Department of Justice and Attorney-General
Queensland Corrective Services

OFFICE OF THE CHIEF INSPECTOR

Report into the incident at Cleveland Youth Detention Centre on 10 November 2016

Queensland Government

INTRODUCTION

On 10 November 2016 a series of incidents occurred at the Cleveland Youth Detention Centre ("the centre") in Townsville, culminating in riot which involved 20 young people gaining control of the facility and commissioning a violent, purposefully destructive and prolonged attack resulting in substantial property and infrastructure damage and significant staff physical and psychological injury.

The centre is situated in Townsville, North Queensland. It underwent significant redevelopment and expansion which was completed in January 2015 and has increased the centre's capacity to 96, including accommodation for up to 16 females. The centre is purpose-built and has an open-campus style environment, located on the outskirts of a residential suburb. This open-campus plan, along with the ergonomics and design of gardens, recreational areas, walkways, buildings, fixtures and fittings is intended to create a less harsh appearance and reduce stress and trauma-inducing aesthetics.

The Office of the Chief Inspector undertook a root cause investigation into the incident culminating in a number of recommendations designed to address the shortcomings identified during the investigation.

TERMS OF REFERENCE

- Identify and analyse relevant behaviour reports and intelligence/information concerning the young people involved in the incident
- Conduct a review of decisions made, strategies implemented and actions taken in relation to the relevant intelligence and information concerning the young people involved in the incident
- Conduct a review of the decision making process that resulted in the Queensland Police Service responding to the incident
- Review and analyse decisions and strategies implemented during the incident and their impact on the outcome.

FINDINGS

Finding 1

There are systems, processes and practices in place for the assessment of the risks and needs of each young person in detention. However, risks related to offending behaviour and institutional behaviour, including a young person's willingness to address their offending behaviour, are not sufficiently considered in determining their access to privileges and high risk activities.

Finding 2

There was information available at the time of the incident on 10 November 2016 to indicate that a number of the young people permitted to play on the football team posed an unacceptable and imminent risk of harm to others.

Finding 3
The high level of risk that some of the young people on the football team posed was not adequately identified or mitigated in the planning and preparation for the football game.

Finding 4
The Operational Plan was not detailed or specific enough to effectively communicate the level of risk posed by the activity (football game) or the young people involved. Further, it did not contain sufficient information to provide clear direction to staff about how to safely manage the event, and who had the authority to determine if the event should be cancelled if an incident occurred during the event.

Finding 5
When late changes were made to the arrangements for the football game, including identified young people no longer being permitted to play and provision for a post-game cool down session for the football team, the Operational Plan was not updated. This led to a weakening of the communication process and security framework for the football game, and jeopardised the safety and security within the centre.

Finding 6
Regardless of the contents of the Operational Plan, staff did not follow the plan. This led to a weakening of the communication process and security framework for the football game, and jeopardised the safety and security of the centre.

Finding 7
The decision to advise the young people not permitted to play in the football game just prior to the football game resulted in two high risk activities occurring at the same time, weakening the centre's capacity to safely respond to the incidents which subsequently occurred.

Finding 8
The decision to cancel the football game was appropriate given the assessed risks, operational requirements and staffing in the centre at the time.

Finding 9
The Youth Detention Procedure relating to roof top incidents, allows for the Centre Director, in consultation with other staff, to make the determination about whether QPS assistance is required. On 10 November 2016, when the roof top incident occurred, the determination was made that QPS were not required and that the situation could be resolved with the resources available. This was consistent with prior responses to roof top incidents which had been resolved without QPS intervention. Given the increasing levels of infrastructural damage being caused by the young people, the young people refusing to engage in negotiations, arming themselves with makeshift weapons and making threats of harm to staff along with insufficient numbers of staff to be able to safely restrain the large number of young people involved in the incident, QPS involvement at this time is likely to have supported a safer and more timely de-escalation and resolution of the roof top incident.

Finding 10

The Youth Detention Procedure relating to riots, allows for the Centre Director, in consultation with other staff, to make the determination about whether QPS assistance is required. On 10 November 2016, when the radio broadcast of the riot incident was initially called the young people involved in the incident were dispersed throughout the grounds of the centre, were unable to be contained, were armed with weapons and were actively using them against staff. Despite these risks being communicated to the Centre Director, the QPS was not contacted and the incident continued to be managed with the limited staffing resources available. QPS involvement at this time is likely to have supported a safer and timelier containment and resolution of the riot.

