prisoners in a safe, secure and humane manner.

Conclusion

Overall, this review found that the delivery of regional and remote prisoner transports is a complex operation that is generally delivered in a safe, secure and humane manner. Maintaining a focus on policy and procedural compliance, across all aspects of prisoner transport, will assist the Department in preventing unsafe or inhumane practices.

Recommendations

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Recommendation 14 – Review the circumstances of Anna's experience, and the findings we have identified, and take actions to ensure the dignity and welfare of prisoners are protected in Department-led transports 39

1 Clear focus on prisoner welfare, but gaps exist

In policy and practice we found a clear focus on prisoner welfare existed at the various stages of planning and undertaking a prisoner movement. However, we identified some areas where practices are not clearly aligning with the policy intent, or where improvements could benefit both staff and prisoners.

1.1 Pre-movement processes are welfare focussed, but mental health considerations could improve

The Department has a range of pre-movement processes in place that consider the health, safety and wellbeing of prisoners during movements. We found these processes were embedded into practice and were observed to be functioning well. Department staff had a good understanding of the various processes involved in moving a prisoner and understood their specific role within these processes. Generally, the movement of prisoners was found to be efficient and actively considered the safety, security and humanity of prisoners and escorting staff.

Arrangements for vulnerable cohorts considered

The Department has developed a range of specific transport considerations for vulnerable cohorts of prisoners, including those who:

- are pregnant, in labour, or require post-natal care
- have significant medical and/or mobility issues
- identify as trans, gender diverse or intersex.

For the latter, these prisoners are required to be segregated from other prisoners in a separate pod and be provided with opportunities to use toilet facilities separate from others (DOJ, 2022a). The Department is required to inform Ventia of any prisoner they will be transporting who identifies as trans, gender diverse or intersex. Prisoners are also asked the preferred gender of the staff member who will conduct searches. This may include a preference for different gendered staff members conducting the search for the top and bottom half of the prisoner's body (DOJ, 2021).

Prisoners with significant medical or mobility issues are not permitted to be placed in restraints unless approved by the Superintendent or Officer in Charge following an assessment of risk under an External Movement Risk Assessment (EMRA) (DOJ, 2021a). The prohibition of restraints includes prisoners who:

- are not conscious
- are terminally ill
- are elderly and frail
- have significant mobility issues
- have significant injuries or health challenges which may prevent the use of handcuffs, ankle cuffs or hobbles
- are pregnant, in labour, or post-natal care.

An EMRA will also assess the type of vehicle suitable for the prisoner's specific health considerations. Where considered necessary for the welfare of the prisoner, a non-secure vehicle may be approved by the Superintendent following an EMRA (DOJ, 2021b). Ventia is also required to conduct its own risk assessment when conducting escorts for prisoners in the above category.

The Department and Ventia are also required to ensure that prisoners of different genders and those with protection status are appropriately separated.

Notwithstanding the above, the Department's policy does not provide any specific consideration to the needs of Aboriginal prisoners. The Aboriginal Legal Service Western Australia previously argued that consideration of Aboriginal people's special health needs was required, given they are more likely to experience lengthy journeys across regional Western Australia (Standing Committee on Public Adminstration, 2015). They also recommended that Aboriginal persons in custody be provided with more regular comfort breaks throughout long journeys.

Fitness to Travel Assessments ensure appropriate adjustments in place prior to travel

Fitness to Travel Assessments (FTTAs) provide custodial officers with simple but effective information that assist in making a prisoner's journey more comfortable. Typically conducted by the Clinical Nurse Manager, FTTAs provide custodial staff basic medical information necessary for a prisoner's transfer, such as their requirement to carry asthma medication or to be placed in a soft-seated vehicle. We found they were a relatively basic but effective tool used consistently across all facilities.

However, confidentiality and privacy requirements limit the transfer of more fulsome information from health to custodial staff. Health staff complete the FTTA using the Department's prisoner health database, which custodial staff have restricted access to. Once completed, the outcomes of the FTTA are updated on the prisoner's medical status on the offender database. We found the information provided to custodial staff was often lacking detail, particularly around mental health concerns. The provision of more detailed information, such as known mental health triggers or symptoms, may assist officers to de-escalate a prisoner showing signs of deteriorating mental health mid-journey.

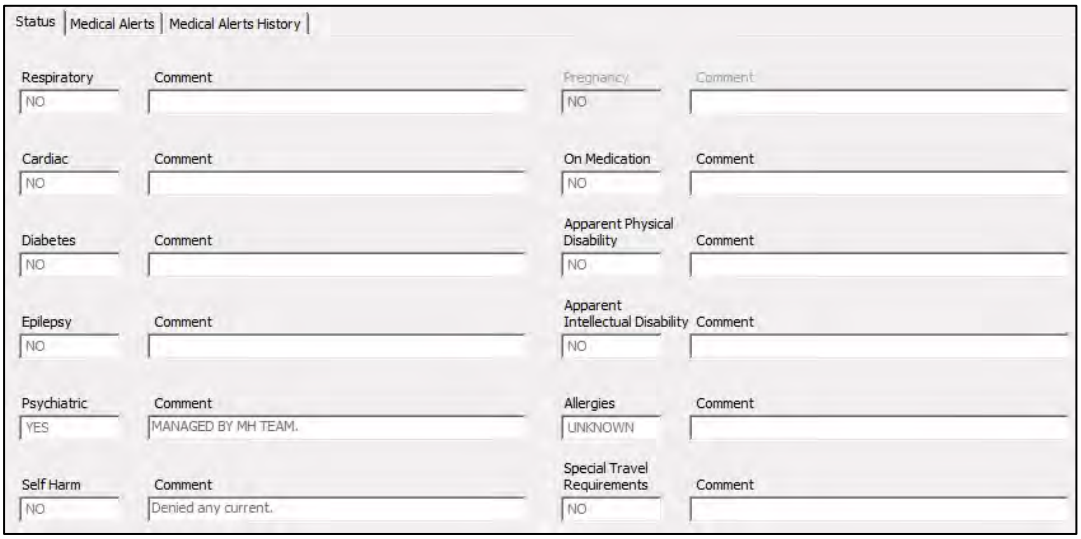


Figure 3: The results of the FTTA appear in the offender database under the 'Special Travel Requirements' line of the prisoner's medical status tab.

While we acknowledge the importance of medical confidentiality, similar information is already accessible to custodial officers through the At-risk Management System (ARMS).

Existing mental health clients are also assessed prior to transfer

The Department's Health Services also require known mental health clients to be assessed prior to an inter-prison transfer. The assessment is conducted by mental health nurses, who seek to ensure the prisoner's mental health is stable enough at the time of transfer (DOJ, 2020). The mental health nurse may ask questions about how the prisoner is feeling about the transfer, whether they have any thoughts of self-harm, query how their mood has been lately, and ask their thoughts about the move. This information is recorded in the Department's prisoner health database for future reference, and appropriate referrals are made to health and mental health services at the receiving prison.

This is an appropriate process which, when combined with other self-harm risk assessments conducted prior to travel, helps ensure the prisoner's welfare is suitably considered.

At the time of writing, all regional prisons had a mental health nurse except Broome Regional Prison, Eastern Goldfields Regional Prison and Roebourne Regional Prison. Where mental health nurses are not available, primary health care staff review any mental health notes in the Department's health database as part of their FTTA process.

The Department has a rigorous policy for assessing a prisoner's risk of self-harm prior to travel, but in practice the benefit is unclear

The Department's policy for inter-prison transfers outlines a rigorous, but somewhat convoluted, process for assessing a prisoner's risk of self-harm prior to travel (DOJ, 2021c). This assessment is used to identify prisoners who are either:

- 'Of Self-harm Concern': including those with a current Self-harm History alert, but with no attempted or actual self-harm incident within the past six months.
- 'Elevated Risk of Self-harm':
    - those currently with an active ARMS or SAMS alert, or
    - those with a current Self-harm Potential alert, or
    - those with a current Self-harm History alert, and with an attempted or actual self-harm incident within the past 6 months (DOJ, 2021c, p. 8).

The policy steps out processes for Superintendents to follow should a prisoner be identified under either of these categories. This includes relevant stakeholders completing a Self-harm Concern Review Checklist for those of self-harm concern, and a Transfer Plan for those with an elevated risk. These plans are developed in consultation with stakeholders from both the originating and receiving prison. A final copy of the plan is lodged with the Department's Operations Centre.

The detailed policy established by the Department is commendable and demonstrates a commitment to safeguarding the welfare of at-risk prisoners throughout inter-prison transfers.

The effectiveness of Transfer Plans is unclear

Our analysis of Transfer Plans found they often replicated known information and did not effectively discuss how to safely transfer prisoners with mental health concerns. Between January and June of 2022 there were 36 prisoners who completed an inter-prison transfer to or from a regional facility while being monitored on ARMS. This would qualify them as being deemed an elevated risk of self-harm. We requested the Transfer Plans for ten of these prisoners, and the Department provided plans for eight of them.

We found these plans were a useful exchange of information between facilities but did not act as a genuine plan for the prisoner's safe transfer. While current risk factors and protective factors were outlined, we did not observe any consideration of potential responses for expressed self-harm intent or attempted or actual self-harm incidents, as outlined in the Department's policy (DOJ, 2021c).

The documentation for a prisoner transferring from Hakea to Bunbury illustrates our concern. In the Self-harm Concern Review Checklist, a counsellor notes that the prisoner was highly stressed about a planned move to Bunbury. They noted that, for this prisoner, high stress situations were a trigger for suicidal ideation. Similarly, the peer support officer wrote that the prisoner had stated that when they're highly distressed they hear voices which tell them to end their life. Despite this information being conveyed, they were not included in the final Transfer Plan. There appeared to be no consideration for how to manage the prisoner should they express any thoughts of self-harm or suicidal ideation mid-journey. The only instruction was for the receiving prison to continue managing the prisoner on ARMS.

The Department advised that Transfer Plans were not required for the remaining two prisoners. One was moved during an emergency using the Royal Flying Doctor Service. A Transfer Plan is not required under the Department's policy in emergency situations (DOJ, 2021c).

The other prisoner was assessed as not a self-harm concern or at an elevated risk of self-harm at the time of their transfer. This is despite the prisoner being on ARMS on the date of their transfer, and Psychological Health Services noting that he was a first-time prisoner, who was anxious and reported to be feeling overwhelmed. According to the Department's criteria, this prisoner should have been assessed as being at an elevated risk and requiring a Transfer Plan. The Department argued the prisoner was supportive of the transfer and denied any thoughts of self-harm. They feel the decision not to create a Transfer Plan was therefore justified but acknowledge that decision was not appropriately documented. We note the Department's policy does not provide such discretion.

While the policy intent is good, the practice as it stands does not appear to proactively consider measures to prevent harm during transfers. It relies heavily on replicating information already produced under the ARMS process. As such, the Department should consider ways to support staff in preparing more fulsome, risk-responsive plans. Otherwise, the process may become a bureaucratic and ineffective step in an already time-poor custodial environment.

Recommendation 1 – Prepare Transfer Plans that outline potential responses for expressed self-harm intent or actual self-harm incidents, in accordance with *COPP 12.4 – Prisoner Transfers*

Reliance on self-harm alerts remain flawed

The use of self-harm alerts as an indicator of a prisoner's risk of self-harming is also flawed. Previously we raised concern that the Department did not have a policy outlining when a self-harm alert should be added, amended or removed from a prisoner's profile. This led to these alerts being inconsistently applied (OICS, 2022a). As a result, they are not an accurate indicator of a prisoner's current risk of self-harm.

The Department also previously informed us that the Self-harm Potential alerts were no longer in use (OICS, 2022a). Despite this, they have been included in the assessment criteria for identifying prisoners at an elevated risk of self-harm (DOJ, 2021c). The Department acknowledged there should be a clear understanding and procedures for the use of alerts on the offender database and committed to reviewing the use of self-harm alerts (OICS, 2022a, p. 25). At the time of writing, we were told this review was ongoing.

Without reliable self-harm alerts, the assessment criteria for prisoners of self-harm concern should include recently deactivated ARMS alerts, which are likely to be a more accurate indicator of a prisoner's potential risk to self.

Recommendation 2 – Amend *COPP 12.4 – Prisoner Transfers* to include consideration of deactivated ARMS alerts in the assessment of prisoners 'Of Self-harm Concern'

Despite no clear policy, prisoners are routinely informed of an upcoming movement

The Department informed us that prisoners are not provided any information about upcoming movements. To mitigate security concerns, the Department noted that movements are conducted without prisoners being informed of:

- the reason for the movement
- the destination
- the expected travel times
- any expected breaks or comfort stops
- any expected meals.

Though, this position is not evident in any of the Department's policies on escorts and transfers.

And, in practice we found prisoners were regularly informed of an upcoming movement, particularly inter-prison transfers. Staff told us the decision to advise a prisoner of a planned movement is made with consideration to the circumstances at the time. When safe to do so, prisoners are advised of an upcoming inter-prison transfer a few days in advance so they can let their family know and pack-up their belongings. Though, many we spoke to were often unsure of the reason they were being moved, which was a source of frustration.

Prisoners may not be informed of a planned movement if there are security concerns. For instance, if officers are concerned a prisoner may react negatively to an impending transfer, a decision may be made to only inform them on the day of travel. Staff are also conscious of prisoners being aware of their next scheduled medical appointment. If an external medical specialist informs a prisoner of their next appointment date, custodial staff may arrange to have that date changed to prevent the

prisoner misusing that information to their advantage. The prisoner will then be informed of their next appointment closer to the time.

Where security concerns can be mitigated, the standard practice should be to inform prisoners of upcoming movements. While this appears to occur in practice, the Department's position illustrates a practice-policy misalignment that needs clarifying.

