Department of Justice and Attorney-General
Queensland Corrective Services

OFFICE OF THE CHIEF INSPECTOR

Chief Inspector Report, 2015

Investigation into the circumstances surrounding the rooftop incident at the Maryborough Correctional Centre on 12 October 2014

Queensland Government

CCC EXHIBIT

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CCC EXHIBIT

1. STATEMENT OF PURPOSE

1.1 The purpose of this document is to report on the outcomes of the Inspectors' investigation into the rooftop incident ('the incident') at the Maryborough Correctional Centre ('MCC') on 12 October 2014 involving prisoners [redacted] ([redacted])[1]; [redacted] ([redacted])[2]; [redacted] ([redacted])[3] and [redacted] ([redacted])[4]. The investigation and report is conducted in accordance with the 'Instrument of Appoint of Inspectors and Terms of Reference' of 28 October 2014 (**Attachment 1**).

1.2 The Chief Inspector, Queensland Corrective Services ('QCS'), appointed Internal Inspector [redacted] and External Inspector [redacted] to conduct an investigation into the incident pursuant to section 294 of the *Corrective Services Act* 2006 ('the Act').

1.3 In investigating the incident, the investigators have reviewed voluminous documentation and interviewed relevant staff.[5] Despite attempts by the Queensland Police Service ('QPS') Corrective Services Investigation Unit ('CSIU'), the prisoners refused to be interviewed.

2. EXECUTIVE SUMMARY

2.1 The four prisoners had been playing tennis. They scaled the wired mesh and climbed onto the walkway roof and made their way to the Secure Unit 6 roof via the exercise mesh yard fence to stage a rooftop protest.

2.2 Whilst the prisoners raised general health care and drug program issues, there was no common specific key issue identified. Each prisoner appeared to have his own agenda.

2.3 Whilst a possible trigger for the demonstration may have been the death of a recently released prisoner, [redacted], and the denial of transfer requests for prisoner's [redacted] and [redacted], there was no intelligence information or other relevant information that would have alerted correctional officers that the prisoners planned to undertake a rooftop protest.

2.4 The prisoners had been appropriately placed at MCC. Any requests for transfers by the prisoners were not purposively obstructed but were denied due to a major ongoing investigation occurring at the prison.

2.5 Once the prisoners made their way on to the Secure Unit 6 roof, the incident in general was managed in a timely manner. The centre security was not

[1] Date of birth [redacted], identifies as [redacted]
[2] Date of birth [redacted], identifies as [redacted]
[3] Date of birth [redacted], identifies as [redacted]
[4] Date of birth [redacted], identifies as [redacted]
[5] Whilst the interviews were recorded, a transcript was not produced.

compromised. The centre was quickly locked down and whilst residential visits proceeded, contingencies were implemented to manage the risk associated with the visits.

2.6 There was some confusion concerning the initial management of the incident, which appears to be related to the misconception surrounding the interplay between the QCS incident management system ('IMS') and the Maryborough CERT model response.

2.7 QPS negotiators were deployed to the prison. At times there were difficulties in co-ordinating information between the QPS and the QCS in managing the incident.

2.8 As the demonstration progressed into the evening, the prisoners attempted to break into the roof space, which housed a number of essential services. The use of a chemical agent was appropriately dispensed to mitigate the risk of the prisoners gaining access to the roof space.

2.9 During the demonstration, other prisoners broke windows in order to pass water to the roof top prisoners. On one occasion the roof top prisoners smashed a window and were provided, water, milk, blankets, coats and tracksuits.

2.10 A fire hose was deployed in the early hours of the morning in an attempt to contain the prisoners to one area of the roof, or in an attempt to make the environment uncomfortable for prisoners.

2.11 The incident occurred over three shifts and involved up to approximately 35 officers. It was a level 1 incident involving four prisoners and the use of force. The officer reports uploaded onto IMOS were inadequate.

2.12 As the infrastructure at MCC currently stands, it provides other multiple points that enable a prisoner to access a rooftop.

3. INVESTIGATION OUTCOMES

a) ***How, when and where the incident occurred, the circumstances surrounding their occurrence, including the involvement of any other prisoner(s) in the incident.***

3.2 The incident occurred on Sunday 12 October 2014. Prisoners [redacted], [redacted], [redacted] and [redacted] were housed in [redacted]. They had requested to play tennis and were escorted to the tennis court, which is located in the prison grounds between Secure Unit 1 and Secure Unit 6. As was usual protocol, they were left unattended.

3.3 At approximately 1.15pm, during the course of the tennis game, the Central Movement Control Operator observed the prisoners climb onto the Secure Unit 1 walkway roof. The prisoners proceeded along the Secure Unit 1 walkway roof onto the Detention Unit walkway roof and then jumped off the roof and proceeded to run across the grounds to the S7 exercise yard. There they climbed up the fence of the exercise yard onto the roof.[6] The route the prisoners took from the tennis court to the roof is depicted on a diagram of the prison grounds **(Attachment 2)**.

3.4 A Code Yellow and Code Silver were called as soon as Central Movement Control identified the prisoners attempting to climb onto Secure Unit 1.[7] Master Control received two Code Yellows and a Code Silver in relation to the incident. All codes were called and officers responded accordingly.[8]

3.5 The prisoners remained on the rooftop until approximately 8.10am the following morning. Over the course of their rooftop demonstration, the prisoners made a number of demands to different persons. A brief summary of the demands made generally by the prisoners, and the demands made by specific prisoners is outlined below:

- The prisoners wanted a drug opiate treatment program and referred to the death of an ex-prisoner [redacted] who had recently died from a drug overdose on the 'outside';
- Bleach for syringes on the wall like in New South Wales;
- Photos at Christmas;
- Wanted to speak with [redacted];
- Wanted a media camera;
- [redacted] said he was yellow and wanted to go home to Brisbane – he reported the medical unit would not take him to hospital;
- [redacted] identified the issues as food, smokes, no medical treatment, no subby program – he requested QCS contact Qld Health and make the opiate

