



Government of **Western Australia**
Department of **Justice**
Corrective Services

Response to Directed Review:

**Department of Justice's performance in
responding to recommendations arising
from coronial inquiries into deaths in
custody**

December 2022

Response Overview

Introduction

The directed review into the *Department of Justice's performance in responding to recommendations arising from coronial inquiries into deaths in custody* (the Directed Review) was announced by the Office of the Inspector of Custodial Services (OICS) on 15 November 2021. A wide range of documentation, statistics and access to systems, policies, processes, custodial facilities including staff and prisoners were made available to OICS upon request for the purpose of the review.

On 28 October 2022, OICS provided a debrief on the review findings and on 14 November 2022, the Department of Justice (the Department) received the draft report on the Directed Review for comment. The draft report highlighted the key findings and made 14 recommendations. The Department has reviewed the draft report and provides comments and responses to the recommendations as outlined below.

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

Review Comments

The Department provides a crucial public service to the community through its administration of the State's courts, custodial facilities, community corrections, and youth justice systems. All aspects of the Department's operations are subject to numerous reviews, audits, and investigations on an annual basis to ensure the quality and integrity of the services it provides.

These activities are performed by various assurance providers, including but not limited to, the Office of the Auditor General, the Corruption and Crime Commission, the Ombudsman WA, the Coroner's Court of WA, OICS and the Department's Performance Assurance and Risk (PAR) directorate. In total, 292 recommendations were made to the Department in the 2021-22 financial year and 1,090 recommendations over the past five years.

The Department's management of these recommendations has evolved over the years, particularly following the amalgamation of the former Departments of Corrective Services and the Attorney General, into the Department of Justice in July 2017. Changes to processes across the Corrective Services division and within the PAR directorate has further refined how recommendations are managed, including their implementation, monitoring and subsequent closure.

The amalgamation coincided with the Department's implementation of a recommendation tracking system *RiskShare*. This, together with a reinvigorated governance process has enabled recommendations to be recorded, responsibilities assigned, and progress monitored and reported to the Department's Risk Management and Audit Committee. The closure of recommendations is also tracked through *RiskShare* with the appropriate evidence and approval/verification process in line with the Department's Managing Recommendations Process.

The Department takes deaths in custody very seriously and places great importance on recommendations made by the Coroner. It draws the basis for each of the recommendations from the Coroner's record of investigation to assist in identifying targeted solutions to address the intent of the recommendations.

The Department is open to recommendations that will improve the safety and wellbeing of people in its care. It is however often faced with significant challenges implementing recommendations due to the inherent complexities of the prison environment, those in our care and limited resources available.

In the past the Department had a practice of supporting all coronial recommendations prior to undertaking a cost/feasibility assessment and before consultation with external relevant stakeholders. This resulted in an accumulation of recommendations that were unable to be achieved, including major infrastructure developments and long-term Department-wide strategies that required significant funding and resources, and could take several years to implement.

The Department now works with the State Coroner to identify solutions that are achievable within resourcing capabilities. In addition, the Department is proactive in requesting additional resources that are critical for the fulfillment of Coronial recommendations.

Since the closing of the Coronial recommendations reviewed by OICS, the Department has also initiated a number of suicide prevention strategies to better manage at-risk and vulnerable prisoners. These have taken effect through the establishment of a dedicated suicide prevention project that aims to improve the safety and wellbeing of these prisoners; reduce incidents of suicide and self-harm; and improve the Department's focus on prevention and safer custody in line with the State's Suicide Prevention Strategy. The Department has also set up a Suicide Prevention Taskforce to provide support, guidance and oversight of progress on project achievements and outcomes.

The suicide prevention project includes a review of the At-Risk Management System (ARMS) for prisoners and the governance processes around the decisions made by the Prisoner Risk Assessment Group (PRAG). Extensive training is being provided to the PRAG Chair and staff involved in the decision-making process.

The Department has expanded its ligature minimisation program to address opportunistic self-harm through a program of ligature removal, retrofitting ligature-proof fixtures in existing cells and ensuring that new builds are based on ligature-minimised standards. As ageing facilities such as Broome Regional Prison are decommissioned and replaced with new builds, the cells will be ligature minimised as a standard.

The Department has a budget of \$1.5 million across three years, ending in the 2022/23 financial year, for its ligature minimisation program. Given the limited budget available, it is not possible to cover all cells or locations and priority is given to facilities with the highest risk and need. The Department continues to actively seek additional resources to further extend the program across all facilities.