New Zealand's Department of Corrections has a policy requiring prisoners to be informed of impending transfers at least seven days in advance (Department of Corrections NZ, 2022). This includes informing prisoners of the proposed destination and being provided with an opportunity to inform their next of kin before the transfer occurs. This requirement can be rescinded where officers are concerned the prisoner may react negatively to this information.

The policy demonstrates a respectful, decent and security-focussed way of moving prisoners. This aligns with Standard 95 of our *Revised Code of Inspection Standards for Adult Custodial Services* (OICS, 2020).

Recommendation 3 – Develop policy that outlines procedures for informing prisoners of upcoming movements

1.2 Long-distance road journeys are now rare

The use of long-distance road journeys is now rare and often only occurred when required to facilitate funeral visits and clear police lock-ups in remote areas. Where feasible, a combination of road and air transport is used to facilitate these escorts.

Most long-distance police lock-up clearances were conducted using a plane. Broome Regional Prison, Eastern Goldfields Regional Prison, Greenough Regional Prison and Roebourne Regional Prison regularly receive prisoners from police lock-ups that are in excess of 200 kilometres away. Between 2018 and 2021, 94 per cent of these journeys were conducted by plane. The most frequent long-distance road journey to a police lock-up was between Carnarvon Police Station and Greenough Regional Prison. This journey is 483 kilometres in length and was conducted by road on 59 occasions (18%).

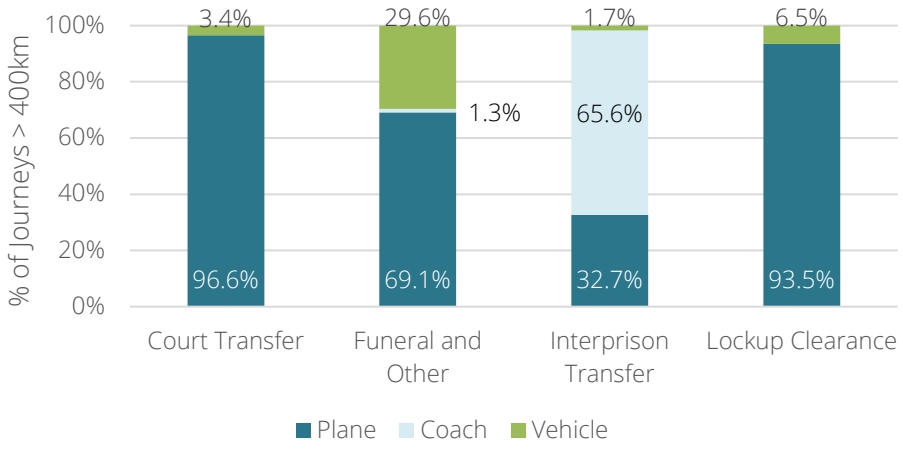


Figure 4: Few Ventia journeys with a round trip distance exceeding 400km were undertaken by vehicle.

Similarly, most long-distance funeral visits departing from a regional prison were undertaken using a plane. Sixty-nine per cent of funeral visits with a round-trip distance in excess of 400 kilometres used a flight. However, long-distance road journeys still occurred out of Roebourne Regional Prison, Eastern Goldfields Regional Prison, and Broome Regional Prison. The average round-trip distances of funeral journeys from these facilities was 705km, 526km, and 448km respectively. Funeral locations are often in remote communities, which may not always be serviceable by charter planes.

Long-distance road journeys for inter-prison transfers occur as an exception. Ninety-eight per cent of inter-prison transfers to or from regional prisons were conducted by Ventia using flights and/or coaches. While coach routes may be long-distance, they are more comfortable than being placed in a confined pod of a secure escort vehicle.

A long-distance inter-prison transfer is more likely to occur by road when the Department is conducting an unscheduled or high-risk movement not serviceable by Ventia. These movements are rare and usually only occur when a prisoner is either:

- assessed as a high-security escort
- has refused or been disruptive in an earlier Ventia escort
- requires urgent physical or mental health care but does not require the use of the Royal Flying Doctor Service.

These long-distance road journeys typically travel to Perth from:

- Albany Regional Prison, Bunbury Regional Prison, and Pardelup Prison Farm in the south
- Eastern Goldfields Regional Prison in the east
- Greenough Regional Prison in the mid-west of Western Australia.

Department-led movements from regional prisons north of Greenough usually involved a charter flight or the use of Ventia's regularly scheduled flight but with a Special Operations Group (SOG) escort.

We initially made recommendations in 2007 for the Department to investigate the use of coaches and planes for long-distance journeys (OICS, 2007). It is pleasing to see that these modes of transport have been utilised for some time now and are established as the standard practice for most long distance journeys.

Figure 5: Long-distance road journeys mainly occurred between Perth and Albany.

1.3 Conditions during inter-prison transfers were generally good

We observed a Ventia-led inter-prison transfer coach from Perth to Albany and a flight from Broome to Perth, via Karratha and Geraldton, and found the conditions for prisoners were generally good.

Inter-prison transfers by coach and plane were efficient and comfortable

We observed the inter-prison transfer coach to Albany and the flight from Broome to Perth and found these were efficient and comfortable. The escorting staff appeared confident in their duties and demonstrated a good rapport with the prisoners. We observed staff providing prisoners with information about the journey ahead and expectations around planned arrival times. Staff appeared security-focussed and vigilant throughout the journeys and worked well as a team.

While the movements were lengthy in duration, the conditions were comfortable for both the prisoners and staff. Prisoners remained restrained throughout the journey, but were aided by escorting staff where necessary, such as when applying their seat belts. Prisoners had access to food, water and ablutions throughout the journeys. Prisoners we spoke to onboard the coach and plane, and throughout visits to various facilities, have generally spoken positively about these journeys.

Ventia conducts welfare checks routinely

Ventia escorting staff conduct welfare checks of prisoners every 15 minutes throughout a journey. This requirement is embedded within the CSCS Contract and in Ventia's operating procedures (SSO, 2016). Operationally, this involves escorting officers checking-in with prisoners or observing them through CCTV and then recording this observation on Ventia's electronic management system. We reviewed a range of journeys undertaken by Ventia and found welfare checks were routinely completed as required.

While this task can be difficult to manage on coaches or aircraft with several prisoners in custody, this is an important requirement that helps ensure the prisoners in Ventia's custody are safe, secure, healthy and well.

Prisoners are provided meals before, during and after inter-prison transfers

We found no evidence to suggest prisoners were not being offered meals before, during and after inter-prison transfers. The Department advised that escorting officers were responsible for providing adequate food and water throughout a journey. This included providing a lunch (usually a sandwich), water and snacks. If the prisoner is departing early in the morning, they will usually have breakfast in their unit or in the reception area of the prison. Similarly, dinner is usually set aside and provided when they arrive at their destination. Very few prisoners told us they had not received a meal before, during or after a transfer.

All secure escort vehicles have CCTV, temperature monitoring and duress alarms

All secure escort vehicles operated by Ventia and the Department have monitoring and surveillance equipment installed. The Department's *Minimum Standards for Secure Escort Vehicles* requires all secure escort vehicle cells to be fitted with video, two-way audio and temperature monitoring and

recording systems (DOJ, 2019). Monitoring systems must be viewable by escorting officers in the front cab of the vehicle to assist with the ongoing monitoring of the prisoner's welfare. Each vehicle is also required to have a duress alarm installed in each cell that, when pressed by a prisoner, activates an audible alarm and indicator light in the front cab of the vehicle.

We acknowledge that this monitoring and surveillance equipment has been maintained as a standard for all secure escort vehicles since the death of Mr Ward.

All vehicles, coaches and planes used for prisoner movements are also required to have seat belts fitted and used throughout a journey, in accordance with Western Australian legislation.

Ventia staff are appropriately trained

Ventia are contractually required to provide a minimum level of training for all escorting officers. Officers are required to complete a Certificate III in Correctional Practice, and undertake ongoing training in first aid, mental health first aid, intelligence reporting, custody management, cultural awareness, and incident reporting. Supervisors are required to obtain a Certificate IV in Correctional Practice. Compliance with these requirements is monitored by the Department.

Generally, custodial staff spoke highly of Ventia escorting officers. There appeared to be a good working relationship between custodial and escort staff, and we received few negative comments about the quality of the service Ventia were providing. Where we did receive negative feedback, this was often expressed as frustration around staffing shortages and the impact this has on prison operations.

Further, some custodial staff felt escorting officers were not trained well enough. We were provided some anecdotal examples of poor skills and techniques. While there may be instances where staff have demonstrated a lack of experience or technical ability, we found no evidence that this was systemic across Ventia's staffing cohort.

1.4 Comfort breaks and welfare checks not mandated during Department-led inter-prison transfers

A lack of policy direction has led to inconsistencies in providing comfort breaks and conducting welfare checks during Department-led inter-prison transfers. As the Department does significantly fewer movements, the impact of this policy gap on prisoners is limited. However, the Department is often required to transport the higher-risk, more disruptive, and acutely unwell prisoners that are either urgent and unscheduled, or that Ventia refuse to accept. Clear policy and procedures will assist staff in undertaking these more challenging movements in a safe, secure and humane way.

Comfort breaks not always provided on road journeys

Our observation of Department-led inter-prison transfers by road found comfort breaks were not always provided. Custodial staff told us that a mid-journey stop to allow a prisoner to use a toilet is typically planned for each journey. However, sometimes it may be considered unsafe to stop. And, sometimes officers will ask the prisoner if they want to stop, and if not, they will just drive straight through. This was confirmed through observation of occurrence books, which showed movements

from Albany Regional Prison to Perth, or Greenough Regional Prison to Perth, did not always include a comfort break.

Prisons need to assess various factors when deciding on whether to provide a comfort break. As part of this decision-making process, custodial staff need to consider:

- the prisoner and their behaviour
- their fitness to travel arrangements
- whether there is a secure location to stop at
- the risk of the prisoner escaping.

Where possible, escorting officers arrange to stop at a local Police lock-up where the prisoner can use a toilet in a secure zone. Where this is not feasible, we were advised that a stop at a local roadhouse is allowable if the prisoner is under appropriate restraints.

The inconsistent use of comfort breaks is also partly explained by a lack of policy guidance. None of the Department's policies on prisoner movements outline requirements for comfort breaks, or the process to assess the risks of stopping.

This is exacerbated by the Department not having a consistent definition or procedures for long-distance journeys. The only reference to distance travelled is under the Department's policy on escort vehicles, which notes that Ventia may use a coach or a flight for long distance travel (DOJ, 2021b, p. 5). However, the term 'long distance travel' is not defined.

The Department's *Minimum Standards for Secure Escort Vehicles* (the Standards) defines a 'long-haul journey' as any road journey in excess of three hours duration (DOJ, 2019, p. 7). However, the term is not referenced at any point throughout the document, nor is it used throughout other Department policies. An earlier version of the Standards contained several provisions for long-haul journeys, including providing prisoners with food and water and, where possible, only using vehicles with in-built toilet facilities (DCS, 2015).

Ventia are contractually required to provide appropriate toilet stops, allow the prisoner to exit the vehicle for a short rest period, and to provide food for journeys with 'longer than usual distances' (SSO, 2016, p. 325). This is defined as any journey that is likely to exceed four hours in duration. Ventia are also required to adhere to the following contractual standards:

- that a person in custody shall not be transported in a vehicle or aircraft without a toilet for greater than two hours
- that a person in custody shall not be transported in an escort vehicle for greater than four hours without the opportunity to alight from the vehicle
- that a person in custody shall not be transported in a vehicle or aircraft for greater than eight hours in a 24-hour period (SSO, 2016, p. 328).

Following the death of Mr Ward, then Minister for Corrective Services Margaret Quirk publicly committed to introducing a requirement for rest stops every two hours (Hayward, 2008). This position is not evident in either the Department's policy or Ventia's contractual requirements.

The use of unclear language and procedures increases the risk of poor decision-making by staff. These decisions may then negatively impact on the welfare and dignity of the person in custody during the transport.

Recommendation 4 – Develop processes for providing comfort breaks during long road journeys, which are equally applicable to both the Department and the CSCS contractor

Unlike Ventia, welfare checks are not prescribed in Department policy

The Department's policies for prisoner escorts and transfers do not set out any formal requirement for escorting officers to check-in with a prisoner mid-journey or record their observations through CCTV or cell calls received. The only reference to performing a 'welfare check' is in Appendix C of *COPP 12.4 – Prisoner Transfers.* It notes welfare checks should be included as an action item in Transfer Plans for prisoners considered an elevated risk of self-harm (DOJ, 2021c).

Despite a lack of policy direction, occurrence book records show officers on Department-led movements do regularly check-in with prisoners or make observations. We found officers would typically record observations through CCTV or interactions with the prisoner on an hourly basis. This also included any observed changes in behaviour. However, as demonstrated in Chapter 4 of this report, we also have evidence that not all interactions are being recorded.

It was noted by the Coroner investigating the death of Mr Ward that the Department, at that time, had no written policies on conducting regular physical welfare checks of prisoners throughout journeys (Hope, 2009). While Ventia has developed requirements, it is disappointing that there remains a lack of policy in this space for Department-led journeys.

Recommendation 5 – Develop processes for conducting welfare checks throughout Department-led movements

1.5 Aboriginal prisoners are more frequently involved in regional transports

Analysis of data has found Aboriginal prisoners are more frequently being moved. Between 2018 and 2021, there were 20,251 prisoners across Western Australia who were moved from one prison to another by the CSCS contractor. Of these, only 23 per cent identified as being Aboriginal or Torres Strait Islander.

However, on average Aboriginal prisoners were involved in 3.9 transfers each, compared to only 2.2 for non-Aboriginal prisoners. And, 90 of the top 100 prisoners with the most inter-prison transfers were Aboriginal. Eighty-four of these were initially received at a regional prison, before being moved across the estate. Sixty-three per cent of inter-prison transfers to or from a regional prison involved an Aboriginal prisoner.

