OFFICE OF THE CHIEF INSPECTOR

Chief Inspector Investigation Report, 2017

A Report of an Investigation into the circumstances surrounding a Major Disturbance / Riot at the Arthur Gorrie Correctional Centre on 18 August 2016.

Queensland Government

REPORT

Investigation into the circumstances surrounding a Major Disturbance / Riot at the Arthur Gorrie Correctional Centre on 18 August 2016.

For: Queensland Corrective Services

Inspection Team

[redacted] **External Inspector, Barrister-at-Law**

[redacted] **Office of the Chief Inspector**

[redacted] **Office of the Chief Inspector**

Period of Investigation

30 August 2016 to 31 December 2016

STATEMENT OF PURPOSE

The purpose of this document is to report on the outcomes of the Inspectors' investigation into the circumstances surrounding a Major Disturbance / Riot at Arthur Gorrie Correctional Centre on 18 August 2016.

The investigation and Report have been conducted and prepared in accordance with the 'Instrument of Appointment of Inspectors and Terms of Reference' dated 31 August 2016 (***Attachment 1***) and 'Updated Instrument of Appointment of Inspectors and Terms of Reference' dated 18 November 2016 (***Attachment 2***).

As indicated in the Terms of Reference, the Chief Inspector, Queensland Corrective Services (QCS) appointed the inspectors pursuant to section 294 of the *Corrective Services Act* 2006 (Qld).

EXECUTIVE SUMMARY

On Thursday 18 August 2016, prisoners in Secure Accommodation Unit B3 (B3) of the Arthur Gorrie Correctional Centre (AGCC) participated in a violent demonstration against Corrective Services Officers (CSOs).

At approximately 3.00pm on Thursday 18 August 2016, a Correctional Supervisor (CS) interviewed Prisoner [redacted] in the interview room in B3 in relation to an alleged sexual assault against another prisoner. Prisoner [redacted] denied the allegation and allegedly became aggressive and non-compliant towards the CS and other CSOs when he was advised he would be re-locating to the Detention Unit (DU). Reportedly, Prisoner [redacted] attempted to assault CSOs but was unsuccessful and force was used to gain compliance of Prisoner [redacted], who was restrained and escorted to the health centre within AGCC for assessment/treatment.

Resultantly, at approximately 3.06pm, remaining prisoners in the common area in B3 became aggressive towards staff when some prisoners had observed and perceived an incident occurring in the interview room between Prisoner [redacted] and officers.

CSOs observed prisoners [redacted] and [redacted] kick the unit common area airlock door from inside the unit[1] and attempt to incite other prisoners. Consequently, a Code Yellow was called for assistance.

At approximately 3.14pm, prisoners smeared a substance over the B3 Officers Station windows and covered them with paper. This minimised the effectiveness of the CCTV camera inside the Officers' Station, which was the only camera in the unit[2]. At approximately 3.21pm, prisoners were further observed spreading a substance on the unit floor in B3 common area in order to make the floor slippery and prisoners barricaded the B3 entry door using the unit's fridge and table tennis table. At approximately 3.25pm, prisoners were seen to start a fire in the kitchen area in B3 and a Code Red was called. At approximately 3.28pm a prisoner attempted to spread the fire towards the B3 Officer Station. At this time, a Code Black was called. Secure Accommodation Unit B4 (opposite to B3) was locked-down and CSOs then commenced a centre-wide lock-down of AGCC.

At approximately 3.29pm, a Correctional Emergency Response Team (CERT) and a Dog Handler with a general purpose (GP) dog readied for entry into the B3 common area. All prisoners in the unit were directed to move into the exercise yard and warned that force and a chemical agent would be used if prisoners failed to comply. Prisoners complied and were secured in the exercise yard and the small fire was immediately extinguished. At this point in time, all prisoners had been secured in the exercise yard and essentially, control had been regained over unit B3.

[1] According to the Flash Brief circulated by QCS on 19 August 2016 the prisoners were attempting to kick in the unit interview room door. However AGCC management have since advised differently. The discrepancy appears immaterial to the overall incident.

[2] According to the Flash Brief circulated by QCS on 19 August 2016 the prisoners "*were observed to place paper over CCTV cameras*". However AGCC management have since advised differently and footage of the incident appears to confirm AGCC management advice. The discrepancy appears immaterial to the overall incident.

In preparation for officers to enter the exercise yard and to restrain and extract prisoners, all prisoners were directed to lie on the ground. All prisoners complied with this direction. At approximately 3.36pm, CSOs entered Secure Unit B3 and took control of the unit. During this process chemical agents and other use of force options were utilised.