[6] Incident Report - [redacted]
[7] Report of CCO [redacted] 12 October 2014
[8] Report of CCO [redacted] 12 October 2014

program the same as it is in North Queensland, Brisbane Women's and New South Wales;

- [redacted] and [redacted] identified the issues as food, smokes, transfer to Gold Coast to see legals face to face as he was a full remand prisoner and should not be at MCC – [redacted] wanted to go to R&R for drug program and to see legal face to face – he said he had put in several transfer forms;
- [redacted] specifically said he wanted to go to Brisbane as he had not seen his three year old for over a year; and
- [redacted] requested an urgent opiate treatment program - he advised he had been a drug addict since he was a kid and Hep C positive since 17. He wanted a subby-tex program to control his drug use. He noted Brisbane Women's, Townsville and Cairns had access to such a program.

3.6 Following the incident Prisoner [redacted] met with Official Visitor [redacted] on 29 October 2014 at BCC. He advised her of the reasons why the prisoners went on to the roof. In [redacted] Official Visitor Report, she states:

"Prisoner [redacted] says the reasons for going onto the roof at Maryborough CC were to highlight complaints he has about all Qld Correctional Centres. He says his complaints are:

1. *A lack of/delay in prisoners being given medical attention to stabilise addictions;*
2. *A lack of clean needles in custody meaning prisoners are contracting Hepatitis C; and*
3. *Overcrowding in Correctional Centres.*

Prisoner [redacted] says he wants to raise these as complaints with an OV to have his voice heard. He says he has raised the issue previously in a blue letter and also with the Ombudsman.

3.7 According to Incident Report [redacted], there were 35 correctional officers involved over the course of the incident. It has been difficult to piece together the exact circumstances during the 19 hours between the prisoners making their way onto the roof and the code being called down. This in part is due to only seven of the 35 correctional officers involved in the incident providing reports. A brief chronology of the events, which occurred immediately following the verification of the prisoners on the roof through to when the prisoners came off the roof, is outlined below.

Chronology of Events

3.8 Following the Code Silver being announced at approximately 1.15pm, CS [redacted] and CS [redacted], and other staff attended the incident site. CS [redacted] called for a centre wide lockdown. CS [redacted] called for a CERT 2 with dog squad.[9] The rooftop prisoners' cells were locked off as crime scenes with staff directed not to enter the cells.[10] CS [redacted] directed officers to secure the perimeter.

3.9 There were about 30 or 40 prisoners on the oval when the incident began. The prisoners on the roof attempted to incite those prisoners on the oval to join them in their protest. Whilst the prisoners on the oval were cheering, no attempt was made to join the rooftop prisoners. The staff responding to the incident attended the oval and removed the prisoners in order to return them to the Secure Unit 6, units. All prisoners were compliant whilst on the walkway.[11] At or around this time prisoner [redacted] ([redacted]) and [redacted] ([redacted]) handed bottled water to the prisoners through the S7 cage.[12]

3.10 The prisoners in S10 were reluctant to be locked away. The Delta Unit with GP dog attended and assisted with the lock away.[13]

3.11 At approximately 1.30pm, Duty Manager [redacted] ('DM') and CSIU were notified of the incident. On being notified, DM [redacted] notified the Deputy General Manager, [redacted] ('DGM') who in turn attempted to contact the General Manager, [redacted] ('GM'). He left a message on the GM's phone.

3.12 The DGM then notified the Deputy Commissioner [redacted] ('DC') of the rooftop incident. She asked to be regularly kept up to date. The GM then phoned the DGM back and advised he would make his way to the prison.

3.13 At 1.44pm, prisoner [redacted] threatened to jump off the roof.[14]

3.14 At 1.51pm, Dog Handler [redacted] tried to talk prisoner [redacted] into coming down. [redacted] said they had not been up there long enough.[15]

3.15 At 1.59pm, a Code Yellow was called in Detention Unit ('DU') Cell 6 (called down at 2.03pm).[16]

3.16 At approximately 2.26pm, the centre lockdown was completed.

[9] Incident Report - [redacted]
[10] Staff Briefing Notes
[11] Incident Report - [redacted]
[12] Report of CCO [redacted], 12 October 2014
[13] Incident Report - [redacted]
[14] Handwritten incident log
[15] Handwritten incident log
[16] Handwritten incident log

3.17 At 2.39pm, DM [redacted] arrived to the prison. On arrival, he received a briefing from CS [redacted] and spoke with CS [redacted]. He attempted to engage with the prisoners to establish what their demands were. DM [redacted] noted the inner perimeter had been secured around Secure Unit 6. He observed Dog Handlers adjacent to S9 and S10, and S7 and S8, with custodial staff strategically placed on the other side.[17] He confirmed QPS negotiators had been called in and were on their way.

3.18 At 2.52pm, the DGM arrived to the prison.[18] The GM arrived a short time later. The DM provided a briefing to the DGM and GM. The GM took over as the Incident Controller and an Incident Command Centre was set up in the Administration Block.

3.19 A discussion ensued between the GM, DGM and DM regarding the management of the incident. It included agreeing that the prisoners would be placed in the reception store when they came down; how secure movements would be managed as residential visits were scheduled to occur, and it was agreed they would proceed; staffing arrangements should the incident proceed into the night; that building services would be required to isolate the water and power; that regular contact would need to be kept with the QPS negotiators; and to continue monitoring the walkways. The logistical organisation of staffing and the general operation of the prison continued throughout the incident.[19]

3.20 At 3.25pm, prisoner [redacted] was observed smoking and passed it to [redacted] and [redacted].[20]

3.21 At 3.30pm, QBuild arrived to the prison.[21]

3.22 At approximately 3.49pm, a Code Green was called for S9. Prisoner [redacted] ([redacted]) and Prisoner [redacted] ([redacted]) smashed their cell windows and attempted to throw water and food to the prisoners. The prisoners were removed from their cells and placed in vacant cells in S9.[22]

3.23 At approximately 4.05pm, prisoner [redacted] was seen to pick up a stone out of the guttering in the roof and place it in his right hand as he walked across the top of the roof.[23]

3.24 Two Queensland Police Service ('QPS') negotiators arrived to the prison. They received a briefing from the GM. The police outlined what they proposed to do. The GM requested hourly situational reports from the QPS negotiators throughout the incident.