Therefore, while there are fewer Aboriginal prisoners they are being transferred more frequently and more often between regional prisons. We identified one female Aboriginal prisoner who had been transferred 27 times between 2018 and 2021. Another was transferred 21 times.

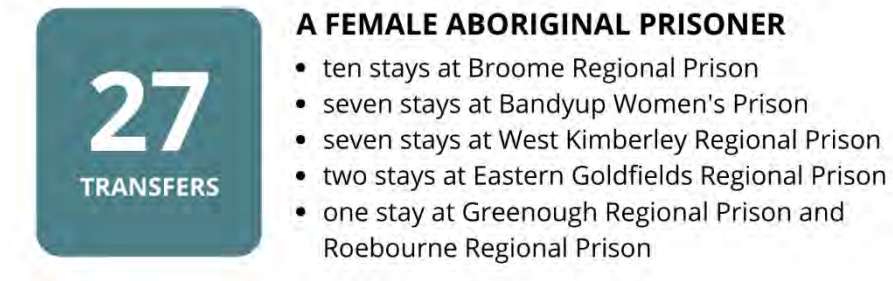


Figure 6: Aboriginal prisoners were more frequently required to travel while in prison.

The need for West Kimberley prisoners to transfer to Broome prior to transferring onwards to a metropolitan prison, counting as two movements, would contribute to this over-representation. Ventia's contract does not currently include providing inter-prison transfer flights from West Kimberley. As a result, prisoners from West Kimberley, who mostly identify as Aboriginal, are required to travel by road to Broome a day prior to taking a flight to Perth. This increases the total travel time for these prisoners.

Further, the transfer of prisoners from West Kimberley to Broome places additional pressure on the capacity of Broome Regional Prison. When these prisoners arrive at Broome, they are placed overnight in the maximum-security section (MSS) of the prison. We have previously commented on the depressing, overcrowded state of the MSS (OICS, 2017; OICS, 2020a). Unfortunately, our experience of the MSS during this review reflected the comments we made in previous reports.

We observed several prisoners arrive from West Kimberley and be placed in the MSS at Broome Regional Prison. The transfer vehicle arrived late in the day, which meant prisoners were then rushed to find food and which cell they were sleeping in. Many were required to sleep on mattresses on the cell floor due to overcrowding. There did not appear to be a process for determining who was on the floor, which likely caused some stress and consternation among prisoners. Generally, there was a tense feeling within the unit and custodial staff expressed frustration at the situation. They were short-staffed and we were advised they were eight prisoners over capacity that evening. It was clear that this arrangement was not a positive experience for the prisoners or the staff.

Extending Ventia's inter-prison transfer air services to West Kimberley would enable more efficient inter-prison transfers and result in a more welfare-focussed experience for prisoners.

Recommendation 6 – Extend Ventia's inter-prison transfer flight to West Kimberley Regional Prison

Aboriginal prisoners also represent 89 per cent of prisoners who are transported under s. 83(1)(B) of the *Prisons Act 1981* for the purposes of attending a funeral or visiting a relative with an illness. In some cases, these prisoners are required to transfer to a regional prison prior to being escorted to the funeral, increasing the number of movements and total travel time. This is exacerbated by Aboriginal prisoners not being placed at a prison on Country and close to family.

We acknowledge the reasons for prisoners living off Country are complex. This includes the individual circumstances and needs of the prisoner, and the services and care they require, which may not be available at a regional prison. Regional prison population pressures may also result in prisoners being transferred off Country. Where possible, Aboriginal prisoners should be placed in a facility on Country and close to family members.

In response to a draft of this report, the Department advised that in some cases prison transfers are self-initiated by the prisoner and require transit through other facilities before arriving at their destination. This was the case for many of the transfers for the female Aboriginal prisoner who had been transferred 27 times between 2018 and 2021. Several transfers were also conducted for management reasons and to access medical treatment.

2 Risk mitigation is prioritised

Both the Department and Ventia have processes in place to assess and mitigate risks prior to undertaking a prisoner movement.

2.1 Risk assessments are conducted prior to certain external movements occurring

The Department has an established risk assessment process that is conducted prior to prisoners undertaking a movement in a non-secure vehicle or when a variation is required to minimum security requirements.

External Movement Risk Assessments (EMRAs) are conducted prior to Department-led movements in a non-secure vehicle, or when a variation to the minimum number of escorting officers is required, or when a variation to the recommended standard of restraints is required (DOJ, 2022a; DOJ, 2021a; DOJ, 2021c).

A Prisoner Movement Risk Assessment (PMRA) is conducted prior to a prisoner travelling on a coach or aircraft, and also allows a Superintendent to vary the minimum number of restraints or escorting officers (DOJ, 2022a; DOJ, 2021a; DOJ, 2021c).

Risk assessments are not required for prisoners who undertake regular travel for their approved external activities such as the Prisoner Employment Program (PEP), activities authorised under s.95 of the *Prisons Act 1981*, re-integration leave, or in emergency situations (DOJ, 2022a; DOJ, 2021a; DOJ, 2021c).

Prisoner Movement Risk Assessments routinely conducted but often lack details

We found PMRAs were conducted routinely as required but were often lacking in detail. Facilities could electronically complete PMRAs on the offender database from August 2019 onwards. We analysed a random sample of coach and air travel inter-prison transfers between 2020 and 2021 and found 97 – 98 per cent had a PMRA completed prior to the prisoner's travel. This demonstrates the process is established and embedded across the estate.

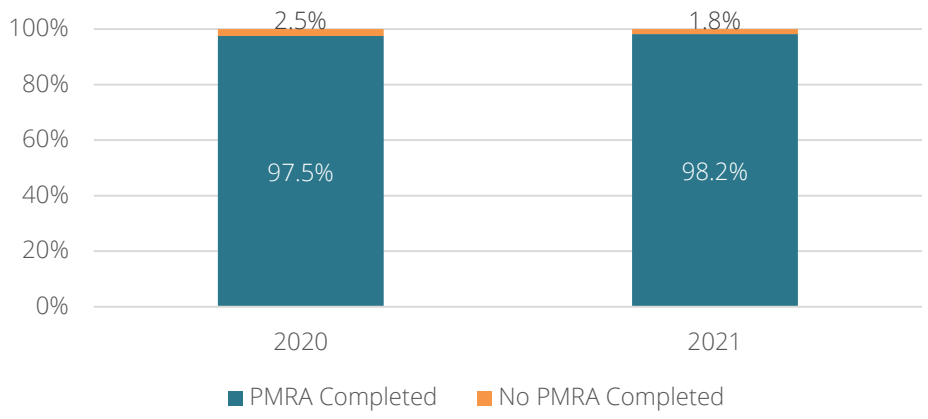
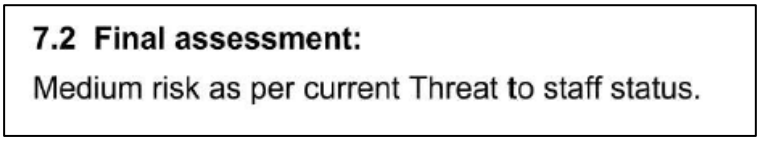


Figure 7: Most of the sample inter-prison transfers we reviewed had a PMRA prepared in the offender database.

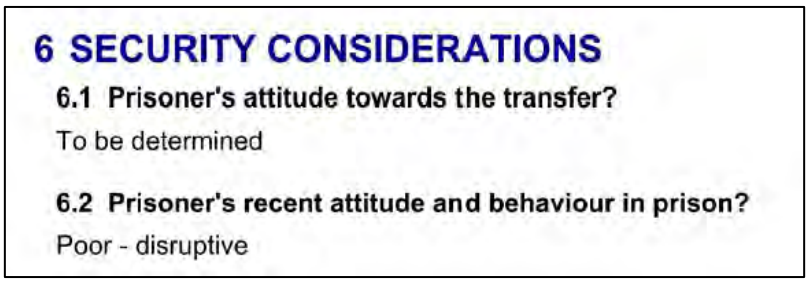
None of the PMRAs we analysed identified risks that prevented the prisoner from travelling. The risk assessment steps the assessing officer through a series of questions to assist them in identifying any concerns. Some assessments identified alerts on the prisoner's profile, such as whether they were currently on ARMS, if they were a protection prisoner, or if they were at risk to or from another prisoner. Some noted recent non-compliant behaviour. Others simply noted that there were no concerns. And, for most prisoners, we recognise this is likely to be an accurate assessment. However, where risks were identified there were often no corresponding actions to mitigate that risk.


7.2 Final assessment:

Medium risk as per current Threat to staff status.

Figure 8: An example PMRA that identified medium level risks but provided no recommendations for actions to address those risks.

Further, some PMRAs were conducted too early or were not appropriately updated prior to travel. From the sample we analysed, PMRAs were conducted on average 4.4 days prior to a prisoner's coach travel and on average 6.9 days prior to travel by air. One PMRA was conducted 19 days prior to travel. And, we identified several that were prepared more than a week in advance. In this time, a prisoner's behaviour or situation may change, which may alter the risks associated with them travelling.


6 SECURITY CONSIDERATIONS

6.1 Prisoner's attitude towards the transfer?

To be determined

6.2 Prisoner's recent attitude and behaviour in prison?

Poor - disruptive

Figure 9: Responses to security considerations within PMRAs were often brief or noted as 'to be determined' later.

For instance, we found three prisoners who were placed on ARMS a few days prior to their coach or air travel. One of these had no PRMA prepared at all. The other two had a PMRA prepared prior to their ARMS placement, and it was not updated to reflect their recent change of behaviour. All three of these prisoners were placed on ARMS for threatening self-harm or suicide. One of these were threatening to harm themselves if their scheduled transfer proceeded. This is important information that should be considered prior to an arranged movement.

The value of a risk assessment process that rarely identifies or mitigates risks, or is responsive to changing risks, is unclear to us.

Albany Regional Prison not routinely performing External Movement Risk Assessments

Data suggests EMRAs are not being performed as required at Albany Regional Prison. EMRAs were paper-based until December 2020, limiting available data on their use. However, the data available to us shows Pardelup Prison Farm performed 165 EMRAs in 2021, while Albany Regional Prison only performed two. This is despite Albany having a capacity almost 4.5 times the size of Pardelup.

Albany Regional Prison management confirmed that EMRAs were not routinely conducted. This is despite routinely placing prisoners in two points of restraints during inter-prison transfers led by Albany staff in their own secure escort vehicle. This is contrary to the Department's policy and would normally require an EMRA. In 2021, Albany staff performed 22 inter-prison transfers. If restraints were applied in all these cases, and only two EMRAs were performed, it suggests that the process for justifying additional restraints was not followed for the remaining twenty (90%) transfers.

2.2 Ventia's approach to risk mitigation maintains a focus on safety

Ventia performs its own risk assessments on all movements

In addition to the Department's own processes, Ventia performs a risk assessment for every prisoner or person in custody they are scheduled to escort. The risk assessor utilises the Department's offender database to consider a prisoner's history of incidents and charges, any medical or behavioural alerts, any attempted or actual escapes, any known intelligence, and their current ARMS status. Logistical information is also considered, such as the location and movement type, and the distance and remoteness of the journey.

This process provides Ventia an opportunity to mitigate potential risks through adjustments to the use of restraints, vehicle type, journey route or staffing arrangements. This allows Ventia to take appropriate steps to improve the safety and security of an escort, as well as taking actions that may positively benefit the welfare and dignity of a prisoner. The process may also result in Ventia refusing to conduct the escort, if they form the view the risks are insurmountable.

We reviewed a sample of risk assessments and found they provided a useful summary of known risks and considerations for escorting staff. They were also performed 2 – 3 days prior to the transfer or escort, ensuring the most up to date information is utilised.

Ventia's contract also incentivises risk-informed decision-making. Financial penalties imposed on the CSCS contractor for performance failures or specified events, such as an escape from custody, increase the pressure on the contractor to mitigate risks. We have previously found that this financial risk, combined with the risk of reputational damage, can result in the contractor being more risk-averse, such as using restraints more often (OICS, 2020b). But during this review we found no evidence to suggest that was occurring.

Journey Management Plans emphasise safety

Ventia staff are required to prepare a Journey Management Plan for movements they have assessed as high-risk. This includes, but is not limited to, remote journeys that are over 100 kilometres in length and journeys that are greater than two hours in length (Ventia, 2022).

The Journey Management Plans requires staff to consider a range of safety measures prior to their journey. This includes completing a vehicle safety and suitability checklist to ensure the vehicle is in working order and has enough supplies. A communication and remote travel controls checklist is also completed, confirming staff have the necessary communication equipment for their journey or if they breakdown. Consideration is also given to potential hazards around local weather conditions, emergency events, road conditions, unfamiliar routes, and fatigue, among other things.

As part of a Journey Management Plan, a safety contact is nominated to accept check-in phone calls from escorting staff every two hours. Should drivers fail to make a scheduled wellbeing call 30 minutes after the agreed time, the safety contact is responsible for escalating the process to the relevant line manager. An incident report is lodged for scheduled calls that are missed. This is a good standard to maintain, which emphasises the importance of regular check-ins during longer or more remote journeys.

Overall, we found the preparation of a Journey Management Plan reinforces a commitment to safety, particularly in regional and remote areas which are typically higher-risk.

Fatigue management considered

Ventia recently endorsed a Fatigue Management Plan to mitigate risks associated with staff fatigue (Ventia, 2022). The plan seeks to ensure that Ventia systems and processes suitably address fatigue to ensure contractual service delivery obligations are met. This includes establishing core working standards for staff, such as:

- escort staff working a standard 7.6-hour day, five days a week with a two-day break
- staff not being permitted to work more than 14 hours in any 24-hour period, including shift handover and travel time
- requiring a minimum break of 10 hours between shifts
- limiting staff to working a maximum of eight consecutive days (Ventia, 2022).