Prisoners [redacted], [redacted], [redacted] and [redacted], who had been identified as the primary agitators during the Code Black, were restrained and escorted to the medical centre for assessment/treatment for various injuries the prisoners had received as a result of force used during the extraction process.

All the remaining prisoners in the B3 exercise yard were escorted and secured in their cells one at a time without further incident. Medical centre staff assessed all prisoners for injuries and any effects from the chemical agents where relevant.

B3 remained locked down for the day. No injuries were reported by CSOs involved in this incident and the incident was referred to the Corrective Services Investigation Unit (CSIU). Additionally, GEO Group Australia Pty Ltd undertook an internal review of this incident.

As a result of the investigation undertaken by the Inspectors, a number of key findings were identified and are evaluated at pages **53** and **54** of this Report. In specific terms, Inspectors list the key failure points in relation to the incident. In addition, recommendations for improvement are made at pages **54** and **55**.

Concerning '*Injuries inflicted – Specify'* the entry states 'No'. However, in the body of the IR, injuries to various prisoners are noted. Centre management advise that the Injuries tab in IOMS was updated to "Yes" during the week after the incident as a result of an internal compliance review of the incident. However the tab currently appears to be inactive.

Prisoner [redacted] is not mentioned despite being affected by C/S gas. Centre management have advised that he "*was not identified to the author at the time the incident report was compiled*". Nevertheless the fact remains that his omission was an error.

Regarding 'Behavioural Factors', that is why force was used against a person (not staff), the IR states 'Violent behaviour'. Inspectors note:

1. Violent behaviour perpetrated by various prisoners occurred prior to the 'use of force' exerted by staff on prisoners.
2. The use of force occurred after CERT entered the exercise yard and at a time video confirms all prisoners were complying with directions.
3. C/S gas was deployed, at times, without any lawful basis (see previously above concerning CSO [redacted]).
4. Inspectors find that some officers applied excessive force on prisoners not because the prisoner was noncompliant or failing to follow instructions, but punitively and what appeared to be in retribution for being involved in or causing the riot in the first place. The later reasons do not comply with section 143 of the *Corrective Services Act* 2006.
5. Once a prisoner becomes compliant, use of force is no longer justified irrespective of what the prisoner may have done earlier. The prisoners' earlier actions in that regard (such as causing or partaking in a riot, damaging property etc.) are then subjected to robust investigation. Wrong-doing is later dealt with either by the Courts or internally via breach actions.
6. Inspectors find that some elements within AGCC have a poor understanding of the legislation, policy and procedure surrounding 'use of force' and AGCC must do more to minimise the occurrences of officers injuring prisoners under the guise of prisoner noncompliance. In particular, this incident is not an isolated occurrence of officers not complying with section 143 of the *Corrective Services Act* 2006 and Inspectors being told that the prisoner 'resisted' or was 'noncompliant' warranting use of force which is later unsupported when reviewing CCTV.

Inspectors interviewed General Manager [redacted] who gave an account of AGCC's post-incident actions in response to this and previous incidents:

1. CSO [redacted] was suspended. At the time of completing this report, Inspectors are aware that [redacted] employment was terminated.

2. AGCC has implemented a 'Use of Force' Review Committee (see ***Attachment 8*** – AGCC Operating Procedure – Incident review Committee.). Inspectors note that a requirement to review any Use of Force pre-existed this initiative; however, AGCC erroneously did not review incidents it believed were likely to be investigated by either internal or external agencies. Consequently, not all use of force incidents were reviewed and those that were investigated by external agencies often took a considerable period of time to report. Inspectors commend AGCC's initiative to undertake Incident reviews as proposed; however, what AGCC is now proposing was a pre-existing requirement that the centre had previously failed to comply with.
3. The proposed reporting structure for AGCC Incident Review Committee appears to be robust (see ***Attachment 9***) and the proposed time frames for reporting appear to be timely and apposite (see ***Attachment 10***).
4. Additionally, AGCC had recently employed Mr [redacted] (formerly from QCS) as a new appointment as the 'Training / HR Manager for AGCC to coordinate compliance training and develop and deliver enhanced training programs for AGCC personnel.
5. AGCC changed its procedure governing the completion of Form 302. Only a Supervisor / Manager not involved in the incident will now complete the form and to ascertain whether or not the prisoner wished to make a complaint.
6. Regarding Wolfcams, AGCC was increasing data storage capacity to better record and archive video footage from the cameras and to incorporate Wolfcam retention into AGCC's CCTV retention procedures.
7. AGCC will also examine options to assist in identifying individual CERT Officers through an appropriate identifier system and will review any recommendations with GEO.