The Department has also established a lessons-learned process whereby workshops are held following an unnatural death in custody. The intent of the workshops is to examine the circumstances of the death in custody with a view to identifying opportunities that will improve the safety of prisoners in the Department's care and to reduce the likelihood of future deaths in custody.

The 10 coronial recommendations examined by OICS for the purposes of this review were submitted for closure based on circumstances and actions taken to address the recommendations at the time, noting that changes to policy, strategic direction and the current environment may warrant further action.

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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.

The PAR directorate will perform a one-off audit of all closed coronial recommendations in its next annual follow-up audit. This will include previously audited recommendations, reinforcing the need to have recommendations not only appropriately closed, but with adequate management monitoring controls in place so they remain closed.

PAR, as the internal audit function of the Department, has also committed to continue with the methodology of sample testing 50 per cent of closed Coroners' recommendations strictly in accordance with the Institute of Internal Auditors Standards and Treasurer's Instruction 1201-2.

Response to Recommendations

1 Ensure a high / significant or extreme risk rating is attached to coroners' recommendations so that PAR audits 100 per cent of coroners' recommendations in the annual audit process.

Level of Acceptance:	Supported in Principle
Responsible Division:	People, Culture and Standards
Responsible Directorate:	Performance Assurance and Risk

Response:

Assurance providers who make recommendations to the Department regarding deaths in custody are responsible for allocating a risk rating to those recommendations.

For example, the Office of the Auditor General (OAG) allocates a risk rating of significant, moderate, or low to its recommendations. The Coroner's Court of Western Australia does not assign a risk rating to its recommendations in regard to a death in custody. It is noted that OICS also does not assign risk ratings.

In the conduct of internal audits, risk rating and sampling are conducted strictly in accordance with the *Institute of Internal Auditors' (IIA) Standards and Treasurer's Instruction (TI) 1201-2*. As such, PAR cannot allocate a risk rating to the recommendations of an external body, only doing so for its own issued recommendations. PAR has also a higher level of coverage (50 per cent) than what is the internal audit practice for sample testing. It is noted that this compares well with the OICS sample tested of 10 out of 35 coronial recommendations (29 per cent).

Considering the findings in this report, PAR will take an additional assurance measure as was done in the first audit in 2020 by performing a one-off audit for all closed coronial recommendations in the next annual follow-up audit. This will include previously audited recommendations, reinforcing with management the need to have recommendations not only properly closed but with adequate monitoring controls in place so they remain closed. Moving forward, PAR will continue with the methodology of sample testing 50 per cent of closed coroners' recommendations in line with PAR's internal audit role.

2 Track and disseminate 'suggestions' made by the Coroner.

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

Response:

The Department is subject to numerous reviews, inspections, inquiries, and audits each year by a range of independent external oversight bodies including the Coroner, the Office of the Auditor General, the Corruption and Crime Commission, the Ombudsman WA and OICS.

These activities result in a significant number of recommendations being made. A total of 292 recommendations were made to the Department in the 2021-22 financial year and 1,090 recommendations over the past five years.

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The Department welcomes the independent oversight and the recommendations and suggestions that are made to improve the quality and integrity of the services it provides

While suggestions made are acted upon where possible, the Department currently does not track suggestions as formal recommendations.

Noting the importance of the suggestions made by the Coroner, the Department will assess the feasibility of adopting a mechanism that will assist in formally tracking and disseminating these suggestions.

3 Ensure PHS is adequately resourced for all prisons across Western Australia.

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

Response:

The Department recognises the importance of Psychological Health Service (PHS) resources in prisons and the critical role they play in providing mental health and counselling support to people in custody.

Over the years, the Department has increased PHS positions across the custodial estate. However, recruiting to these positions has been challenging due to the specialised nature of the role and the shortage of clinical staff in health and mental health care.

Since 2017, PHS staffing levels increased by 15.5 FTE to meet the increasing demand, and these positions were allocated to various prisons based on need. Vacancies, however, affect the ability to maintain an appropriate level of service. The Department continues to submit business cases for additional resources, including:

- dedicated PHS resources to operate the Alcohol and Other Drugs Rehabilitation Program (Mallee Unit) and a new Mental Health Unit at Casuarina; and
- an Expenditure Review Committee (ERC) submission as part of the 2023/24 budget process to address key deficits in PHS resources, primarily at Hakea and Casuarina Prisons.

Vacancies continue to be monitored and recruitment carried out to ensure adequate PHS resources are maintained across prisons. Referrals made for counselling services are being monitored daily and prioritised for contact. To reduce the waitlist and associated risk, group interventions and telehealth consults have also been held.