Any worker who feels fatigued or is assessed by their Supervisor as being fatigued, are not permitted to operate a vehicle (Ventia, 2022).

Staff are also required to plot break times in their Journey Management Plan. Staff must take a 10-minute rest break every two hours, and a 15-minute rest break every 5.25 hours. Rotation of drivers is also recommended.

The Department also has Fatigue Management Guidelines, but these do not specifically address the need for staff to take breaks from driving to avoid fatigue (DCS, 2015a). While custodial staff are rarely required to conduct escorts, where these occur in regional and remote areas, they can be long days across lengthy distances. Often staff will be provided accommodation at their destination and return the following day. But sometimes staff make the decision to return the same day.

Recommendation 7 – Establish fatigue management policies for custodial officers undertaking long-distance escorts

2.3 The use of restraints was generally consistent with policy

Restraints are routinely used in prisoner movements to mitigate risks that could jeopardise the safety and security of staff and the community. We found no evidence that restraints were being used in contravention to the *Court Security and Custodial Services Regulations 1999*, departmental policy or Ventia's own procedures. Generally, we found staff had a good understanding of the restraints required for movements. Restraints appeared to be routinely used in non-secure locations and in non-secure vehicles. There was no evidence to suggest prisoners were being restrained to moving vehicles, and the types of restraints used were consistent with policy.

Minimum security prisoners still require restraints during escorts

Our office has previously raised concern about the use of restraints during medical escorts for minimum-security prisoners. During this review we have found that the practice remains unchanged.

The Department's policy requires all prisoners to be restrained when in non-secure locations (DOJ, 2021a). This includes prisoners approved for external activities, such as work camps, s.95 activities, the Prisoner Employment Program, and Re-integration Leave, when undertaking escorts not related to their approved external activity (DOJ, 2021a). However, the policy does permit a Superintendent to authorise an escort of an unrestrained minimum-security prisoner following the completion of an EMRA.

Case Study: Pardelup Prison Farm

Pardelup Prison Farm, a minimum-security facility, regularly undertakes EMRAs to escort their prisoners unrestrained. This enables the escort of up to two unrestrained minimum-security prisoners at a time in a non-secure vehicle. This approach aligns with the facility's philosophy as a low-security reintegration prison. New arrivals at Pardelup are generally not allowed any scheduled external appointments in their first 28 days at the facility. This allows the prisoner to settle in and gives staff the opportunity to get to know the prisoner and their risk profile. Staff are then better informed about a prisoner's behaviours when completing an EMRA and determining the risks of conducting an external escort unrestrained.

During the 2017 inspection of West Kimberley Regional Prison, minimum-security prisoners expressed humiliation when being restrained to a wheelchair during an external medical appointment (OICS, 2017a). Prisoners felt the use of restraints in this manner drew attention to them from local community members. Our review into prisoner access to dental care also found that the use of restraints for external medical appointments may be preventing some prisoners from seeking the care they needed (OICS, 2021a).

Following our inspection of West Kimberley, we recommended the Department revise its medical escort security procedures to use restraints in a manner that reflected the tiered system of security classifications and approvals for external activities (OICS, 2017a). The Department supported this recommendation and noted it was undertaking a comprehensive review of its suite of policies. It anticipated that changes would be made to ensure medical escort procedures reflect security classification and other relevant factors. We cannot identify any practical changes made between the Department's current policy and its predecessor.

Recommendation 8 – Revise medical escort security procedures to reduce the use of restraints to reflect the system of security classifications and approvals for external activities

Non-routine restraints at times applied in secure pods without justification

Our review of occurrence books found prisoners were at times being placed in restraints without documented justification during Department-led movements, despite being placed into a pod of a secure vehicle. At times this included being placed in both handcuffs and leg cuffs while secured in a

vehicle. This contradicts the Department's recommended use of restraints during escorts and the requirement for superintendents to complete an EMRA when using additional restraints (DOJ, 2021a; DOJ, 2021d).

During our inspection of Albany Regional Prison, we raised concern that it was standard practice at that facility to place prisoners in restraints when secured in a vehicle (OICS, 2021b). We queried this further and were advised that restraints were required as the Police lock-ups they used for comfort breaks were not secure zones. Prisoners travelled with handcuffs and then, upon arrival to the Police lock-up, a second set of handcuffs were applied between the prisoner and an escorting officer.

However, we viewed the secure escort vehicle and the design of the hatch door for the secure pod allows handcuffs to be applied once the vehicle arrives at the Police lock-up, as per the Department's policy (DOJ, 2021a, p. 7). Albany does not have a standing order that establishes the use of handcuffs for all Department-led movements. They also confirmed they do not complete EMRAs to seek approval for using restraints in a secure vehicle. As such, this standardised use of handcuffs for all prisoner movements appears unjustified.

We also identified the use of restraints in secure escort vehicles departing Greenough Regional Prison during Department-led escorts. This included prisoners being escorted locally to external appointments and those on longer journeys to Perth. We observed the occurrence books for three medical escorts conducted in June 2022 and found:

- EMRAs had been conducted prior to the escort, but did not seek approval to vary the use of restraints recommended in the Department's policy
- restraints were then applied either before the prisoner entered the vehicle, or at the time they were loaded into the vehicle at the prison
- the occurrence books for all three escorts failed to state clearly what restraints were applied and when, and instead simply noted 'restraints applied' or words to that effect.

Greenough also does not have a local policy that standardises the use of restraints for Department-led movements.

Inaccessible records meant we were unable to complete a systematic review on the use of non-routine restraints during Department-led movements. Typically, officers will record what restraints are applied to a prisoner during an escort in the movement occurrence book. As these records are not electronic, we are unable to conduct a broad review without manually reviewing the records for each journey, from each prison.

These record-keeping flaws undermine transparency and the Department's ability to monitor the use of restraints for compliance against policy.

Recommendation 9 – Ensure prisons apply restraints in accordance with *COPP 12.3 – Conducting Escorts* or justifies the use of additional restraints with an External Movement Risk Assessment

There was an inconsistent approach to the use of restraints on flights

We found there was an inconsistent approach to the use of leg restraints during flights. Most flights are conducted by Ventia, whose policy does not require prisoners to wear leg restraints (Ventia, 2021). However, this practice contradicts the Department's requirement for two points of restraint in non-secure locations, which includes aircrafts (DOJ, 2021a).

Conversely, the Department routinely uses both hand cuffs and leg restraints for prisoners being escorted by Department staff on chartered flights. These restraints can be varied using an EMRA. For instance, on medical grounds for a prisoner flying with the Royal Flying Doctor Service.

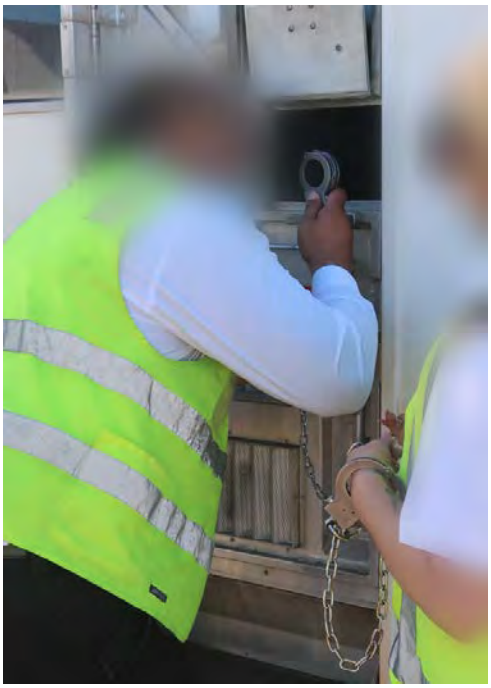


Figure 10: Ventia escorting officers placing restraints on a prisoner through a secure escort vehicle hatch, prior to boarding a plane at Broome airport.

Aviation regulations do not restrict the use of leg restraints. Both Ventia and the Department confirmed that there are no known provisions within aviation regulations that prohibit the use of leg irons during flights. However, the use of mechanical restraints is at the discretion of the aircraft's operator, in accordance with Section 9 of the *Aviation Transport Security (Possession of Restraints) Notice 2015*. Ventia confirmed it has not sought approval from their aircraft operator to either use, or not use, leg restraints. However, the issue has been discussed with service providers and most view leg restraints as a safety risk should an emergency disembarkation be required.

We acknowledge that the use of leg restraints on flights may impede prisoners from safely evacuating if required. The decision not to use leg restraints therefore mitigates that risk. However, it also directly contravenes departmental policy. Clarity should be sought on the issue to ensure the use of leg restraints on flights is consistent across Ventia and Department-led movements.

Recommendation 10 – Review the use of leg restraints on flights for compliance against aviation regulations and departmental policy

2.4 Despite the challenges of an ageing fleet, vehicles are generally maintained to a high standard

The development of the Standards and a relatively stringent compliance and monitoring framework has assisted in assuring that safety, security and prisoner welfare are not compromised.

Vehicle standards have improved since the death of Mr Ward

Following the death of Mr Ward, the Department developed and has maintained a suite of vehicle standards implemented to safeguard the safety and welfare of prisoners. This included ensuring all

vehicles had installed and regularly maintained duress alarms for both staff and prisoners, CCTV monitoring and recording, a cell call intercom system, and air-conditioning and air temperature monitoring. Further, each cell is designed to be safe-cell compliant to minimise opportunities for self-harm. These provisions are outlined in the Standards and compliance is monitored through monthly and annual vehicle inspections (DOJ, 2019).

Seatbelts are fitted on all secure escort vehicles in the fleet. Unsecure vehicles used by Ventia, such as coach buses and planes, are also required to be fitted with seatbelts in accordance with Department of Transport requirements.

The Department also has GPS tracking on all secure escort vehicles. This enables real-time tracking of vehicles, and the ability to capture information on vehicle speeds, odometer readings and other details. However, there is no tracking of coach buses or planes used by Ventia. This is mitigated by Ventia's electronic record-keeping capability, which enables escorting officers to update their transport management system every 15 minutes as part of their welfare checks.

Monthly vehicle inspections undertaken on all vehicles

The Department, through a sub-contractor, conducts monthly vehicle inspections on all vehicles within the fleet. The inspections assess each vehicle against the Standards, including whether:

- monitoring and audio-visual equipment are operating as required
- toilets are operating correctly, emptied appropriately, and have a full tank of fresh water
- seatbelts are in working condition and operating correctly
- air conditioning operating correctly
- fire extinguishers are working and regularly inspected
- first aid kits are in the vehicle
- the vehicle has spare tyres and a tyre change kit.

If a fault is identified, a rating is applied based upon the risk that fault presents to the safety of prisoners onboard, escorting officers, or members of the public. A high-risk fault is, or will soon be, a direct safety issue and non-compliant with the Standards. A high-risk rating may result in a recommendation that the effected cell or vehicle be listed as inoperable until repaired.

Generally, these inspections appeared to be an effective oversight tool that ensured vehicles were maintained in accordance with the Standards. Identified faults were included in Ventia's monthly vehicle reports to the Department. Commentary was provided for outstanding faults and the cause of any delays in the fault being rectified.

At times, issues of non-compliance had not been identified by Ventia staff prior to the monthly inspection. In our analysis of monthly vehicle reports, we found several issues had been identified during monthly inspections that had rendered the vehicle as inoperable or semi-inoperable. This included air temperature monitoring systems not reading temperatures correctly, audio-visual equipment not recording, and hazardous sharp points not being identified. These vehicles had been operating with these faults prior to the monthly inspection. This suggests Ventia's pre-journey vehicle checks are not always being conducted thoroughly.

Vehicle cleanliness monitored

We found no evidence to suggest there were systemic issues with the cleanliness of vehicles. We had heard anecdotal evidence that vehicles, particularly those in the north of Western Australia, were regularly unclean and unhygienic. While we were not able to physically inspect every vehicle, our observations of vehicles and conversations with Ventia and Department staff did not identify any concerns.

Ventia has processes in place to monitor vehicle cleanliness. Ventia staff are required to assess the cleanliness of their vehicle prior to departure and record details of this assessment on their vehicle checklist (Ventia, 2021). Toilets are also required to be cleaned daily, and any identified bodily fluid spillage reported and deep cleaned, as per the Standards (Ventia, 2021).

Monthly vehicle inspections also report on potential hazards to passengers, including vehicle cleanliness. We found this process regularly identified, for instance, dried bodily fluids within vehicle pods that required forensic cleaning. Details of when forensic cleans were undertaken are then included in monthly vehicle reports to the Department. As such, we feel there is a good degree of oversight on this issue.

Figure 11: The secure pods of Department vehicles were found to be clean and tidy.

The cleanliness of Department-operated vehicles has not been raised with us, nor have we observed any issues. These vehicles are used less frequently than Ventia's fleet, reducing the risk of prisoners being moved in an unhygienic environment. Forensic cleans are also undertaken in these vehicles when required or as directed following a vehicle inspection.

Additionally, both Ventia and the Department have processes in place to forensically clean vehicles if a passenger was positive, or later became positive, to COVID-19.

Ventia's vehicles are ageing and maintenance requirements have increased

The existing fleet of vehicles operated by Ventia is ageing, creating a higher demand for maintenance. The fleet was commissioned by the Department in 2010 and went through a chassis replacement program between 2014 and 2015 by Serco, who was the service provider at the time. In 2017, at the completion of Serco's contract, the fleet was handed over to the Department. Broadspectrum, and later Ventia, then took over the management and operation of the fleet.

As of June 2022, the average odometer reading across Ventia's fleet was 264,332 kilometres. Perth-based vehicles had a higher average of 340,221 kilometres in comparison to regionally-based vehicles, which averaged at 188,443 kilometres. The highest odometer reading for a regionally-based vehicle was 396,145 kilometres for a vehicle stationed in Karratha.