[17] Interview with DM [redacted] 10 December 2014
[18] Gate log
[19] Interview with GM [redacted] 10 December 2014
[20] Handwritten incident log
[21] Gate log
[22] Incident Report - [redacted]
[23] Report of CCO [redacted] 12 October 2014

3.25 At approximately 4.27pm, the police negotiator, [redacted] attempted to engage with the prisoners on the rooftop.[24] QPS Officer [redacted] was one of the investigating officers into ex-prisoner [redacted] death. He advised prisoner [redacted] that [redacted] died of steroids and speed.[25] Officer [redacted] also explained the circumstances surrounding [redacted] death to [redacted] and [redacted].[26]

3.26 At 4.34pm, persons attending the visits session left the prison.[27]

3.27 At 4.46pm, the Queensland Ambulance Service ('QAS') was put on notice regarding the incident.[28]

3.28 At approximately 5.24pm, the water was turned off to Secure Unit 6 to prevent prisoners providing water to the rooftop prisoners.[29]

3.29 At approximately 5.30pm, CCO [redacted] saw prisoner [redacted] start to climb down the S9 exercise yard. He ran down to the exercise yard to secure [redacted] but as he did, prisoner [redacted] climbed back up on to the roof.[30]

3.30 At approximately 6.03pm, prisoner [redacted] attempted to remove guttering from the roof but was unsuccessful.[31] At or around this time QPS negotiators formed the view that [redacted] seemed to be the 'ring leader' with [redacted] not far behind. The other two prisoners seemed to be following [redacted] and [redacted].[32]

3.31 At approximately 7pm, thermal imaging cameras were deployed to the incident scene[33] (a CCO who is a member of the rural fire brigade sourced the equipment).

3.32 At 7.16pm, [redacted] and [redacted] thought about coming down if the QPS stopped using the loudspeaker system (the LARD system was used to attempt to keep the prisoners alert).[34]

3.33 At approximately 7.17pm, prisoner [redacted] ([redacted]) smashed his cell window in S9 in an attempt to pass food and water to the rooftop prisoners. He was removed from his cell and placed in the DU.[35]

[24] Incident Report - [redacted]
[25] Handwritten incident log
[26] Handwritten incident log
[27] Gate log
[28] Gate log
[29] Handwritten incident log
[30] Report of CCO [redacted], 15 October 2014
[31] Incident Report - [redacted]
[32] Email GM to [redacted], 12 October 2014
[33] Incident Report - [redacted]
[34] Handwritten incident log
[35] Incident Report - [redacted]

3.34 At 8.01pm, the QPS negotiators discussed a surrender plan with the prisoners.[36] A ladder was put in place for the prisoners to come down. The attempt in having the prisoners come down was not successful.[37]

3.35 At approximately 8.20pm, the prisoners attempted to remove flashing from the roof to gain entry to the roof space.[38] The roof space behind the flashing contained the plant room, which housed the electrical and water services for Secure Unit 6. The area where the prisoners attempted to access the roof space is identified in photographs taken of the scene **(Attachment 3)**.

3.36 CS Dog Handler [redacted] discussed the potential consequences of the prisoners accessing the plant room with the DGM. CS Dog Handler [redacted] requested authorisation to utilise his QCS streamer to deter the prisoners from gaining access to inside the plant room.[39] The GM was consulted and provided the necessary authorisation to use the chemical spray to deter the prisoner's from gaining access to inside the roof.[40] The order was made after contra indication checks were made with medical.[41]

3.37 At 8.36pm the GM, DGM and DM [redacted] went to the Secure Unit 6 roof space to assess the potential threat to the prison if the prisoners gained access to the roof space, and to better understand what they were dealing with.[42] The GM departed Secure Unit 6 at 8.43pm and did not engage with any of the prisoners.[43]

3.38 CS Dog Handler [redacted] attended the roof space with CSO [redacted] and CS [redacted]. By this time the entire flashing had been removed and there was a gap in the wall. CS Dog Handler [redacted] saw a prisoner approach the gap in the wall.[44] The prisoner was warned to move back and then at approximately 8.36pm a short burst of the streamer was activated towards the advancing prisoner.[45] The prisoner immediately pulled back away from the opening and CCO [redacted] advised the prisoners that any further attempts to breach the plant room wall would result in further use of force. The prisoners then ceased their attempts to tear away any more of the panelling and stayed clear of the missing panel.

3.39 At 8.50pm, the prisoner in DU, Cell three made contact with master control via the cell intercom system to advise "*this is all for* [redacted]" (the prisoner had earlier in the evening whilst the incident was occurring threatened to 'slash up' and requested transfer to medical, a code blue had been activated).