(c) Any other matter(s) you consider to be relevant to the events, and/or which you believe may have contributed to the occurrence of this incident, including any recommendations for remedial action.

A number of factors contributed to the 'negative outcomes' for this incident. Inspectors make the following broad observations (the below order does not denote any level of significance):

Wolfcams

1. Wolfcams were introduced into AGCC (and in other centres) for the purpose, *inter alia*, for recording incidents and occasions where video and audio would benefit the post-incident review process and to increase transparency and accountability for both officers and prisoners.
    (a) Officers informed Inspectors that they received limited training on the Wolfcam, which focused on: how to sign the camera out; placement of the camera on their apparel; how to switch it on and off; how to change the settings from video and audio to audio only; and where and how to download any recordings at the conclusion of their shift.

(b) AGCC did not implement 'local policy or procedure' around the use of the Wolfcams and did not provide specific instructions to officers regarding 'activation', other than to activate the camera for an Incident or Code.

(c) When the Wolfcams were activated, Officers carrying the cameras could be heard informing officers as they approached, '*Camera on, camera on'*. If officers act appropriately at all times, such a warning is simply not required. The question therefore is: what would the officers do in the event they believe they are not being filmed? Inspectors ask this confronting question given that CSO [redacted] applied C/S gas to a restrained prisoner at a time he knew the incident was being filmed by multiple cameras from multiple locations. The presence of cameras did not stop this brazen act.

(d) Inspectors recommend AGCC implement a robust Policy and Procedure surrounding the Wolfcam devices with clear guidance as to when the cameras ought to be proactively switched on and not to wait for an incident or a code. Furthermore, officers equipped with Wolfcams ought to understand that filming 'use of force' situations is a priority and to keep the cameras focussed, where practicable, where force is being applied to a prisoner.

Incident Command and Control

2. Although DGM [redacted] appropriately performed the role of Incident Commander and maintained a line of communications with his appointed Field/Forward Commander CM [redacted], the command and control of this incident collapsed and became ineffective within the B3 area of operations.

   (a) Despite the presence of numerous Supervisors and CERT Team Leaders, no one took effective command and control of the officers within B3 to provide clear instruction, strategies and tactics.

   (b) Inspectors acknowledge that prisoners rioting and commencing multiple fires within the unit created an urgent situation that warranted a quick response. However, once all the prisoners had been effectively secured in the exercise yard and the fires extinguished, the same level of urgency was no longer a determinative factor.

   (c) Effective leadership, command and control ought to have slowed the response at that time so as to re-assess the situation; develop an appropriate response plan; assign tasks, and give clear instructions to all staff to ensure everyone understood the identified risks and everyone knew what was to occur and what their individual role was in that response. This did not occur.

   (d) Consequently, officers continued to operate in a state of mistaken urgency resulting in tactically unsound and unsafe actions and underutilising the appropriate resources that were present (such as shield officers and dog squad).

   (e) Inspectors acknowledge that DGM [redacted], as the Incident Commander, gave precise and appropriate instructions for the safe deployment of resources, but these instructions were not relayed to the officers who ultimately entered the exercise yard in what can only be described as a haphazard and uncoordinated manner, which increased the risk of injuries to officers and prisoners alike.

(f) The unruly incident response that followed resulted in CERT Officers in full PPE attempting to talk to and restrain prisoners, whilst other officers without PPE, and who were intermingling, delivered baton strikes to any prisoner they believed were noncompliant.[44] Prisoners (known not to be the ring leaders of the riot and who had taken a passive role) were struck with batons for lifting their heads to look in the direction of officers struggling with prisoners. The force used in this regard was not proportionate or reasonable to the prisoner's level of noncompliance.

(g) There was no coordination between the CERT Officers and the other custodial staff assisting.

(h) Inspectors find that at times the level of force applied to prisoners was excessive and unwarranted. As to CSO [redacted], the deployment of C/S gas (as outlined previously in this report) was likely to be unlawful.

(i) Concerningly, despite the presence of numerous cameras and numerous Supervisors, officers were not appropriately managed in this incident that led to unnecessary and unwarranted injuries to some prisoners.

(j) Inspectors recommend AGCC develop and implement further training for Supervisors and Managers on Incident Command and Control and incident response.

Training and Training Compliance Oversight

3. Inadequate training of CERT Officers and CERT Team Leaders and inadequate oversight for training compliance. As an example:

   (a) CSO [redacted] received limited CERT training (2-day course at the QCS Academy) and despite this CERT Training course being the first time he had anything to do with CERT, he was made a Team Leader.[45]

   (b) CSO [redacted] did not receive any additional training for his role as Team Leader and had not received any training on incident command and control.