The average odometer reading across the Department's fleet was only 40,971 kilometres. The Department obtains most of its vehicles through a six-year leasing arrangement, enabling vehicles to be replaced more regularly.

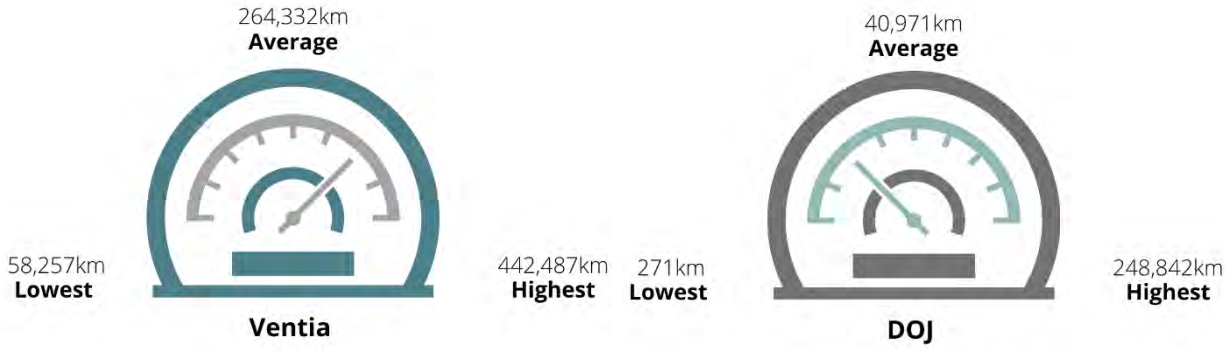


Figure 12: Ventia's vehicles were generally older than those managed by the Department.

From June 2021 to June 2022, Ventia's monthly vehicle reports noted a range of unplanned rectification works performed on different vehicles. Generally, these issues were only present for a short period, but in one instance a fault in a Broome-based vehicle lasted up to 135 days. Depending on the issue, vehicles may have been inoperable or only semi-operable for a period. These faults and maintenance requirements add pressure to the system and Ventia's ability to meet service demand.

We experienced the impact of an inoperable vehicle during our observation of the inter-prison transfer flight from Broome to Perth. Ventia's large 14-seat vehicle was offline due to a mechanical issue. As a result, two journeys in a smaller vehicle were required to escort the prisoners from West Kimberley Regional Prison to Broome Regional Prison on the Thursday, and from Broome Regional Prison to the airport on Friday morning. While this was handled professionally by Ventia, it led to delays and additional time on the road across both days.

Despite high-maintenance requirements, vehicle breakdowns occurred relatively infrequently. The Department advised us that there were six vehicle breakdowns involving 16 prisoners during the April 2021 to April 2022 period. The infrequency of vehicle breakdowns mid-journey suggests the systems in place to monitor vehicles are effective at identifying issues prior to a journey.

A new Ventia fleet has been approved, subject to testing

Ventia is progressing the delivery of a new fleet of vehicles. In 2019, the Department and then Broadspectrum commenced discussions for the rollout of a new prisoner transport fleet. The Department conditionally agreed to the concept fleet comprised of 43 vehicles with a total seating capacity of 300 prisoners. This would increase the size of the fleet from the existing 34 vehicles.

The new fleet will include a range of innovations. There will be more vehicles with soft seats and wheelchair access, providing Ventia with greater flexibility when scheduling escorts. Seatbelt designs will be improved to further reduce opportunities for self-harm, and defibrillators are being installed in every vehicle. The fleet will also utilise more vans, which are more discreet in their appearance.

These smaller vehicles will also be more fuel efficient, will be fitted with roof-mounted solar panels, and will allow for easier access to sally-ports across the custodial estate.

However, various factors have delayed the delivery of the new fleet. Since the concept fleet was approved, the Department revised its *Minimum Standards for Secure Escort Vehicles* and developed additional policies on data management. These changes have impacted the development of vehicle prototypes. The acquisition of Broadspectrum by Ventia in 2021 also impacted the delivery timeline, in addition to the COVID-19 pandemic and subsequent impacts to supply chains.

More recently, Ventia delivered a prototype vehicle to the Department for testing. We understand this process is ongoing but Ventia remain hopeful they will begin delivering new vehicles throughout the 2022-23 financial year.

2.5 Ventia recorded relatively few critical or major incidents

Between 2018 and 2021 there were few incidents recorded that jeopardised, or had the potential to jeopardise, the safety, security or welfare of prisoners. Ventia recorded 1,077 incidents from 38,233 movements of prisoners in regional Western Australia. Most of these (81%) were assessed as a major incident, and less than one per cent were classified as critical incidents. This equates to one major incident occurring for approximately every 44 movements, and one critical incident for every 5,461 movements. The remaining 19 per cent of incidents were classified as low-level.

Eighty-five per cent of major incidents recorded were assessed as incidents or events that could disrupt the ability of the contractor to provide the required services. This included a range of non-security administrative incidents such as medical appointments being cancelled, prisoners refusing to attend appointments or hospital sits not being serviced by contractor staff. These types of incidents do not appear to directly jeopardise safety or security.

Twenty-one (2%) major incidents involved vehicle or aircraft faults, breakdowns or accidents. These generally referred to mechanical faults that prevented the vehicle or aircraft from departing, such as faulty CCTV or engine issues. As such, there were few security risks or welfare concerns for the prisoners onboard.

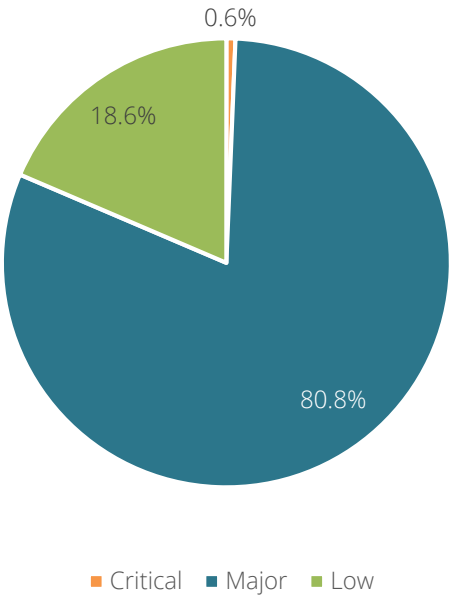


Figure 13: Most regional transport incidents recorded by Ventia or Broadspectrum were classified as Major.

We identified two incidents where mechanical issues resulted in the vehicle being unable to complete a journey. On both occasions, the vehicle outer doors were opened to provide fresh air to the prisoners onboard, water was issued, and alternative vehicles were supplied within a reasonable time. There were also a few minor accidents recorded, such as vehicles colliding with bollards.

Other common major incidents recorded related to the detection and seizure of contraband, and prisoners threatening, attempting or actually self-harming.

An escape from custody and two attempted escapes were included in the incidents recorded as critical. The escape from custody occurred during an inter-prison transfer flight while the aircraft was refuelling at Karratha airport. The prisoner, who was the only prisoner onboard at the time, pushed their way past the escorting officers and exited the plane. They absconded by foot over the perimeter fence and into nearby bushland but were apprehended by police 30 minutes later.

One attempted escape also occurred on an aircraft departing Kununurra after collecting a person in custody from the local police lock-up. The person released their seatbelt, made their way to the front of the aircraft and tried to open the door before being apprehended by escorting officers. The other attempted escape occurred at Laverton Airport where police handcuffs were removed prior to Broadspectrum officers applying their own. The person took the opportunity to make an escape attempt, before being apprehended.

The relatively low number of incidents with the potential to affect safety, security or prisoner welfare suggests the systems in place, by both the Department and Ventia, are effective at minimising risks.

Incidents are classified as critical, major or low in accordance with the *Court Security and Custodial Services Act 1999,* the *Court Security and Custodial Services Regulations 1999,* the CSCS Contract and departmental policy (DOJ, 2020a).

3 Good governance, but oversight and transparency are poor in some areas

Both the Department and Ventia have developed comprehensive policy and procedural frameworks for the delivery of prisoner transports. These frameworks reiterate a priority on safety, security and welfare. However, transparency issues and limited oversight hamper the Department's ability to assure Department-led movements are conducted in accordance with policy.

3.1 The Department has an established system of governance for prisoner transports

Throughout the focus period of this review, the Department published a suite of new Commissioner's Operating Policy and Procedures (COPPs) relevant to prisoner transports. Despite few changes to actual procedures, the COPPs have brought together relevant instruments into a more concise suite of documents. This has resulted in greater clarity around processes and responsibilities, which is commendable. This is consistent with findings we have made in other reviews (OICS, 2022a; OICS, 2022b).

Those most relevant to the transportation or movement of prisoners include:

- *COPP 12.1 – Escort Vehicles*
- *COPP 12.2 – Coordination of Escorts*
- *COPP 12.3 – Conducting Escorts*
- *COPP 12.4 – Prisoner Transfers*
- *COPP 12.5 – High Security Escorts.*

These policies articulate an intention to transport prisoners in a safe, secure and humane manner. Further, *COPP 12.1 – Escort Vehicles* states that prisoner transports should be in 'secure and decent conditions' that ensure a prisoner's 'physical, emotional, mental and cultural needs are respected and their safety and dignity is maintained' (DOJ, 2021b, p. 3).

COPP 12.2 – Coordination of Escorts and *COPP 12.3 – Conducting Escorts* also note the stress that confinement in a secure vehicle can have on Aboriginal prisoners and those with an impairment (DOJ, 2021a; DOJ, 2022a). It encourages staff to take relevant precautions to ensure the health and welfare of these prisoners are front of mind. The Department also expressly acknowledges Western Australia's history of Aboriginal deaths in custody and the impact that this trauma may have on those who 'are connected to, or can recall, specific cases' (DOJ, 2022a, p. 4; DOJ, 2021a, p. 4).

COPP 12.4 – Prisoner Transfers acknowledges inter-prison transfers may exacerbate or introduce a prisoner's risk of self-harm and notes an intention to plan transfers for at-risk prisoners with an appropriate level of care (DOJ, 2021c).

The COPPs have also been prepared with consideration of relevant principles within the *Guiding Principles for Corrections in Australia* (CSAC, 2018).

Each prison facility also has a Standing Order outlining locally-specific procedures for the maintenance of secure and non-secure vehicles owned by the Department.

Department's Minimum Standards for Secure Escort Vehicles establish core requirements for protecting prisoner welfare during transports

The Department's *Minimum Standards for Secure Escort Vehicles* (the Standards) establishes the core safety and wellbeing standards for both the Department and the Contractor to adhere to in the delivery of escort services. The Standards outline procedures that seek to:

- ensure each vehicle used to transport prisoners are compliant with a standardised set of requirements
- minimise safety and security risks to the prisoners, staff and the community
- ensure prisoners with a physical, intellectual or psychological impairment are safely transported (DOJ, 2019).

The Standards provide detailed specifications on vehicle design, cell fit-outs, maintenance schedules, and reporting requirements.

Ventia has a well-established system of governance for transports

Ventia also has an established system of governance that guides daily operations. This includes a suite of standing operating procedures that detail expectations of Ventia staff. Where required, these procedures relate back to obligations under the CSCS Contract or departmental policy requirements.

The policy suite is thorough, with no obvious systemic failings or significant gaps.

3.2 Ventia subject to regular contract and operational compliance monitoring

Through reporting, inspection and other oversight mechanisms, the Department has established a relatively rigorous system of monitoring Ventia's performance across its contractual obligations.

Abatements maintain Ventia's focus on compliance

Performance-based abatements encourage Ventia to maintain a focus on service delivery and compliance. Under the CSCS Contract, the Department may apply a fixed abatement amount when a Specified Event occurs. For instance, an abatement of $5,000 may be applied if Ventia fails to provide a service, which leads to a scheduled appointment for a prisoner being cancelled or rescheduled. If a death in custody occurs or a person in custody escapes, an abatement of up to $200,000 may be applied. Penalties also apply when a prisoner or person in custody self-harms.

Further abatements may also be applied if Ventia fails to meet established key performance indicators. The contract establishes a framework for the Department to assess performance failures and calculate penalties. If a failure is repeated, the penalty may be multiplied by a factor.

In the 2020-2021 year, Ventia's abatements increased by 64 per cent to reach $1.3 million (OICS, 2022). The financial risk of the contract's abatement regimes incentivises Ventia to maintain a focus on performance and innovation. It also encourages Ventia to balance the servicing requirements of the Department with the delivery of a safe and secure transport system that considers the welfare of prisoners.

Ventia submits monthly performance and vehicle reports

Delivery of monthly performance reports assists the Department in maintaining oversight over Ventia. These reports summarise Ventia's performance against contractual service requirements for the preceding month. This includes statistical summaries of movements conducted, incidents and specified events that have occurred, and failures to achieve key performance indicators.

Additionally, Ventia also submit monthly reports for each vehicle within their fleet. The report summarises a vehicle's monthly usage, planned and unplanned maintenance requirements, and any faults or areas of non-compliance identified through inspections. In conjunction with monthly vehicle inspection reports, the Department is provided with information to confirm Ventia's ongoing compliance with the Standards (DOJ, 2019).

The Department also maintains oversight over the training of Ventia's staff. Staff training statistics are included in Ventia's monthly reports to the Department, including participants undertaking initial training courses and staff compliance with refresher training requirements. Audits on staff training compliance have previously resulted in abatements being applied. Details of training provided is also reported in the CSCS annual report, as per the recommendation from the parliamentary inquiry following the death of Mr Ward (Standing Committee on Environment and Public Affairs, 2011).

The Department's Contract Management Group also meet monthly with Ventia to discuss performance and service delivery. This includes reviewing specified events, key performance indicators, improvement notices and other relevant issues.

These mechanisms assist the Department in maintaining adequate oversight over Ventia's performance and delivery of movement services in a manner that does not compromise safety, security and prisoner welfare.