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[36] Email GM to [redacted] 12 October 2014
[37] Handwritten incident log
[38] Incident Report - [redacted]
[39] Report of CS Dog Handler [redacted]n, 12 October 2014
[40] Interview with GM [redacted], 10 December 2014
[41] Interview with DGM [redacted] 10 December 2014
[42] Interview with GM [redacted] 10 December 2014; Gate log
[43] Gate log; Interview with GM [redacted] 10 December 2014
[44] Report of Dog Handler CS [redacted], 12 October 2014
[45] Handwritten incident log

3.40 At 9pm the prisoner who had been sprayed with the streamer was given water by staff on the outside of the roof space for the use of any effects from the Chemical Agent.[46] Medical attention was also offered but declined.[47]

3.41 At 9.25pm, the rooftop prisoners smashed the window in S8 Cell 14[48]. The prisoners were provided water, milk, blankets, coats and tracksuits.[49]

3.42 CS Dog Handler [redacted] says he discussed the management of prisoners who were breaking windows to assist the prisoners on the roof with the GM. He suggested those prisoners who participated have their cells completely stripped and a proclamation be made to all prisoners, should they participate they too would have their cells stripped. The GM approved the strategy and it was subsequently implemented. [50]

3.43 At 9.50pm, the GM returned to the upstairs plant room. He left at 9.53pm.[51]

3.44 At 10.20pm, the GM, DGM and DM [redacted] went to S6. They left at 10.23pm.[52]

3.45 At 11.22pm, CCO [redacted] saw prisoner [redacted] approach the opening in the wall. He issued a direction for the prisoner to move away from the opening or advised gas would be used. The prisoner continued to advance so CCO [redacted] initiated a short burst from his streamer. He understands the prisoner was hit in the left shoulder/neck area. The prisoner responded by stating, "*the Fucking Dog cunts Sprayed me again*".[53]

3.46 At 12.42am and 1.13am, new QPS negotiators arrived to the scene. At 1.36pm the first two QPS negotiators left the prison.[54]

3.47 At around 2.00am, the GM went down to the incident site to assess the situation. He was conscious of not being spotted by prisoners and did not engage with anyone.[55]

3.48 At 2.03am, a fire hose was used to attempt to make the environment uncomfortable for prisoners.[56] The attempt was unsuccessful as the prisoners were warned and were able to move away from the fire hose before it was deployed.

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[46] Handwritten incident log
[47] Report of Dog Handler [redacted] 12 October 2014
[48] It is assumed this is the time the rooftop prisoners smashed a fellow prisoners cell window as reported by the GM and QPS Officer [redacted]
[49] Handwritten incident log
[50] Interview with Dog Handler CS [redacted] 29 January 2015
[51] Gate log
[52] Gate log
[53] Handwritten incident log; Officer report of CCO [redacted], 12 October 2014 (was not attached to the incident report and only provided on 2 February 2014 following a request from investigators)
[54] Handwritten incident log
[55] Interview with GM [redacted] 10 December 2014
[56] Handwritten incident log

3.49 At around 4am, CCO [redacted] arrived to the prison in order to relieve other staff. There were two supervisors at the incident site, CS [redacted] and CS [redacted]. They were both giving directions.[57] CS [redacted] spoke with CCO [redacted] and directed him to the rooftop.[58] CCO [redacted] took over from CCO [redacted] who had been at the prison all night.[59] CCO [redacted] was provided a handover, which included being told he could use the streamer if warranted.[60]

3.50 At approximately 5.45am, CCO [redacted] and CCO [redacted] witnessed prisoner [redacted] rush towards the opening in the wall. When the prisoner was approximately 1.5metres from the gap, CCO [redacted] deployed a shot of gas. CCO [redacted] made contact around prisoner [redacted] neck and left shoulder area. Prisoner [redacted] veered to CCO [redacted] left and jumped on to the next level of the roof.[61] There was no immediate danger of prisoner [redacted] falling from the roof as the top of the exercise cage was parallel to the roof where he was sprayed.

3.51 The prisoners were heard to say they were going to come down but would not now they had been sprayed with the gas. However, CCO [redacted] says he heard the prisoners talking about remaining on the roof all day and that they would be on the news.[62]

3.52 At approximately 7.00am, DM [redacted] returned to the prison (he had departed at around midnight). He received a briefing and liaised with QPS negotiators. He was advised the prisoners were close to coming off the roof. DM [redacted] arranged for health services to come to the incident scene so the prisoners could be reviewed when they came off the roof.[63]

3.53 At 7.50am the prisoners agreed to come down and at 8.10am the four prisoners came off the roof.[64] The prisoners were secured in the reception store. They were medically checked and provided breakfast. The prison remained in lock down until all prisoners were settled and the roof checked.[65] QBuild carried out an audit of the centre that day.[66]

3.54 At 8.22am, the Code Silver was stood down.[67]

3.55 Prisoners [redacted], [redacted], [redacted], and [redacted] had their classifications and placements reviewed by the relevant delegate as a result of the rooftop incident. The delegate approved a maximum security order in respect of each prisoner. Each maximum security order for these prisoners took effect from 13

[57] Interview with CCO [redacted], 10 December 2014
[58] Interview with CCO [redacted] 10 December 2014
[59] Interview with CCO [redacted] 10 December 2014
[60] Interview with CCO [redacted] 10 December 2014
[61] Report of CCO [redacted], 13 October 2014
[62] Report of CCO [redacted], 13 October 2014
[63] Interview with DM [redacted], 10 December 2014
[64] Handwritten incident log
[65] Email [redacted] to various stakeholders, 13 October 2014
[66] Gate log
[67] Gate log

October 2014 to 13 April 2015.[68] The prisoners were transferred from MCC to the maximum security unit at Brisbane Correctional Centre ('BCC') under the relevant maximum security orders.

3.56 The GM conducted a welfare check of staff and held a short debrief with 'key players' immediately after the incident.[69] A full town hall meeting and operational debrief occurred on the Friday after the incident. It was forecast in advance and staff who were not on duty were provided the opportunity to attend.[70]

Comment

3.57 The incident was contained to the Secure Unit 6 rooftop.

3.58 Whilst the general themes of the demonstration were better health care and drug programs there was no specific key issue identified with each prisoner appearing to have his own agenda. It is likely the trigger for the demonstration may have been the relatively recent death of prisoner [redacted] and the denial of transfer requests for prisoner's [redacted] and [redacted].

b) *Whether there were policies, procedures and practices in place for the proper assessment and continuing management of the prisoners and whether those policies, procedures and practices were complied with*

3.58 There were numerous policies, procedures and practices, which came into play during the incident. Investigators address only those, which have any significance concerning the investigation. They are addressed in chronological order as the incident unfolded.