   (c) Inspectors recommend greater training of CERT Officers and CERT Team Leaders and greater oversight for training compliance.

CSO [redacted] stated to Inspectors that he had undertaken Control and Restraint training in 2013 and January 2016. As of 1 July 2017 this training is mandatory and must be undertaken every 12 months.

Officer Reports

[44] Video recording captured CSO [redacted], armed with a baton, moving forward and striking the legs of a prisoner that was clearly restrained by CERT Officers. The concern being, that CSO [redacted] might not know what instructions the CERT Officers had just given the prisoner which can then be compromised by an unexpected and unauthorised baton strike. The Prisoner reacting to the pain from the baton strike moves in response (voluntary or involuntary movement) which the CERT Officers interpret as noncompliance which is then followed by more force being applied by the CERT Officers. The need for a coordinated approach is critical to avoid misunderstandings and to avoid any contradicting instructions to prisoners or personnel.

[45] CSO [redacted] interview with Inspectors.

4. The initial Officer Reports from staff involved in this incident were inadequate and lacked necessary detail.

   (a) Inspectors became aware that most (if not all) the officers involved in this incident had been instructed by the centre to re-write their Officer Reports under instruction and/or supervision (for some officers). Some officers submitted three versions of their Officer Reports.

   (b) Inspectors were further informed that DJAG Ethical Standards had asked the centre (via DGM [redacted]) for officers to 'resubmit' reports as the reports originally furnished contained insufficient detail in relation to what the officers had observed and witnessed whilst involved in the containment of the incident; e.g. some officers simply stated, "*Attended unit and escorted prisoners back to their cells, this completed my involvement*" and this was clearly deficient in detail.[46]

   (c) Inspectors find that the quality of the initial Officer Reports indicates a lack of training and awareness for staff as to what these reports require and to what level of specificity it ought to be completed.

   (d) Mostly, officers recorded prisoner 'non-compliance' without specifically stating what the prisoner actually did that was non-compliant behaviour, and officers did not seem to understand the importance of accurate details, especially where a use of force resulted.

   (e) Inspectors recommend that AGCC ensure that Officer Reports contain full detail of their knowledge, observations and participation in an incident, including the actions of themselves, colleagues and prisoners. If the officer used force, he or she must detail the justification for doing so, the specific techniques used and the result.

Post-Incident Medical Reviews / Assessments

5. Wolfcam video footage[47], post-incident nurse / medical assessment of prisoners in their cells:

   (a) This footage shows the nurse being taken to each cell with several CSOs. The prisoner is told to sit with his hands behind his head, two officers enter the cell and place a hand on each shoulder of the prisoner, and the nurse asks if he has any injuries he would like her to look at or if he is hurt at all.

   (b) The difficulty with this process is that at no time does the nurse see the prisoner's face; she walks in behind the prisoner only seeing his back and the back of his head while the officers stand either side.

[46] On 29 August 2016, the DJAG Ethical Standards Unit wrote to DGM [redacted] asking for revised officer reports because the reports attached to the incident were inadequate and did not provide sufficient detail. It was recommended that each officer involved should be advised that they must provide a report with full detail of their knowledge, observations and participation in the incident. This includes the actions of themselves, colleagues and prisoners. If the officer used force, they must detail the justification for using force, the specific techniques used and the result.

[47] CSO [redacted] in B3.

(c) A prisoner could have facial injuries, but unless the prisoner speaks up, being mindful that a CSO standing nearby may have been also involved in the use of force, the nurse may not become aware of any injuries.

(d) Unless there are clear operational or safety requirements, the post-incident medical review ought to include nursing staff looking at the face / front of the prisoner.[48]

The Inspectors' findings are outlined further below.

[48] Cell extractions and / or restraint and control of a prisoner who was lying on his stomach with his hands behind his back means that if force is used from behind, which is often the case, it is the front of the prisoner that is likely to receive injuries from being pressed or hit into the ground.

FINDINGS

In this section, the investigation makes findings and links these to potential root causes whilst providing an analysis of the information to assist QCS in considering mitigation strategies. Additional comment is provided which qualifies and/or further defines the finding/s.

In relation to the Terms of Reference, the Inspectors hold the view that there is sufficient evidence, on the balance of probabilities, to substantiate the following findings (in an approximate order as identified chronologically in the report above).

Finding 1

Notwithstanding the exigencies of the situation and the fact that the incident was subsequently recorded in Incident Report 188126, given the violent nature of the interaction between officers and prisoner [redacted] in the interview room of unit B3, involving the use of force and injuries to the prisoner requiring medical attention, that violent interaction could and should have been recorded in the B3 Daily Activity Log Book.