Operational Compliance Branch monitors Ventia's performance

The Department's Operational Compliance Branch monitors Ventia's performance on the ground to ensure they delivered movement services in accordance with the CSCS contract. Compliance reviews are also conducted to ensure Ventia operates in accordance with relevant policy and procedures.

A compliance review of Bunbury Courthouse was conducted in 2020. As part of the review, compliance checks were conducted on Ventia's handling of persons in custody received or departing on regional transports. Areas of non-compliance were identified and Ventia were offered an opportunity to provide comment or advise how they would achieve compliance. This is a relatively thorough process that helps assure Ventia performs to a high-standard of compliance.

However, this was the only compliance review conducted between 2018 and 2020 that was relevant to Ventia's delivery of transport services from a regional base. In our inspection of court custody centres, we commented on our concern that the Operational Compliance Branch had a limited focus on regional services (OICS, 2022). This reiterated concerns we raised during the previous inspection, and a recommendation that the Department improve regional facility monitoring (OICS, 2019). In response, the Department advised that the Court Risk Assessment Directorate (CRAD), which evaluates threats to the secure operation of courts, had enough oversight of regional court custody

centres and this compensated for a lack of compliance reviews occurring at those sites. However, the CRAD's remit does not extend to monitoring movement services at regional sites.

As such, there is a clear gap in the monitoring of Ventia's movement services at regional locations, which should be addressed by the Department. This aligns with the findings of the Coroner following the death of Mr Ward, and a recommendation for the Department to conduct regular reviews of transport contractor services in regional locations (Hope, 2009).

Recommendation 11 – Conduct regular monitoring and compliance reviews of Ventia's movement services from regional locations

3.3 Oversight of Department-led journeys limited in its effectiveness

Paper-based records, limited data extractability, and limited traceability of authorised decisions diminish transparency and the Department's monitoring of Department-led transports. Limited on-the-ground observations of practice and inclusion of transport-related policies in compliance reviews further inhibits the Department's assurance practices. Many of these issues around transparency and oversight are not limited to prisoner transports, and have been raised previously by us in other reports (OICS, 2022b; OICS, 2020b; OICS, 2022a; OICS, 2021a; OICS, 2021).

Paper-based occurrence books limit transparency

Paper-based occurrence books are used to record key aspects of prisoner escorts and inter-prison transfers conducted by the Department. Details of the movement, including departure and arrival times, welfare checks, cell calls received, comfort stops, and the use of restraints, are recorded by escorting officers throughout a journey. The occurrence book is usually stored in the escort bag, which is sealed until required for use. The contents of the occurrence book are not scanned or transposed onto the offender database after a journey is completed. For improved transparency and oversight, the details of journeys should be easily accessible. This is particularly the case for long-distance regional movements, where the welfare, safety and security risks are higher.

The Special Operations Group (SOG) use the offender database to record details of escorts. Instead of using paper-based occurrence books, the SOG electronically record details of their journey at the completion of the escort. This demonstrates an ability to move away from paper-based processes. Still, there are some flaws with their approach. The escort log is restricted to SOG personnel, limiting transparency. And, from the sample we viewed, there was an emphasis on procedure and security, and limited details recorded about prisoner observations and welfare.

Ventia also use an electronic record-keeping system. Escorting officers on each journey are provided a tablet with access to Ventia's electronic management system. This enables officers to electronically record all information relating to a journey, providing live status updates to Ventia's head office. Those with access to the system can also recall a previous journey and observe the records that were kept. We found the system demonstrated well the benefits of electronic record-keeping throughout a journey.

The use of an electronic occurrence book for movements conducted by Department staff would similarly increase transparency and enable more effective oversight. In recent years, the Department

has increased the use of electronic record-keeping. For instance, electronic supervision logs are now utilised on the offender database for prisoners who are confined or separated from others. This has increased transparency and enabled greater oversight of prisoners held under restricted regimes. Similar innovations for Department-led journeys should be explored.

Recommendation 12 – Investigate opportunities for implementing electronic occurrence books for Department-led transports

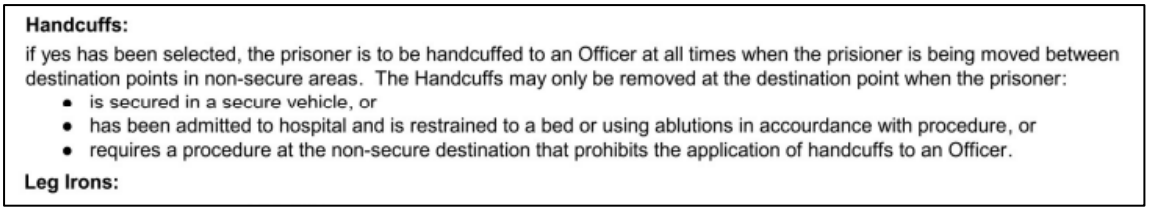
The use of External Movement Risk Assessments is not easily traceable

We were unable to verify whether EMRAs were being performed as required. EMRAs have only been performed electronically on the offender database since December 2020. Those performed prior to this were paper-based and not available to us for bulk analysis. Those conducted on the offender database are also not extractable for analysis because they rely on free text comment boxes. As such, we were unable to verify under what circumstances EMRAs were conducted and whether this was consistent with the Department's policy.

Figure 14: Information provided in the Transfer and Discharge Sheet on the offender database does not include the use of restraints, the type of vehicle used, or how many escorting officers are required for a Department-led inter-prisoner transfer.

Further, we were unable to verify what variations to policy were being authorised by Superintendents following the completion of an EMRA. For instance, an EMRA can justify the use of a non-secure vehicle. However, the Department's data on movements and the Transfer and Discharge Sheets do not specify what vehicle is used. This means decisions to use a secure or non-secure vehicle are not easily traceable.

Similarly, an EMRA can authorise the use of additional restraints. However, the use of restraints during a movement is not logged on the offender database for inter-prison transfers, and often only recorded in paper-based occurrence books. These books are not traceable in data. Transfer and Discharge Sheets record what restraints are authorised for use for most movement types, but not for inter-prison transfers. We also reviewed Offender Movement Information sheets for inter-prison transfers we were aware used additional restraints and found that section of the report was left blank. As such, we found no way of tracing the use of additional restraints.



Handcuffs:

if yes has been selected, the prisoner is to be handcuffed to an Officer at all times when the prisioner is being moved between destination points in non-secure areas. The Handcuffs may only be removed at the destination point when the prisoner:

- is secured in a secure vehicle, or
- has been admitted to hospital and is restrained to a bed or using ablutions in accourdance with procedure, or
- requires a procedure at the non-secure destination that prohibits the application of handcuffs to an Officer.

Leg Irons:

Figure 15: Offender Movement Information sheets often did not state what restraints were authorised to be used on a prisoner during inter-prison transfers.

An EMRA may also provide justification to authorise a variation in the number of escorting officers required on a movement. But this information is also not logged on the offender database and is therefore not traceable in data.

If these three variables are not easily traceable, then it is difficult for us (and the Department) to verify whether EMRAs were conducted in accordance with policy.

By allowing policy-directed practices to be varied through a risk-assessment process that is not easily traceable, the Department is accepting an unknown level of risk. If we cannot identify when an EMRA should have been used, confirm that it had been used, and verify what variations to policy it then authorised, it is likely that the Department has the same limited oversight, and this is of concern.

Internal compliance and monitoring of Department-led journeys have not occurred

Between 2018 and 2021, the Department's Operational Compliance Branch did not conduct any internal reviews that assessed compliance with transport processes. The Department advised that compliance reviews had focussed on Ventia-led escorts, given they conduct most prisoner escorts across the estate.

While we recognise Ventia perform most escorts, there are a range of pre-travel processes undertaken by prison staff prior to Ventia taking custody of a prisoner. These processes are designed to ensure escorts are conducted in a safe, secure and humane manner. It is concerning that these processes are not regularly being tested or monitored by the Department.

Further, the Department is often responsible for undertaking higher-risk journeys. Department-led escorts typically occur during emergency situations or when the risk profile of a prisoner is elevated due to factors such as their behaviour. It's during these high-risk journeys that variations to policy and practice are often requested, such as changes to the use of restraints. While these escorts may be less frequent, their risk profile warrants closer monitoring to ensure practices remain aligned to policy.

The Department did advise that Wandoo Rehabilitation Prison (September 2018) and Melaleuca Women's Prison (June and July 2022) had both been assessed for their compliance against the Department's policy on reception processes. This includes processes for receiving prisoners into the facility and preparing prisoners prior to travel, such as the processing of paperwork and property. However, the reviews did not assess compliance against the Department's primary policies and procedures for the coordination and delivery of escorts and transfers.

Recommendation 13 – Conduct regular internal reviews for compliance against the Department's COPPs 12.1 – 12.5 on the coordination and delivery of prisoner transports

4 Ensuring dignified travel: Anna's experience

The case study outlined in this chapter demonstrates how the actions of staff, a range of procedural errors and a lack of transparency can undermine the Department's intention of transporting prisoners in a safe, secure and humane manner. We have used a pseudonym to protect the identity of the person.

4.1 Without access to a toilet, Anna wet herself while being transferred from Geraldton to Perth in a Department-led transport

Anna was received at Greenough Regional Prison in 2022. Prior to this, she had two previous receptions at Greenough and had a history of ARMS and Support and Monitoring Systems (SAMS) placements. After a few weeks at Greenough, she was transferred to Bandyup Women's Prison by Greenough staff in a secure pod of a Department-owned vehicle. She was wearing hand cuffs and leg irons, despite being in a secure vehicle. While secured in her pod, where she had no access to a toilet, she urinated on herself and was not offered a change of clothes. She completed the journey in urine-soaked clothes.

Anna was known to have a psychosocial disability

Soon after Anna was received at Greenough, she was referred to SAMS for ongoing monitoring and support. Notes on her SAMS profile state that she was known to both Psychological Health Services and the Mental Health Nurse from previous admissions to Greenough, and that she may be at chronic risk to self. It noted that she has an extensive psychiatric history as well as a history of self-harm and suicidal behaviour. It noted she typically has limited social support and would benefit from ongoing support through the SAMS process.

A disability flag was also added to Anna's profile on the offender database for schizophrenia. This flag advised custodial staff that Anna had a known psychosocial disability.

Behaviour prior to first attempted inter-prison transfer

Anna displayed non-compliant behaviour early in her stay at Greenough. Notes on the offender database show Anna was at times uncooperative and verbally abusive to staff. She was noted as displaying erratic behaviour, including walking around the unit naked and displaying inappropriate behaviour. Two formal incidents reports were recorded for refusing an order and for smoking in a non-designated area. The first incident report notes Anna's 'limited intellect and limited cognitive skills'.

Anna was refusing her medication in the days leading up to her inter-prison transfer. It is unclear how long she continued to refuse her medication. This may have contributed to her erratic and non-compliant behaviour.

Prisoner Movement Risk Assessment failed to effectively assess the risks of travel

A PMRA was completed for Anna nine days prior to her inter-prison transfer flight to Bandyup Women's Prison in Perth. The PMRA notes Anna's recent attitude and behaviour at Greenough as

'satisfactory – no major concerns', despite Anna's offender notes describing her non-compliant behaviour and her refusal of medication.

The PMRA noted there were no medical or psychological concerns that could impact the planned travel arrangement. This is despite Anna's known psychiatric history and her recent refusal to take her medication.

The PMRA also notes that Anna's attitude towards the transfer was 'to be determined'. No update to this was made prior to the attempted transfer.

The PMRA concluded that there were no perceived risks with Anna conducting the inter-prison flight to Bandyup and recommended the travel proceed.

Finding 1 - PMRA did not adequately consider the risks associated with Anna travelling and her known behavioural issues, psychiatric condition, and recent refusal to take medication.

First attempted inter-prison transfer by Ventia failed

Anna was initially scheduled to transfer from Greenough to Bandyup in late April, but this was aborted by Ventia due to Anna's behaviour. The incident report submitted to the Department by Ventia notes that upon exiting the secure escort vehicle at Geraldton airport, staff realised that Anna had urinated in the pod. Anna was also refusing to wear a face mask. Escorting officers felt that Anna was erratic and not following directions, and this posed a risk to others onboard the flight. A request was made to the Ventia control centre to have Anna removed from the inter-prison transfer flight due to her unpredictable behaviour.

Anna was returned to Greenough Regional Prison without further incident.

A second PMRA was conducted before Anna had been returned to Greenough

A new PMRA was conducted for Anna at 14:09 on the day of the aborted inter-prison transfer. This was 21 minutes before Anna had even returned to Greenough Regional Prison. This PMRA made no changes to the one completed earlier, other than noting that Anna's recent attitude and behaviour was now 'Poor – disruptive'.

The PMRA noted the previous failed attempt to transfer and Anna urinating in the pod and stated that the risks of her travelling would be reassessed prior to the next attempt. No further risk assessments were conducted prior to the next attempted move later in the month.

Finding 2 – A second PMRA was conducted prematurely and again did not appear to effectively consider the risks associated with Anna travelling.

Anna was transferred to Bandyup by Greenough officers in a Department-operated secure escort vehicle, where she urinated in the pod

A week after the first attempted transfer, Anna was escorted to Bandyup by Greenough staff in a Department-owned secure escort vehicle. Anna was placed alone in the rear pod of the vehicle. A

male prisoner was placed in the non-secure soft-seat section of the vehicle, restrained to an officer. Two other officers were in the front cab of the vehicle. The occurrence book for the escort notes they left Greenough at 10:50 and arrived at Bandyup at 15:25 – a total journey time of 4 hours and 35 minutes.