Tennis

3.59 Prior to the incident, Secure Unit 6 prisoners were allowed to access the tennis court located between Secure Unit 1 and Secure Unit 6.

3.60 There was a logbook in the control room, and provided the prisoners were not on any restrictions and a booking time was available, they could book the court.

3.61 The prisoners were escorted by a CCO from their unit to the court. Whilst on the court, the prisoners were observed by Central Control. When the prisoners had finished, a CCO would escort them back to their unit.

3.62 Following the incident access to the tennis court and oval was suspended until further notice.[71]

[68] See the relevant Sentence Management Decision Making Records
[69] Interview with GM [redacted] 10 December 2014
[70] Interview with GM [redacted] 10 December 2014
[71] Staff Briefing Note

Comment

3.63 Operational practices had been implemented by MCC over a period of time to reduce the perceived risk of secure prisoners having access to the secure accommodation units (S1 and S6) tennis court. However, there is no evidence a formal risk assessment had previously been undertaken in relation to secure mainstream prisoners accessing the tennis court, noting the tennis court fence directly abutted the walkway rooftop. As a result of the incident Secure Unit 6 mainstream prisoners are no longer able to access the tennis court.

Visits

3.64 Visits had been scheduled for residential, and the visitor's car park was full of visitors when the incident occurred. There was initially some confusion as to whether the visits would precede.[72] Originally the prisoners were going to be moved back to residential. However, the GM undertook a risk assessment in relation to whether to cancel the visits or whether the visits would proceed. This involved considering the number of visitors who had driven many hours in order to visit and the unrest the cancelation of the visits would have on the remainder of the prison population. The GM decided the visits could proceed.[73]

3.65 To avoid the risk of the residential prisoners attempting to join the protest, they were double handcuffed when escorted to and from residential. One officer interviewed was of the view the visits should have been cancelled due to an increased risk of events escalating.[74] Others concurred with the decision of the GM.

Comment

3.66 The decision by the GM concerning the visits was an operational decision by a very experienced corrections officer. The various risks were considered prior to making the decision. There is no evidence to suggest the decision to proceed with the visits detracted from the management of the incident or that the safety and security of the prison was compromised as a result of the GM's decision.

Code Silvers and CERT response

3.67 Rooftop incidents have known to occur from time to time in the correctional setting. A review of incidents over the last five years has identified 12 rooftop incidents since 12 October 2009. Prior to this incident, the last rooftop incident at MCC occurred on 23 March 2011. This rooftop incident involved two prisoners climbing on to a roof of one of the residential cluster officer stations and making their way along the residential compound walkways.

[72] Interview of CS [redacted], 10 December 2014
[73] Handwritten incident log; Interview with GM [redacted] of 10 December 2014
[74] Interview with CS [redacted], 10 December 2014

3.68 Historically, QCS incident contingency code procedures governed the response process. A new state-wide QCS Incident Management System ('IMS') was endorsed in early 2013 (no specific date could be provided by QCS) with training in the new IMS model conducted for correctional supervisors and correctional managers. The QCS IMS is based on incident management systems implemented by other emergency service agencies. The QCS IMS was not published until 31 March 2014, when QCS implemented a Custodial Operations Practice Directives suite of procedures that were designed to provide a consistent procedural framework.

3.69 Under the QCS IMS, the code identifier for a rooftop incident is a Code Silver. The QCS Incident Management Custodial Operations Practice Directive (COPD) is an overarching document, which addresses the various codes and incident responses. It addresses preparation; incident and response; and the post-incident requirements for all incidents. It stipulates that the GM of each prison must provide for the development, administration and control of emergency plans for their facility.[75] This is through the development and implementation of Local Action Plans ('LAP') for identified risks. The GM is required to provide oversight local management of incidents. Further, the GM is required to activate the notification tree and alert police of the incident and provide email notification to higher authorities. There is a timeline for in which these tasks are to be undertaken.[76]

3.70 The MCC LAP for a Code Silver was implemented on 31 March 2014 (**Attachment 4)**. There had not been any contingency training for a Code Silver other than desktop exercises prior to the incident.[77] The LAP had though been disseminated to correctional staff.[78]

3.71 In the QCS IMS model, the most senior or highest ranking QCS person who arrives first on the scene will be the Incident Controller (IC). In most instances this will result in a Correctional Supervisor assuming initial command of the incident until the arrival of senior facility management and/or handover of the incident to the GM who will then assume the role of Incident Controller. A scribe is to be appointed and is to maintain an incident log.

[75] Custodial Centre Practice Directive – Incident Management
[76] Custodial Centre Practice Directive – Incident Management, p20
[77] MCC Contingency Test Matrix 2014
[78] Interview with DM [redacted] 10 December 2014

3.72 The MCC LAP acknowledges the response to any rooftop occupation will be different, however identifies basic steps, which are required when responding to a Code Silver. They include:

- The first officer keeping sight of the prisoner(s) as much as possible, first and second response will assist in containing and isolating any prisoner or prisoners during any rooftop occupation;
- Activate the incident control centre (ICC);
- Centre wide lockdown and headcount;
- All non-essential radio transmissions to cease;
- Vehicle access other than emergency vehicles to and from the centre to cease;
- Staff response as per the Maryborough CC Response Model;
- Deactivate the prisoner telephone system (PTS);
- Negotiation with prisoner/s to commence; and
- Work out access down from the rooftop, using ladders or in conjunction with Fire service.

3.73 The MCC Response Model requires the Correctional Supervisor, to assume initial command until the arrival of senior facility management and/or handover the incident to the GM or nominated officer who will then assume the role of the Incident Controller and/or the QPS negotiator on their arrival.

