

## 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

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