The Coroner's original recommendation was closed in 2019 having demonstrated significant efforts to recruit counselling staff and successfully filled 80 per cent of positions at the time of closing the recommendation, with further recruitment processes underway.

4 Change policy to ensure that prisoners with a mental health history are seen by a mental health professional within 24 hours of reception.

Level of Acceptance: Supported in Principle

Responsible Division: Corrective Services

Responsible Directorate: Offender Services

Response:

Due to the demand on mental health professionals, all prisoners are assessed by primary health care nurses within 24 hours of reception to identify their health needs, including mental health, and make referrals to mental health specialists.

The senior health and mental health practitioners within the Department also have access to the Department of Health's Psychiatric Services Online Information Service (PSOLIS), which is the state-wide mental health services database that contains information on a person's mental health history. This information is also used as part of the assessment process.

The Department is seeking to improve the triage process for prisoners with known histories of self-harm and/or suicide ideation through an updated health and mental health model of care. As part of this work, consideration will be given to the practice of mental health staff conducting initial assessments within 24 hours of reception.

5 Include mental health assessments by a qualified mental health practitioner in applications to place prisoners on a confinement order.

Level of Acceptance: Supported in Principle

Responsible Division: Corrective Services

Responsible Directorate: Adult Male Prisons

Response:

It would be resource intensive and not feasible for mental health assessments to be conducted by qualified mental health practitioners as part of the application process for separate confinement.

COPP 10.7 Separate Confinement requires mental health assessments to be conducted at the earliest reasonable opportunity and at the latest within 72 hours following the prisoner's placement in separate confinement.

Section 5.1 Application Process of COPP 10.7 requires Superintendents to consider the impact separate confinement may have for prisoners with vulnerabilities (i.e., disability, mental health conditions), including those on the At-Risk Management System (ARMS) or Support and Monitoring System (SAMS), and those under medical observation. This is reflected in the application, including management strategies for managing their mental health needs as part of their regime.

The Department acknowledges this recommendation is a repeat of recommendation 5, made in the Review into the Use of Confinement and Management Regimes, tabled in Parliament on 22 November 2022.

6 Physically locate mental health staff in management units.

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Adult Male Prisons

Response:

Due to the demand on mental health resources and the challenges faced recruiting these resources, it is not practical for mental health staff to be permanently located in management units.

Custodial unit infrastructure does not provide the appropriate office and consulting space required by mental health staff. In addition, mental health staff are not trained custodial officers and would require an increased presence of custodial staff to ensure their safety and security while performing day-to-day duties.

Mental health staff make every effort to visit prisoners in management units daily to ensure their ongoing mental health needs are being met. PHS has a weekly booking to see prisoners referred from the management unit, creating care plans and informing custodial staff as to the specific needs of the individual, as well as an assessment of risk and any concerning factors to be aware of. Custodial staff can contact PHS (nursing, psychology and prison support services) at any time should there be a need to attend sooner.

Vacancies continue to be monitored and recruitment processes are ongoing, with a further ERC submission being made as part of the 2023/24 budget process for additional FTE.

7 Reconsider the Coroner's recommendation to review light fittings in cells.

Level of Acceptance: Supported – Current Practice / Project
Responsible Division: Corporate Services
Responsible Directorate: Procurement, Infrastructure and Contracts

Response:

The Department utilises vanguard correctional light fittings in all prison cells, which are ligature approved. These have previously been tested with a selection of tools and objects found within a compliant cell and against 'obvious ligature reduction' requirements. The Department has committed to a further review of light fittings as part of the ligature minimisation program.

While it is acknowledged that light fittings may become vulnerable when exposed to heat and fire sources, prisoners are not permitted to possess items which generate heat/fire (e.g., heaters, lighters, electrical items) unless the appropriate security checks and risk assessments have been conducted. The Department is also transitioning to smoke-free facilities where the possession of lighters will become prohibited.

The Department is ultimately reliant on security and searching controls in place to prevent light fittings from being manipulated or damaged by unauthorised items which compromises its ligature-approved status.

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8 Ensure a minimum standard of infrastructure and services is maintained at Broome Regional Prison until the new prison is built.

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

Response:

While Broome Regional Prison has significant infrastructure limitations due to the age of the facility, the Department is committed to undertaking critical and regular maintenance. For example, recent maintenance undertaken includes installation of a replacement kitchen roof and moisture barrier.

The prison has also strengthened its surveillance monitoring to enhance the safety and security of prisoners through the installation of additional CCTV cameras across the facility. Essential offender services will continue to be provided for the working life of the prison.