3.74 The Incident Management Centre is located in the Administration Block Conference Room or X-Block. It is to be staffed by the GM who is the Incident Commander; the DGM who is the Incident 2IC; Manager B/Services-Co-ordinator; Business Adviser- Communications/IT; Incident Clerks; and Intel.

3.75 As a part of the IMS model, the Incident Controller can access CERT personnel to assist with the management of the incident.

3.76 The MCC Cert Model is well documented in a MCC Centre Emergency Response power point presentation (MCC believe the document was created approximately 5 years ago but have no precise date) **(Attachment 5).** In that model, the Supervisor of an area where the incident has arisen becomes the Field Commander. The CERT 2 team consists of a team leader from another area; two designated responding staff; and a Dog Handler and GP Dog. The team leader takes direction from the Field Commander. The responding posts for a Cert 2 in Secure Unit 6 are the Residential Team Leader; the Secure Unit 1 team leader and responding officers; the dog squad back-up support and centre services if required.

3.77 In the initial stages of the rooftop incident there appeared to be some confusion as to who was the Incident Controller. CS [redacted] is of the view there was some disorder as to who was managing the incident, as he and CS [redacted] were both undertaking various activities to manage the incident. CS [redacted] puts the confusion down to the fact that CERT Team Leader s had withdrawn from their Team Leader roles at the time of the MCC rooftop incident. The

reason that CERT Team Leaders had apparently withdrawn from their roles was because of a decision by the GM to leave the perimeter unattended by Dog Handlers due to the redeployment of staff and the decision not to backfill staff absentees in the Dog Squad[79] (refer to paragraphs 3.169 to 3.172). CS [redacted] says all officers responded as responding officers not in their CERT roles.[80]

3.78 CCO [redacted] says there was no one clear person managing the incident and that various supervisors were giving directions throughout the incident, which led to no leadership or direction.[81]

3.79 CS [redacted] did not recall any formal handover to DM [redacted] or DM [redacted] taking on the role as Incident Controller when he arrived. However, CS [redacted] recalls briefing DM [redacted] and walking down with him to address the prisoners.[82] CS [redacted] says DM [redacted] took over the incident whilst he and CS [redacted] assisted with other duties.[83]

3.80 DM [redacted] did not formally take on the role of Incident Controller. He says this was because he was confident CS [redacted] and CS [redacted] had taken the appropriate measures. Further, that he was aware the DGM and GM were arriving to the centre very shortly and the GM would assume the position of Incident Controller.[84]

3.81 DM [redacted] thought in hindsight there could have been better delegation, as there was some confusion as to what tasks had been completed but acknowledges it was difficult coming into the middle of an incident, which was ongoing.[85]

3.82 Once the GM came on site, it became clear he assumed the role of Incident Controller. An Incident Control Centre was set up in the Administration block were the GM was primarily located throughout the course of the incident. The DGM acted as the conduit between the incident site and the Incident Control Centre. The incident site was essentially broken up into two areas, one commanded by CS [redacted] and the other by CS Dog Handler [redacted] ter [redacted].

3.83 CS [redacted] was under the impression DM [redacted] was at the incident scene overseeing everything regarding tactics and the DGM and GM were the strategists. CS [redacted] and CS [redacted] would report back to DM [redacted] the tasks they had completed. DM [redacted] says the incident did not warrant one person directing activities at the scene. It was a combined effort with various persons completing tasks as necessary and liaising with the GM accordingly.[86]

[79] Interview with CS [redacted] 10 December 2014
[80] Interview with CS [redacted] 19 December 2014
[81] Interview with CCO [redacted] 18 March 2015
[82] Interview with CS [redacted] 19 December 2014
[83] Interview with CS [redacted] 19 December 2014
[84] Interview with DM [redacted] 10 December 2014
[85] Interview with DM [redacted] 10 December 2014
[86] Interview with DM [redacted] 10 December 2014

3.84 The GM is of the view despite the length of the incident and the resources involved very little liaison was required. The two key issues were in relation to the deployment of gas and managing those prisoners who were smashing windows.[87]

3.85 CS Dog Handler [redacted] says he is of the view that due to the nominated CERT Team Leaders withdrawing from the team leader role he was not consulted earlier and it was not until the GM asked for advice concerning the prisoners attempting to enter the rooftop and other prisoners breaking their cell windows. CS Dog Handler [redacted] is of the opinion had the CERT model been in place the team leader would have been involved in earlier decision-making.[88]

3.86 CS [redacted] is of the view had there been a Team Leader, the Team Leader would have coordinated the lock down, organised staff, retrieved the necessary riot equipment, and looked after the CERT response. With no CERT team leader who would also have taken on the role of Incident Controller until a more senior person came to the prison, responding officers managed the incident.[89] He advised in a subsequent Code Silver when everyone was back in their roles, the incident was managed more smoothly.

3.87 CCO [redacted] is of the view the lack of direction occurred due to nobody taking on the role of Field Commander and did not think this was related to the nominated CERT Team Leaders withdrawing from the team leader role. He says in a subsequent Code Silver, DM [redacted] was appointed as the Field Commander and wore a yellow vest so everybody knew he was in charge. He says as a result, the incident was managed better. [90]

Comment

3.88 The confusion at the outset of the incident appears to be related to the application of both the QCS IMS Model and the MCC CERT Model. An example was CS Dog Handler [redacted] who despite being a CERT commander, a use of force instructor and a CERT team leader instructor, was not familiar with the QCS IMS.

3.89 Both models require the supervisor of the relevant area to manage the incident. The QCS IMS refers to the supervisor taking on the role of Incident Controller, whereas the MCC CERT model refers to the supervisor becoming the Field Commander but working in close assimilation with the CERT team leader. Both systems require the GM to become the Incident Controller when on site and for the Incident Control Centre to be set up in the Administration Block Conference Room or X-Block.