Finding 11

More comprehensive consideration of the information available about the individual and collective risks posed by the particular group of young people involved in the incident, may have better informed the decision-making process about the appropriateness of the earlier QPS attendance.

Finding 12

Determination to contact the QPS was made by the Centre Director following ongoing reports of incident escalation including injuries to staff and notification of staff retreating to the visits building. The timing of QPS notification resulted in significant delays in containing and resolving the riot.

Finding 13

There are weaknesses in the systems, practices and attitudes regarding the dynamic and static security requirements to maintain safety and security in the centre.

Finding 14

A lack of overall incident command and control severely impacted on the centre's capacity to contain the roof ascent incident and prevent it escalating further.

Finding 15

A lack of overall incident command and control significantly impacted on the centre's capacity to safely, quickly and effectively contain and resolve the riot.

Finding 16

Neither the riot or the roof ascent incidents were managed with full procedural compliance.

Finding 17

The procedures in place at the time of the incidents on 10 November 2016, did not provide staff controlling and responding to the incident with all of the relevant, sufficient information, guidance and direction required to safely and effectively contain and resolve the incidents.

Finding 18

While the need for Personal Protective Equipment (PPE) could well have become redundant if Queensland Police (QPS) Service were involved earlier in the incident, the fact that QPS were not involved earlier led to the utilisation of PPE. However, there was

insufficient PPE for all responding staff; not all responding staff who were issued with this PPE were trained in or familiar with this equipment and there was no clear operational or tactical direction given to staff regarding its use. This weakened the incident response, further jeopardising the safety and security of the centre, the young people in the incident and the responding staff.

Finding 19

There was procedural provision for staff to be issued with Personal Protective Equipment (PPE), including helmets, at the time of the incidents on 10 November 2016. Information about the escalating risks of harm to staff in both the roof ascent incident and the riot was relayed to the Centre Director and Deputy Director, however responding staff were not issued with this PPE. Staff sustained injuries in the incidents as a result of having no protective equipment for their heads and facial areas.

Finding 20

There were deficits in training and contingency testing that resulted in the staff responding to the incidents on 10 November 2016 not being adequately prepared and equipped to safely and effectively contain and resolve the incidents.

Finding 21

There were significant infrastructure and physical security weaknesses at the time of the incident on 10 November 2016 that severely impacted on the safety and security of the facility and that resulted in physical and psychological injury to staff.

RECOMMENDATIONS

Recommendation 1

A review of the Behaviour Development system, multidisciplinary panels and Incentives and Privileges process and practises is undertaken to ensure that identified risks and observed behaviour of young people is proportionate to the types, frequency and conditions of their recreational activities schedule and the incentives and privileges they receive are consistent and fair.

Recommendation 2

The creation of an operational risk assessment framework, cohesively developed in line with the agency and centre's own strategic plan, that outlines potential risks, hazards and threats from all operational areas and outlines key mitigation strategies and persons responsible, and includes an annual review process.

Recommendation 3

The centre reviews its current operational planning process and documents and makes amendments that reflect a more thorough analysis of risk, more robust mitigation strategies, a sole point of contact and overall person/position in charge of the event and clear direction regarding the delivery and oversight of the event, including accountability for the plan being followed and applied; and post-event reflections and debriefing.

Recommendation 4

The development of a formal, structured and empirically-based Incident command and control model that is founded on a prescribed incident command post and an appointed incident commander position. While the incident controller, sometimes referred to as field or forward commander in other agencies, maintains command and control at the 'coalface' of the incident, the Incident Commander maintains overall responsibility for the management and operation of the whole facility. This would incorporate:

- A review of current procedures in regards to incident management and emergency procedures to ensure there is clarity, consistency and the incorporation of a more structured and formal incident command post.
- This procedural review should also include an analysis and evaluation of the types and amount of Personal Protective Equipment (PPE) available to staff during critical incidents, where the delegation sits for the approval of use and threshold for issue and use are.
- This procedural review should also include an examination of, and amendment to, the factors for consideration and threshold for contacting relevant emergency services in the event of a critical incident at the centre. For example, young people on a roof poses a threat that may, at a minimum require the Queensland Ambulance Service to be put on stand-by. When young people arm themselves with weapons and/or are in a large group that make it procedurally impossible for staff/young people ratios for restraint and containment to be achieved, Queensland Police Service intervention is required.
- A comprehensive training and development framework for Shift Supervisors, Unit Managers, other operational and non-operational managers and Senior Managers at the centre to develop knowledge of and skills in situational awareness, incident command and control, and risks assessment and decision-making.
- The development of an annual contingency testing schedule, in line with procedural requirements , that allows for all staff to be regularly exposed to desktop testing, live, practical testing as well as multiagency live tests that involve relevant partnering organisations such as Education Queensland, Queensland Health, Queensland Ambulance, Queensland Fire and Rescue Service and Queensland Police Service.
- A review of current and planned staff training to ensure that all training that is developed and delivered incorporates effective integration of dynamic and static security approaches and allows for the consideration of strategies to balance thinking and approaches to critical issues such as the categorisation, issue and use of Personal Protective Equipment (PPE). Specifically, while in some instances PPE may be perceived as intimidating and re-traumatising for young people, in other instances it is required for the protection and safety of staff to resolve and contain a dangerous situation where there are high risks of harm and physical injury . Further, procedural and legislative changes in regards to the separation of young people may be warranted so that electronic and statistical data regarding separation is not skewed and staff do not feel pressured to jeopardise the safety and security of the centre in order to minimise justified instances of separation to withstand public scrutiny and misperception.

Recommendation 5.

A review of current and planned staff training to ensure that all training that is developed and delivered incorporates effective integration of dynamic and static security approaches and allows for the consideration of strategies to balance thinking and approaches to critical issues such as the categorisation, issue and use of Personal Protective Equipment (PPE). Specifically, while in some instances PPE may be perceived as intimidating and re-traumatising for young people, in other instances it is required for the protection and safety of staff to resolve and contain a dangerous situation where there are high risks of harm and physical injury . Further, procedural and legislative changes in regards to the separation of young people may be warranted so that electronic and statistical data regarding separation is not skewed and staff do not feel pressured to jeopardise the safety and security of the centre in order to minimise justified instances of separation to withstand public scrutiny and misperception.

Recommendation 6

A comprehensive, whole of centre safety and security review of infrastructure, fittings and fixtures to evaluate and rectify potential risks and hazards as well as any current damage. For example, it should focus on areas such as anti-climbing structures, impenetrable ceilings and roofs, appropriate window specifications, zoning and fencing of high risk locations within the facility and to assist the containment of an incident to a specific location. This should be conducted by appropriately qualified and experienced professionals who specialise in the design, construction, and maintenance of secure facilities.

Recommendation 7

A review of workplace culture should be conducted with comprehensive workplace wellness and workforce development plans created and implemented. Further, consideration should be given to the introduction of a reflective practice style of leadership and management that fosters an openness to feedback, the willingness and ability to critically self-evaluate individual and team performance, with methods such as in-depth analysis and tactical strategizing post-incident for critical and major incidents.

CONCLUSION

On 10 November 2016, at the centre, there were a series of incidents that culminated into a major disturbance and riot that lasted more than twelve hours. Specifically, it involved a violent demonstration in an accommodation unit, followed immediately by a large group of young people absconding from the oval and running throughout the centre, which led to a roof top incident that lasted over two hours and escalated to a riot that required a large police contingent to contain and resolve.

It resulted in significant infrastructure damage and physical destruction of fixtures and fittings throughout the facility. But most notably it caused physical injuries to staff and a psychological impact that is still being felt. Given this, above all else, there needs to be substantial, immediate attention paid to the provision of basic emotional first aid, as well as longer term wellbeing support, to the staff who deliver such essential services because if they are not functioning at their optimum, best practice standards in the management and supervision of young people in detention cannot be achieved.

The rapport and interpersonal connections between youth detention staff and young people is the foundation of youth justice services. As such, the primary focus of the work done by the staff at Cleveland Youth Detention Centre is to foster meaningful, mentoring relationships with the young people they are entrusted to supervise and care for. Not only is the wellbeing and development of young people dependent on these relationships, but they are the one of the most fundamental elements in maintaining the safety and security of the centre. Despite these critical dynamic security and humanistic factors, there will inevitably be times in youth detention, given the young person profile, the risks associated with their offending behaviour and the inherent dangers with volatile, impulsive and traumatised adolescents; when robust physical and procedural security is paramount to protect the safety and wellbeing of all young people and staff. Given the universal humanitarian requirements to maintain a safe environment for young people in detention and not unnecessarily expose them to situations and incidents which traumatise or re-traumatise them, this further reinforces the absolute obligation for maintaining procedures, practices and staff training and competence focused on operational security. The key to effective service delivery and positive outcomes for young people, then lies in achieving and maintaining the delicate balance between the competing duality of welfare and rehabilitation needs with safety and security risks.