The occurrence book notes the following:

- 10:27 leg irons and cuffs were applied to Anna, prior to departing
- 11:00 it is noted that Anna used the cell call system and was abusive to officers
- 11:33 cell call was used again, also abusive to officers
- 12:23 it is noted that Anna is sighted in CCTV stretching then slumping over in pod, a note describes Anna as being 'all okay'
- 13:10 cell call used again, Anna asking where she was going
- 13:27 it is noted that the vehicle stopped at Cataby for fuel. Notes say that Anna 'toilet break in pod'. Vehicle continued at 13:35
- 14:00 cell call used again, Anna abusive to officers
- 15:00 Anna was sighted via CCTV sitting forward playing with her hair
- 15:25 they arrived at BWP
- 15:45 Anna received into BWP and restraints removed.

CCTV footage and cell call recordings were not available

In our attempt to understand what occurred during Anna's journey we requested the CCTV footage and cell call recordings but were advised that these were not available. No reason was provided, other than there being no data for the Greenough to Bandyup escort on the date of her transfer.

Later, we requested the CCTV footage and cell call recordings for another Greenough to Bandyup escort that occurred a few weeks prior in the same vehicle. The Department also advised us that this data was not available. This time they noted that an audio-visual issue had been reported for the vehicle, where data was only being recorded 'intermittently'. Further investigation found the hard drive in the vehicle was not performing as required, and the vehicle was taken to Perth for repairs.

Failure to record and store the CCTV footage and cell call recordings is in breach of the Standards for secure escort vehicles (DOJ, 2019). Under these Standards, all vehicle cells are required to be fitted with effective video, audio and temperature monitoring and recording systems. This equipment must enable the secure, digital recording of cell pods and the recording of all intercom discussions between escorting officers and prisoners. This recording must start as soon as the prisoner enters the vehicle.

Finding 3 – CCTV footage and cell calls were not recorded and stored in accordance with the Department's *Minimum Standards for Secure Escort Vehicles*.

The identification of this audio-visual issue also illustrates a failure in the Department's vehicle maintenance and reporting requirements. The Superintendent is responsible for maintaining all vehicles based at its prison, to ensure they continue to comply with the Standards (DOJ, 2021b). A monthly inspection of vehicles is undertaken by a third-party contractor and any inconsistencies

against the Standards are reported to the Department as requiring remedy. The monthly inspection reports for the secure escort vehicle at Greenough did not identify any audio-visual issues between June 2021 and June 2022.

Upon further investigation, the Department's contractor found that the vehicle's hard drive was faulty and only recording parts of audio-visual activity. The hard drive was subsequently replaced. The Department assured this issue was unique to this vehicle due to its age. But, as a precaution, the contractor conducted testing on other hard drives to ensure the issue was not present in other vehicles. No other faulty hard drives had been identified as of mid-August 2022.

They further noted that monthly compliance checks are based on a sample of playback data obtained from vehicle hard drives to confirm they are functioning correctly. As the hard drive in the Greenough vehicle was recording some audio-visual activity, the contractor presumed it was functioning properly. The contractor does not have access to the Department's systems to confirm when the vehicle was used. Therefore, they cannot verify if the volume of recorded audio-visual content on the hard drive correlates with the journeys that vehicle had undertaken in the preceding month. This has highlighted flaws in the monthly vehicle inspection process.

Finding 4 – Audio-visual equipment issues in Greenough's secure escort vehicles were not adequately identified in monthly maintenance and compliance reports prior to Anna's journey.

Escorting officers were aware that Anna had wet herself

Noting that the vehicle Anna was transferred in did not have an onboard toilet, we queried what was meant by the line 'toilet break in pod' written in the occurrence book. The Department advised us that upon arrival at Cataby, Anna activated the cell call system and was verbally abusive to the escorting officers. The officers queried whether she needed to use the toilet or required anything else and Anna allegedly answered no before proceeding to urinate within the secure pod.

With no CCTV footage or cell call recordings available to scrutinise, we have no way of determining whether this is an accurate explanation of what occurred. The cell call made upon arrival to Cataby is not logged in the occurrence book. Three other call calls are logged in the occurrence book, with each stating that Anna was abusive. However, we have no details about what was said during these calls, including whether Anna made enquiries about when she could use a toilet or if she expressed a need to use a toilet.

We spoke with the male prisoner who was also on that journey. He could not recall stopping at Cataby but did recall Anna being abusive to staff. He could not provide us with details of what was said but was aware that she had urinated in the vehicle.

Finding 5 – The occurrence book does not accurately record whether either prisoners were offered a comfort break at Cataby.

Further, the Department's response above confirms that the escorting officers were aware that Anna had wet herself. She was allowed to continue the journey in wet clothing for a further two hours. There is no mention of providing Anna with a change of clothes, or a towel or toilet paper.

We spoke with Anna at Bandyup. She told us that she did ask for time out of the vehicle for fresh air but was not allowed. She said she was told that she had to stay in the vehicle, and then the officers allegedly started talking amongst themselves and were laughing. When she was not allowed out of the vehicle, she explained to us that she 'had to go to the toilet in the pod'. She had to do this twice on the journey. She told us she had wet clothes for half of the journey, and it made her feel cold. She was not offered a change of clothes.

Finding 6 – Officers were aware that Anna had urinated in the pod and wet herself, but there is no evidence that any action was taken to assist her and protect her dignity.

No formal reporting of Anna urinating in the pod

There are no records on the Department's offender database around Anna urinating in the pod or being abusive to officers. No formal incident report was prepared, as was done by Ventia the week prior, and there were no notes added to Anna's profile.

A day after arriving at Bandyup, Anna was re-referred to SAMS and it was noted that she was:

> wet with urine on arrival, she did not appear distressed but was irritable with staff.

Further, it noted Anna:

> …has recently transferred from GRP into Bindi Bindi Unit. It is noted upon arrival she had urinated within the pod, most likely due to the length of trip.

The Department's policy notes that an incident is any event that may, among other factors, include a situation where a prisoner's safety or health is jeopardised (DOJ, 2020a).

Finding 7 – No formal reporting was conducted of Anna urinating in the vehicle.

Incontinence aids were available for Anna

The Clinical Nurse Manager at Greenough confirmed that continence aids are available for prisoners to use and were available for Anna prior to her journey to Bandyup. This includes pull-up underwear and an underwear liner. To her recollection, Anna was deemed to require a continence aid prior to her first journey but refused. However, she felt that Anna was wearing an aid of some sort during her second journey.

We found no evidence to support this. Anna's Fitness to Travel Assessment does not stipulate a requirement for her to wear a continence aid. There were no notes on Anna's profile on the offender database about using an aid, or Anna refusing to use an aid. There were no notes in the occurrence

book on this, nor was it mentioned in the SAMS referral at Bandyup. We also interviewed Anna and she told us that she was not asked to wear an aid.

Finding 8 – No records were found that confirmed Anna was offered or refused a continence aid.

Anna was required to wear hand cuffs and leg irons the entire journey

Despite being placed in a secure escort vehicle, Anna was required to wear both hand cuffs and leg irons for the duration of the transfer. We queried this with the Department and were advised that the Superintendent at Greenough authorised placing Anna in mechanical restraints due to her frequent disruptive behaviour and misconduct. They further advised:

> The Superintendent determined that mechanical restraints were required to ensure the good order and security of the escort, and the safety of escorting officers and fellow prisoners on board.

This is despite Anna being placed in the pod alone, with no physical contact with other people throughout the journey. The design of the pod door also allows for hand cuffs to be placed on a prisoner through a hatch prior to exiting the vehicle. This negates the need for them to be restrained throughout the entire journey.

The Superintendent can vary the use of restraints for a prisoner movement following the completion of an EMRA. However, no EMRA was conducted for Anna's journey and no notes were made on the offender database authorising a variation to the standard use of restraints.

The restraints applied to Anna were not in accordance with the recommended used of restraints in the Department's policy and were not justified by the completion of an EMRA.

Figure 16: The pod door and hatch for secure escort vehicle Ace 12 based at Greenough Regional Prison.

Anna told us that being placed in these restraints made her feel like she was a 'murderer'.

Finding 9 – Restraints were applied to Anna without an External Movement Risk Assessment justifying their use, and without appropriately documented authorisation from the Superintendent, which contravenes the Department's policy.

4.2 Another female prisoner urinated in the same vehicle departing Greenough, two weeks prior

Prior to Anna's transfer, another female prisoner departed Greenough in early April 2022 and urinated in the vehicle. Upon arrival to Bandyup, staff were made aware that this prisoner had

urinated in the pod during the journey. Many of the issues we identified with Anna's experience were also present in this earlier case, including:

- No incident reports being logged, or notes made on her profile about her urinating in the vehicle. The Department acknowledges this was an oversight.
- The occurrence book lacking detail and did not record offering her an opportunity to use a toilet. The Department later told us she was offered a toilet break at two locations, but this was not recorded.
- There were no notes recorded in the occurrence book or her profile about being offered an incontinence aid. The Department says she was offered and refused.
- There were no audio-visual recordings from the CCTV or cell-call system to verify what occurred throughout the journey.

It is concerning, and disappointing, that staff failed to learn from this earlier incident and implement measures, such as bringing a change of clothes or a towel, that would have helped protect the dignity and welfare of Anna during her journey a few weeks later.

Finding 10 – Following a female prisoner urinating in the same vehicle a few weeks prior, Greenough took no known actions to mitigate the risks to a prisoner's welfare should a similar incident occur in the future.

4.3 Poor transparency is concerning and prevents similar experiences from being exposed

The lack of transparency around Anna's experience is concerning. There were no electronic records of the incident occurring, other than brief notes in the SAMS log by staff at Bandyup. The occurrence book is paper-based, limiting access to information about Anna's journey. When we retrieved a copy of the occurrence book it lacked detail and, as the Department later informed us, did not include all interactions with Anna. This poor record-keeping of Amy's experience suggests a degree of indifference towards the situation and its impact on her dignity and wellbeing.

Further, it is deeply concerning that when requested the Department was unable to produce audio-visual evidence of an incident that occurred inside a vehicle that it owns, maintains and operates. It is unacceptable that an unidentified audio-visual fault, which meant we could not verify what occurred or what was said, now effectively abdicates the Department of responsibility and accountability for such a degrading incident. Conversely, should that incident have involved self-harm or a death in custody, it would not have been able to provide audio visual evidence to demonstrate they were not negligent and wholly liable.

Additionally, a lack of detailed record-keeping, the use of paper-based records, and a lack of incident reporting has prevented our ability to determine if Anna's experience was unique or common. As such, we are unable to understand how regularly prisoners are being transported in Department-operated vehicles in a manner that may be denigrating to their dignity and wellbeing. We are unable to determine who else may have been treated in a similar, dehumanising way.

We strongly encourage the Department to review our findings of Anna's experience and take appropriate actions to mitigate the risks of a prisoner's dignity and welfare being compromised during a Department-led transport.

Recommendation 14 – Review the circumstances of Anna's experience, and the findings we have identified, and take actions to ensure the dignity and welfare of prisoners are protected in Department-led transports

Appendix A Transport services provided by Ventia

The following transport services were provided by Ventia in accordance with the *Court Security and Custodial Services Contract* in place at the time this report was prepared (SSO, 2016). In January 2023, a contract extension and variation was awarded to Ventia. Under this new contract, Ventia will commence performing medical escorts, hospital sits and funeral escorts from West Kimberley Regional prison.

	Prison Location	Court transfer	Inter-prison transfer	Lock-up clearance	Medical escorts	Hospital sits	Funeral escorts	Other escorts
Metropolitan	Acacia	✓	✓	x	✓	✓	✓	✓
	Bandyup	✓	✓	✓	✓	✓	✓	✓
	Boronia	✓	✓	x	x	x	x	x
	Casuarina	✓	✓	x	✓	✓	✓	✓
	Hakea	✓	✓	✓	✓	✓	✓	✓
	Melaleuca	✓	✓	✓	✓	✓	✓	✓
	Wandoo	✓	✓	x	x	x	x	x
	Wooroloo	✓	✓	x	x	x	x	x
Regional	Albany	✓	✓	✓	✓	✓	✓	✓
	Broome	✓	✓	✓	✓	✓	✓	✓
	Bunbury	✓	✓	✓	✓	✓	✓	✓
	Eastern Goldfields	✓	✓	✓	✓	✓	✓	✓
	Greenough	✓	✓	✓	✓	✓	✓	✓
	Pardelup	✓	✓	✓	x	x	x	x
	Roebourne	✓	✓	✓	✓	✓	✓	✓
	West Kimberley	x	✓	x	x	x	x	x

Appendix B The Department's response to recommendations

Response to Review:

The Transport of Regional and Remote Prisoners

December 2022

Version 1.1 FINAL - Amended 17 Jan 2023

Response Overview

Introduction

On 31 May 2022, the Department of Justice (the Department) received notification that the Office of the Inspector of Custodial Services (OICS) would be conducting a review titled *The Transport of regional and remote prisoners* (the Regional Transport Review).

The purpose of the review was to examine the transportation of prisoners in regional and remote parts of Western Australian (WA) prisons and whether these transports were conducted in a safe, secure and humane manner.

The review did not include the transport of young people across regional and remote WA or the transport of prisoners within the Perth metropolitan area.

A draft copy of the report was provided for comment to the Department on the 15 November 2022 and contains 14 recommendations and key highlights.

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

Since the tragic death of Mr Ward in 2008 the Department has invested significant resources into improving its prisoner transport fleet to ensure the safety and welfare of prisoners during transportation, particularly in regional areas of Western Australia.

These improvements included replacing the entire prisoner transport fleet in 2010 with a new range of modern vehicles fitted with air-conditioning, remote temperature monitoring, duress alarms, CCTV, GPS and mobile satellite phones, molded seats and seat belts. Updates have also been made to policies and procedures through the introduction of the *Minimum Standards for Secure Escort Vehicles.* Changes to the approved modes of transport for inter-prison transfers ensure majority of long-distance transfers are now conducted by air.