[87] Interview with GM [redacted] 10 December 2014
[88] Interview with Dog Handler CS [redacted] 29 January 2014
[89] Interview with CS [redacted] 19 December 2014
[90] Interview with CCO [redacted] 18 March 2015

3.90 Whilst under the new IMS model, members of the CERT team are an adjunct to the Incident Response there seems to be some misunderstanding that the CERT Model remains the primary response model at MCC for an incident, not the IMS.

3.91 Despite the incident being managed appropriately and without incident, investigators suggest MCC revisit its incident response model to ensure all staff are familiar with and follow the correct procedure.

Use of Force

3.92 In accordance with s143 of the Act, a corrective services officer may use reasonable force. It may involve the use of weapons. QSC has a COPD on the 'Use of Force'. The policy states, "*A corrective services officer must utilise all methods of tactical communications and situational response and consider the most appropriate option for a safe and effective outcome to ensure only a reasonable amount of force justified by law is used to effect a lawful purpose*". An accredited operator with the approval of a delegated officer should only dispense the use of a chemical agent and where practical a prisoner should be provided a warning prior to dispensing.[91] The chemical agent carried by accredited officers is Oleoresin Capsicum (OC) in an aerosol form.

3.93 A discussion occurred between the GM, DGM and CS Dog Handler [redacted] concerning the use of the spray to protect the roof space where a number of vital services were housed. The use of a GP Dog in the circumstances was impractical so it was agreed, spray could be used. However, prior to providing the order, the GM ensured medical was consulted regarding any contraindications.

3.94 QSC Officers [redacted] and [redacted] had a current QCS SAF014.2 – CS Chemical Agents Operator accreditation to dispense gas (chemical agent) at the time of the incident. QCS Officers who had been deployed to the area on standby to dispense gas if necessary also had current accreditation at the time of the incident.[92]

3.95 Following an officer's involvement in a use of force, the officer must record the incident in the IOMS incident report, including the Use of Force section. All reference data in the open fields in the report are to be completed.

3.96 CS Allwood completed an Incident Report on 12 October 2014 (addressed below). The Use of Force section was completed. The force identified was Chemical Spray.[93]

[91] Use of Force Practice Direction (printed 11 December 2014)
[92] Training records for the Officers were provided to investigators
[93] Incident Report - [redacted]

Comment

3.97 Investigators have viewed the inside area of the roof space in which the prisoners were attempting to enter. If the prisoners had gained access to the roof space, there was potential for prisoners to suffer significant injury by falling, or causing significant damage to prison services, which would have dramatically escalated the incident. There is no evidence to suggest the use of force in these circumstances was not warranted or that the appropriate processes were not followed.

Use of Fire Hose

3.98 According to the QPS the fire hose was used to spray the prisoners without consultation with the QPS negotiators. However, the DGM recalls it was the QPS who suggested the idea of the hose in order to contain the prisoners to one area of the roof. The GM agreed to the use of the fire hose following a briefing from the QPS. The DGM and GM both denied using a fire hose in previous circumstances such as these.[94]

3.99 CS Dog Handler [redacted] says he raised the strategy of using the fire hose earlier in the incident with a supervisor but it was not taken any further. He thought it should have been used to wet the prisoners as it was very cold overnight and it is likely it would have brought the incident to an early end.[95]

3.100 When the fire hose was used, the QPS provided a warning to the prisoners and they moved away from the area where it was being deployed.[96] CS Dog Handler [redacted] says the hose was not used effectively.[97]

Comment

3.101 It would appear that QCS policy and procedure provided no authorisation for the use of a fire hose during a a Code Silver roof top incident. This is understandable because the use of a fire hose in such circumstances may increase the slip propensity of the roof.

[94] Interview with DGM [redacted] 10 December 2014; Interview with GM [redacted] 10 December 2014
[95] Interview with Dog Handler CS [redacted] 29 January 2014
[96] Interview with Dog Handler CS [redacted] 29 January 2014
[97] Interview with Dog Handler CS [redacted] 29 January 2014

Communication with QPS

3.102 QPS Officer [redacted] is the District Negotiator Co-ordinator for the Wide Bay District. He was notified at the outset of the incident and arranged for himself and Officer [redacted] to attend the scene.[98] At around 2am two other officers relieved them, with [redacted] returning at about 7am. All QPS officers were trained negotiations, which requires that they undergo re-qualification every 12 months by completing a three-day training course.[99]

3.103 There were comments by QCS personnel that they did not find the QPS negotiators particularly helpful. The QPS negotiators made comments that some of the actions by the QCS personnel were not helpful.

3.104 On arrival to the centre, the QPS negotiators received a briefing from the GM and his staff. The GM advised what they could and could not offer, which was not much.[100] He requested to he be kept updated regularly and asked that if there was anything they needed to know they were to see him.[101] This would either involve the DGM liaising between the QPS negotiators and the GM, or the QPS negotiators presenting to the Incident Control Centre.

3.105 The QPS advised they tried to constantly engage with the prisoners and whenever they attempted to sleep, they would disturb them with noise through the LARD system or Karaoke.[102]

3.106 Some of the issues identified by QCS included:

a) the QPS using the LARD system to purposely direct noise to other areas of the prison;
b) the late ineffectual use of the fire hose in the early hours of the morning;
c) not necessarily appreciating the difference between a contained rooftop incident and an event like a hostage scenario (the prisoners were safe, contained and had nowhere to go until they came down); and
d) the prisoners 'playing' and taunting the officers.