Finding 2

The knee to the head of Prisoner [redacted], delivered by CSO [redacted] was unnecessary and therefore excessive in the circumstances. In the event C/S gas was used on Prisoner [redacted] by CSO [redacted], that use of force was also unnecessary and therefore excessive and unreasonable in the circumstances. It is noted that CSO [redacted] is no longer employed at AGCC as a result of this incident.

Finding 3

CSO [redacted] use of force by spraying Prisoner [redacted] with C/S gas whilst Prisoner [redacted] was restrained failed to comply with the requirements of section 143 of the *Corrective Services Act* 2006 (Qld). As noted, CSO [redacted] is no longer employed at AGCC as a result of this incident.

Finding 4

Medical staff failed to accurately record what the prisoner/s had actually stated as to how their injuries were received. Medical notes must accurately reflect what the prisoner actually says (irrespective of the known truth or otherwise) to ensure transparency and accountability.

Finding 5

Command and control of this incident failed and became ineffective within the B3 area of operations. Despite the presence of the Field/Forward Commander, numerous Supervisors and a number of qualified CERT Team Leaders, there was no effective command and control of the officers within B3 to provide clear instruction, strategies and tactics.

Finding 6

Response officers operated in a state of mistaken urgency when breaching the exercise yard resulting in tactically unsound and unsafe actions and officers underutilising the appropriate resources that were present (such as shield officers and dog squad).

Finding 7

There was no coordination between CERT Officers and the other custodial staff assisting.

Finding 8

Some officers applied excessive force on prisoners, not because the prisoner was noncompliant or failing to follow instructions, but punitively and for what appeared to be in retribution for being involved in or causing the riot in the first place. The later reasons do not comply with section 143 of the *Corrective Services Act* 2006 (Qld).

Finding 9

AGCC did not implement 'local policy or procedure' around the use of the Wolfcams and did not provide specific instructions to officers regarding 'activation', other than to activate the camera for an Incident or Code.

Finding 10

AGCC's training of CERT Officers and CERT Team Leaders was inadequate. AGCC's oversight of officer training compliance was inadequate. Inspectors acknowledge that Mr [redacted] has since been appointed as the Training and HR Manager for AGCC to assist in training compliance monitoring and oversight and for the review of training courses including CERT.

Finding 11

The quality of the Officer Reports initially submitted for this incident were inadequate and deficient and is indicative of a lack of officer training and awareness as to what these Reports require and to what level of specificity they ought to be completed.

Finding 12

Post-incident medical assessment of prisoners in their cells was inadequate to identify all prisoner injuries.

RECOMMENDATIONS

The following recommendations arose or arise from the investigation of this matter. It is acknowledged that some may have already been implemented or are in the process of being implemented.

1. As a prisoner may be reluctant to state that he received injuries from an officer or officers when the officer completing the form is the officer (or one of several officers) involved in the

said incident, so as to avoid any perception or inference of duress or coercion, a Form 302 not be completed by any officer directly or indirectly involved in the use of force on the prisoner.

(It is acknowledged that AGCC implemented a change concerning Form 302s post-incident and the forms are now completed only by Supervisors or Managers not involved in the incident.)

2. CERT apparel be modified to include an identifier such as a number or letter or combination of the two.

3. When an officer kits up into the CERT gear, the individual officer signs out a specific identifier.

4. As AGCC's computer monitors lacked the required level of definition to enable the identification of certain aspects of this incident, AGCC acquire a 'high definition' monitor to ensure that this type of detail would not be missed in the future if a similar incident were to occur.

5. Medical staff at AGCC be required or reminded to accurately record what prisoners state as to how their injuries occurred, particularly where use of force by officers is alleged.

6. AGCC implement a robust Policy and Procedure surrounding the Wolfcam devices with clear guidance as to when they ought to be proactively switched on and not wait for an incident or a code.

7. Officers equipped with Wolfcams be instructed that filming 'use of force' situations is a priority and to keep the cameras focussed, where practicable, on the prisoner and the officer/s when force is being applied to a prisoner.

8. AGCC develop and implement further training for Supervisors and Managers on Incident Command and Control and incident response.

9. AGCC develop and implement further training of CERT Officers and CERT Team Leaders and ensure adequate oversight for training compliance.

10. AGCC ensure that Officer Reports and entries on IOMS contain full detail of officers' knowledge, observations and participation in the incident in question, including the actions of themselves, colleagues and prisoners. If the officer used force, he or she must detail the justification for doing so, the specific techniques used and the result.

11. In the absence of clear operational or safety requirements, any post-incident medical review include nursing staff looking at the face / front of the prisoner.