9 Remove ligature points in the minimum-security ablutions block at Broome Regional Prison.

Level of Acceptance: Not Supported
Responsible Division: Corporate Services
Responsible Directorate: Procurement, Infrastructure and Contracts

Response:

The Department has expanded its State-wide ligature minimisation program, retrofitting ligature proof fixtures in existing cells as far as possible across all facilities with the funding made available, and ensuring that cells as part of new builds meet the ligature-minimised standards.

The number of potential ligature points is an issue for all prisons in the custodial estate. The Department has a budget of \$1.5 million across three years, ending in the 2022/23 financial year, for its ligature minimisation program. Given the limited budget available, priority is given to facilities with the highest risk and need.

Whilst improvements to reduce ligature points in high-risk areas within Broome Regional Prison, including the maximum-security ablutions block have been made, the minimum-security ablutions block is not included in the current ligature minimisation program.

Furthermore, the Department utilises other controls to ensure the safety and wellbeing of prisoners such as continued monitoring through the ARMS and SAMS processes and referrals to PHS staff for additional support as required.

10 Deliver anti-social personality disorder training to custodial staff.

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

Response:

Prison officers are required to undertake mandatory annual training, including training on managing prisoners with various challenging and complex human conditions, specifically in relation to mental health and behavioural issues. The training includes:

- communication and de-escalation;
- trauma informed approaches;
- offender manipulation and deception (grooming);
- psychology of the offender;
- Mental Health First Aid; and
- Mental Health Commission (MHC) online modules.

Anti-social personality disorder (ASPD) requires a clinical diagnosis that recommends calm, receptive, and non-judgmental communication as best practice strategies for managing people with ASPD. These techniques are frequently used by prison officers for managing various common prisoner behaviours, as addressed in Module 3 (Communication) of the MHC online training.

Although there are no specific references to ASPD in the Mental Health First Aid or MHC online modules, these training programs address a comprehensive range of common mental health illnesses and disorders, including the strategies and techniques for effectively communicating and managing prisoners with challenging behaviours and personality traits which are common in those with ASPD.

Prisoners that are clinically diagnosed with ASPD are managed by prison officers in collaboration with mental health staff, who undertake risk assessments of prisoners to formulate a targeted support plan.

11 Re-engage with the Mental Health Commission in an effort to secure contextualised and ongoing Gatekeeper training for custodial staff.

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

Response:

As part of the Suicide Prevention Project, the Department is working in collaboration with the MHC to improve gatekeeper training, including the development of a program tailored specifically for delivery in a custodial setting. The feasibility of refresher training is also being considered as part of this process.

It should be noted however that the development and implementation of a revised gatekeeper program for the Department is dependent on support from the MHC.

In the interim, the Suicide Prevention Project has secured Suicide Prevention Training from Lifeline which is being rolled out across the Prison Estate for prison-based staff as well as peer support. A total of 280 people have received the training to date with

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further sessions to follow. Feedback on the training has been positive and well received. Online training is also being revised with the new updates anticipated to be rolled out in 2023.

12 Ensure all senior officers receive regular critical incident management training.

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

Response:

The Department notes the basis for this recommendation within the report relates to senior officers requiring the skills and training to respond to critical incidents at the tactical level, e.g., Forward Commander / Team Leader. This training is currently delivered by the Department's Special Operations Group where requested by individual facilities.

The Department will look at ways in which to promote the training and increase its uptake by senior officers across all facilities.

The Department will also consider the inclusion of this training in the Assistance Senior Officer Program.

13 Ensure AVS positions are filled across the prison estate.

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

Response:

The filling of Aboriginal Visitor Scheme positions across the prison estate will remain a priority for the Department. However, the challenges associated with attracting and retaining suitable staff continues to prevent the filling of vacancies. This issue is more prevalent in regional areas due to the lack of incentives for public sector positions, resulting in staff losses to other sectors.

Work on a revised service delivery model for AVS is expected to address the current staffing issues and improve conditions and outcomes for Aboriginal people in custody. This includes exploring the possibility of contracting Elders from the regions to undertake support work.

In the meantime, efforts to fill vacancies continue with a recruitment process underway to ensure AVS positions are filled across the prison estate.

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14 Ensure criminogenic programs that are delivered demonstrate efficacy.

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

Response:

In 2019, Corrective Services initiated an independent review of its criminogenic treatment programs across the adult prison and community corrections environments to ensure programs are contemporary and meet the needs of the prisoner/offender cohort.

The independent review was completed in October 2019 and indicated that criminogenic programs appeared to be having a positive impact. The review made several recommendations across a range of areas including data, evaluation, governance, staffing, mode of program delivery and identification of programs to address current gaps in service delivery.

Work on implementing these recommendations is in progress.