In 2019, the Department commenced negotiations with Ventia (formerly Broadspectrum) to replace the 2010 fleet. The concept fleet will see the number of secure escort vehicles increase from 34 to 43. New security and safety features, not present in the current fleet, will also be included such as seatbelts designed with self-harm considerations, defibrillators and roof mounted solar panels to increase fuel efficiency.

The replacement fleet will be smaller and more discreet providing greater flexibility with more seating configurations and wheelchair access. A prototype vehicle has been developed and is undergoing testing.

Most prisoner transports are conducted by Ventia, the Department's approved service provider under the *Court Security and Custodial Services Act 1999* (the CS&CS Contract). The Department facilitates all remaining escorts which are primarily short-term and/or unscheduled escorts, such as medical appointments or emergencies.

The Department's CS&CS Contract Management Team and Ventia maintain a good working relationship and meet regularly to monitor service delivery of the contract. The

Contract Management Team maintains a comprehensive abatement regime for failures in service delivery in accordance with the specifications of the contract.

The Departments Operational Policy and Procedures Framework plays a pivotal role in developing, reviewing and delivery of the Commissioner's Operating Policies and Procedures (COPPs) in line with relevant legislation and operational requirements.

The policies undergo regular reviews and amendments to improve service delivery. Recent changes to policies relating to prisoner movements include the requirement and process for conducting and recording welfare checks during the transportation of a prisoner and the provision of comfort breaks. A range of pre-movement processes that consider the health, safety and wellbeing of prisoners during movements are also in place, including special considerations for vulnerable prisoners. Comparisons are made with Ventia's Standing Operating Procedures to ensure practices are consistent and in line with best practice.

All COPPs relating to prisoner movements are due for review in 2023. This review will consider the findings in the OICS report and improvements will be made where appropriate.

All decisions regarding the use of restraints are based on risk assessments conducted for the movement of individual prisoners. This includes a fitness to travel assessment, external movement risk assessments and Superintendent directed escorts.

The Department acknowledges there is a high frequency of prisoners being moved, particularly Aboriginal prisoners through inter-prison transfers to or from regional prisons, resulting in these prisoners living off Country. Individual circumstances and needs of the prisoners and the services and care they require are complex sometimes requiring them to be transferred to a prison where their needs can be met. A high volume of transfers is also self-initiated by prisoners to transfer to their preferred facility or to facilitate visits with their families.

Overall, the OICS report is positive and has commended the Department for its commitment and focus on prisoner welfare during the various stages of planning and undertaking prisoner movements. The report specifically states that *processes were embedded into practice and were observed to be functioning well. Department staff had a good understanding of the various processes involved in moving a prisoner and understood their specific role within these processes. Generally, the movement of prisoners was found to be efficient and actively considered the safety, security and humanity of prisoners and escorting staff*.

Gaps where practices are not clearly aligning with the policy intent will be reviewed and improvements that will benefit both staff and prisoners will be considered for implementation.

The Department will review the findings made in relation to Anna's experience and consideration will be given to amending policies and procedures where required to ensure the safe, respectful, and humane transport of prisoners.

The Department has supported 11 of the 14 recommendations made by OICS and has identified further actions that will be taken to implement these recommendations.

Response to Recommendations

1 Prepare Transfer Plans that outline potential responses for expressed self-harm intent or actual self-harm incidents, in accordance with *COPP 12.4 – Prisoner Transfers.*

Level of Acceptance: Supported
Responsible Division: Corrective Services
Responsible Directorate: Adult Male Prisons

Response:

Corrective Services' Adult Male Prisons directorate and the Mental Health, Alcohol and Other Drugs branch will develop procedures for appropriately responding to incidents where a prisoner may express self-harm intent, or actual self-harm occurs during an escort.

The Transfer Plan will also be amended to capture this information and COPP 12.4 – Prisoner Transfer updated to reflect any procedural changes.

2 Amend *COPP 12.4 – Prisoner Transfers* to include consideration of deactivated ARMS alerts in the assessment of prisoners 'Of Self-harm Concern'.

Level of Acceptance: Supported – Current Practice / Project
Responsible Division: Corrective Services
Responsible Directorate: Adult Male Prisons

Response:

COPP 12.4 - Prisoner Transfers, section 3.1.13, calls for all prisoners to be assessed for self-harm prior to being transferred between prisons.

All prisoner movement checklists are being reviewed as part of the policy review of COPPs relating to movements in 2023. Consideration will be given to the need for *deactivated* ARMS alerts to be considered when assessing a prisoner's risk of self-harm as part of this review.

3 Develop policy that outlines procedures for informing prisoners of upcoming movements.

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

Prisoner movements are minimised where feasible as any movement from a secure facility to an external, non-secure location carries risks that vary based on the circumstances of the movement.

The information shared with a prisoner relating to any movement (e.g., hospital, court, inter-prison) will always be subject to security considerations.

Where practicable and safe to do so, prisoners are advised of any transfer in advance, including the proposed facility and opportunities provided to inform their next of kin before the transfer occurs.

4 Develop processes for providing comfort breaks during long road journeys, which are equally applicable to both the Department and the CS&CS contractor.

Level of Acceptance: Supported
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

COPPs 12.3 - Conducting Escorts and 12.4 - Prisoner Transfers will be amended in 2023 to include the requirement for escorting staff to provide comfort breaks during long-distance escorts via road, which will be aligned with Ventia's Standing Operating Procedures.

5 Develop processes for conducting welfare checks throughout Department-led movements.

Level of Acceptance: Supported
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

COPP 12.4 – Prisoner Transfers was updated on 9 September 2022 to include procedures requiring escorting officers to conduct welfare checks during escorts.

COPPs 12.4 is scheduled for further review in 2023 to enhance the existing provisions and provide thorough guidance for escorting officers.

Following this review, the welfare check procedures will also be incorporated into related COPP 12.3 – Conducting Escorts.

6 Extend Ventia's inter-prison transfer flight to West Kimberley Regional Prison.

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

The current arrangement whereby prisoners are transferred between Broome and WKRP via road is consistent with the CS&CS Contract and presents a journey time of approximately two and a half hours.

Actioning of this recommendation would have significant logistical challenges as the standard inter-prison transfer flight provided by Ventia already makes two layovers between the originating and concluding destinations of Broome and Perth (being Karratha and Geraldton). Restrictions on pilot flight times and consideration of fatigue

management are already challenging in this arrangement and a third layover would not be feasible.

It should be noted that as part of the contract extension and variation, WKRP will start to receive movement services including medical escorts, hospital sits and funerals/compassionate leave escorts which will reduce the pressure on WKRP to facilitate these escorts.

7 Establish fatigue management policies for custodial officers undertaking long-distance escorts.

Level of Acceptance: Supported – Current practice / project
Responsible Division: Corporate Services
Responsible Directorate: Human Resources

Response:

The Department's Human Resources directorate is leading a review of fatigue management and will examine operational practices and procedures for long-distance escorts by road.

8 Revise medical escort security procedures to reduce the use of restraints to reflect the system of security classifications and approvals for external activities.

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

Superintendents are required to consider all circumstances, risks, and the behaviour of prisoners when considering the use of restraints during an escort. These risks remain the same regardless of security classification e.g., an escape risk can equally apply to low, medium and maximum-security prisoners alike.

9 Ensure prisons apply restraints in accordance with *COPP 12.3 – Conducting Escorts* or justifies the use of addition restraints with and External Movement Risk Assessment.

Level of Acceptance: Supported
Responsible Division: Corrective Services
Responsible Directorate: Adult Male Prisons

Response:

A Deputy Commissioners Broadcast will be distributed to all Superintendents (and the General Manager of Acacia Prison), reinforcing the appropriate application of restraints, in accordance with COPP 12.3, including the use of external movement risk assessments (EMRA) that document the necessity for additional restraints to maintain safety and security of the escort.

10 Review the use of leg restraints on flights for compliance against aviation regulations and departmental policy.

Level of Acceptance: Supported
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

The Department's CS&CS Contract Management team will engage with Ventia to review the circumstances regarding the non-compliance of utilising two-points of restraints in the absence of an EMRA during escorts and determine actions to address and prevent non-compliance.

11 Conduct regular monitoring and compliance reviews of Ventia's movement services from regional locations.

Level of Acceptance: Supported – Current Practice / Project
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

Corrective Services' Operational Compliance branch aims to attend each regional prison and nearby court locations every two years to conduct compliance monitoring activities. As part of the activities, both the Department's and Ventia's movement services at these locations are monitored.

Where on-site visits cannot occur and as the provider of the majority of prisoner movements on behalf of the Department, desktop reviews of Ventia escorts are undertaken via the review of Electronic Prisoner Escort Movement System logs.

It should be noted that compliance monitoring activities since 2020 have been impacted by COVID-19 ravel restrictions and staff re-deployments to the COVID-19 Taskforce.

12 Investigate opportunities for implementing electronic occurrence books for Department-led transports.

Level of Acceptance: Supported in Principle
Responsible Division: Corporate Services
Responsible Directorate: Knowledge, Information and Technology

Response:

The Department's Long-Term Custodial Technology Strategy (LTCTS) is overseeing the assessment and implementation of modern technology solutions throughout the custodial estate, and the transition of occurrence books from paper-based records to electronic logs will be considered.

13 Conduct regular internal reviews for compliance against the Department's *COPP 12.1 – 12.5* on the coordination and delivery of prisoner transports.

Level of Acceptance: Supported in Principle
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

Corrective Services' Operational Compliance branch will monitor Department-led escorts during site visits where possible noting a significant portion of Department escorts are unscheduled.

14 Review the circumstances of Anna's experience, and the finding we have identified, and take actions to ensure the dignity and welfare of prisoners are protected in Department-led transports.

Level of Acceptance: Supported
Responsible Division: Corrective Services
Responsible Directorate: Operational Support

Response:

The findings of Anna's experience will be considered and COPPs amended where appropriate relating to safe, humane prisoner transport.

Appendix C Ventia's response to recommendations

Hi Kathleen,

I hope you are well. As per the COB 20th December 2022 deadline.

Ventia CSCS's to ***OICS Report Part Commentary in recommendation 10;*** *Ventia confirmed it has not sought approval from their aircraft operator to either use, or not use, leg restraints. Rather, the decision to not use leg restraints is based on historic practices.*

- Ventia and the key service provider for aviation movements continue to liaise and have ongoing meetings. The use of leg restraints on Persons in Custody whilst a passenger on an aircraft has been a topic of discussion previously. In general terms, most Aviator's take the position that the use of leg restraints is a safety risk in respect to aircraft emergencies and the disembarkation of passengers on board during an emergency. In addition, the Captain (Pilot) of each individual aircraft (at the time of the movement/escort) can also make an assessment and give direction as they have full responsibility of all passengers on board the aircraft from a safety, security and emergency response perspective and Ventia abide by their directions at all times. The Civil Aviation Safety Regulations 1998, Aviation Transport Security Act 2004, and the Aviation Transport Security Regulations 2005, are fully complied with in respect to the Aviators requirements.

- Risk Assessments are conducted on all prisoners who are due to be moved/escorted and if it is assessed by Ventia that a specific prisoner is required to be in 'leg restraints', then an application for leg restraints is made either prior to the movement occurring (or at the time of the movement) with the Aviation Service Provider or the Captain of the Aircraft. Ventia then act accordingly on the direction of the aircraft provider. If it is deemed that a Prisoner is of such a high risk to require leg restraints in combination with hand restraints, the prisoner would more than likely be transferred by road and not be placed on an aircraft.

- Given the varying views, assessments and requirements between aircraft operators and individual Captains (Pilot); it can be difficult to get a consistent approach on all aircraft movements and the use of leg restraints.

- The relevant Ventia SOPs' will be reviewed in respect to the 3 Points of restraints, the use of leg restraints, risk assessments and consultation with the aircraft operator.

Regards and Thanks.

Jonathan Snow
Contract Director - Court Security and Custodial Services

Appendix D Serco's response to recommendations

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17 January 2023

Eamon Ryan
Inspector of Custodial Services
Office of the Inspector of Custodial Services
Level 5, Albert Facey House
469 Wellington Street
Perth WA

Dear Eamon

The transport of regional and remote prisoners

Thank you for providing Serco the opportunity to provide a response to the review conducted into the transport of regional and remote prisoners.

Please note the below response include comments relating only to those recommendations that may be applicable to Acacia Prison.

Finding	Comment
1.	Acacia Prison already has in place plans that outline potential responses for expressed self-harm intent or actual self-harm incidents.
5.	Serco will liaise with the Department of Justice toward developing processes for conducting prisoner welfare checks whilst being transported.
9.	Acacia Prison adheres to requirements with respect to the application of restraints.
11.	This is in place.
12.	Serco agrees the use of electronic occurrence books will create synergies, thereby also improving practice.
13.	This practice is in place and is included in Acacia Prison's compliance calendar.
14.	The dignity and welfare of our prisoners remain a focus area for Acacia Prison. This is subject to ongoing, informal review to ensure best practice is followed as far as practicable.

I trust the above comments will add value to the final report and look forward to reading it.

Yours sincerely

John Harrison
Superintendent
Acacia Prison

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 between 2018 and 2022.

We examined Western Australian legislation and departmental documentation including policy, strategy documents, and evaluations. As part of the review we also conducted site visits to Albany Regional Prison, Bandyup Women's Prison, Bunbury Regional Prison, Broome Regional Prison, Casuarina Prison, Greenough Regional Prison, and Pardelup Prison Farm.

We also examined Ventia policy and procedure documents and reviewed data extracted through their ePEMS system. We observed a Perth to Albany prisoner coach journey and an inter-prison transfer flight from Broome to Perth via Karratha and Geraldton.

A key findings briefing was presented to the Department in November 2022.

The draft report was sent to the Department, Serco and Ventia in November 2022 and responses were received from all parties.

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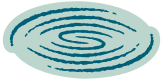

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