3.107 Some of the issues identified by QPS included:

a) QCS officers engaging with prisoners which they felt detracted from their negotiations;
b) QCS officers using chemical spray when they deemed it was not necessary;
c) The GM refusing any concessions; and
d) Information provided by QCS not always being accurate (QPS understood meals and medication rounds would be severely impacted and attempted to use

[98] Interview with [redacted] (QPS), 19 December 2014
[99] Interview with [redacted] (QPS), 19 December 2014
[100] Interview with [redacted] 10 December 2014
[101] Interview with [redacted] 10 December 2014
[102] Interview with [redacted] (QPS), 19 December 2014

this to persuade prisoners to come down but meals and medication rounds proceeded as usual).[103]

3.108 This incident was the first incident the QPS negotiators were involved in at MCC and QPS Officer [redacted] advised it was his first prison negotiation.[104] He admitted he became frustrated because the prisoners just did not care. They had nothing to lose and were not concerned about the other prisoners.[105]

3.109 The QPS personnel had not previously been inside the prison and were not familiar with the infrastructure.[106] QPS Officer [redacted] was not aware of any previous joint contingency training occurring between QPS and QCS in relation to incident management.[107]

3.110 The GM was surprised to hear the QPS felt they did not have the necessary information to make decisions when they had been specifically instructed what they could and could not say, and if they required any information they were to speak with the GM.[108] QPS Officer [redacted] was contradictory at times. He said, as QCS was the lead agency, all strategies had to be approved by the GM and that they had no difficulties in getting messages to the GM either through the DGM or DM.[109] Contrary to earlier correspondence, when interviewed he felt the communication went well and that there were no difficulties in getting any information they required.[110]

Comment

3.111 There is no evidence from the material that the use of the chemical spray was not warranted in the circumstances or that it was used inappropriately. There is evidence that CCO's engaged with prisoners from time to time. However, there is also evidence when a higher-ranking officer became aware of this, the staff were told not to engage with prisoners and stopped from doing so.

3.112 The strategies adopted by the QPS and QCS need to be consistent in managing an incident such as this. Whilst there were regular briefings, and despite an acknowledgement of seeking consent from the QCS for the implementation of strategies, the QPS negotiators appear to have been working fairly much in isolation. That is, there was no specific QCS officer working alongside the QPS providing custodial advice, expertise and knowledge to assist with the negotiation. Relevantly, the general manager himself in effect took on the role of Agency Liaison Officer under the QCS IMS role which is responsible for liaison between the QCS Incident Controller and the relevant supporting agency. The

[103] Email correspondence of 27 October 2014
[104] Interview with [redacted] (QPS), 19 December 2014
[105] Interview with [redacted] (QPS), 19 December 2014
[106] Interview with [redacted] (QPS), 19 December 2014
[107] Interview with [redacted] (QPS), 19 December 2014
[108] Interview with [redacted] 10 December 2014
[109] Interview with [redacted] (QPS), 19 December 2014
[110] Interview with [redacted] (QPS), 19 December 2014

QCS IMS does state that where an Agency Liaison Officer position is not appointed, these duties will reside with the Incident Controller.

Drugs

3.113 There is reference by a number of officers to the prisoners injecting drugs whilst they were on the roof.[111] This is not referred to in any of the logs, the incident report or officer reports. Nobody who was interviewed witnessed the prisoners doing this. The allegation therefore cannot be substantiated.

3.114 In any event, the prisoners were well known to [redacted] regarding drug activity. Prisoners [redacted], [redacted] and [redacted] had been followed since [redacted] was known to intelligence as a result of an incident involving the secretment of drugs through legal mail.[112] The deceased prisoner [redacted] was known to [redacted] as a drug user. All prisoners were known associates.

3.115 [redacted][113].

3.116 Unbeknownst to QCS, the QPS was running Operation [redacted] which involved MCC prisoners utilising mobile phones and TAB accounts to facilitate drug activities.[114]. [redacted] Recently a number of prisoners have been charged in relation to this operation.

Comment

3.117 The prisoners were all well-known drug users. One of their demands was about drug rehabilitation and addiction management. Whilst perhaps a contributing factor, investigators are of the view the issue of drugs and addiction management in prisons is beyond the scope of this investigation.

Incident Reporting

3.118 Following an incident a CCO must report on any incident that may impact on the security or good order of a corrective services facility; or the safety and wellbeing of staff, prisoners or members of the community. The line manager must review the incident report and forward it for approval. The GM must review and approve the incident report and oversee any remedial action if required.[115]

3.119 As a general rule the supervisor in charge of the area where the incident occurred is responsible for the incident report. CS [redacted] started the incident report with the assistance of CS [redacted] on the evening of 12 October 2014.

[111] CCO [redacted]
[112] Interview with [redacted] 10 December 2014
[113] Interview with [redacted] 10 December 2014
[114] Interview with [redacted] 10 December 2014
[115] Custodial Centre Practice Directive – Incident Management, p18

The chronology in the report are estimates but were also obtained from the scribe, and were checked with Master Control. CS [redacted] completed the report the next day he was on shift. The incident report is Incident [redacted] – 12 Oct 14 (**Attachment 6**). The annexed table to the incident report is a list of those officers involved in the incident. CS [redacted] says this list was compiled mostly from memory. Generally speaking it would have been CS [redacted] responsibility to follow up officer reports.

3.120 According to the DGM, the Accommodation Manager for the area where the incident occurred is responsible for undertaking a quality assurance review of the incident report, approving it and sending it to CSIU. In this case the Accommodation Manager was [redacted]. Accommodation Manager [redacted] was not present during the incident and did not attend the de-briefing. She was not advised of what officers had been identified to provide reports.

3.121 CCO [redacted] advised he completed a report on his home computer and brought the hard copy to work when he was next on shift. For some reason, his report had not been uploaded with the other officers' reports onto IOMS. He does not recall being followed-up to provide an incident report. He completed it at his own accord.[116]

3.122 Only seven reports were provided when over 35 officers were involved. Some notable absences include those of DM [redacted], CS [redacted] and CS [redacted] (not provided until requested). DGM [redacted] advised DM [redacted] would not have been directly involved and DM [redacted] advised he was not required to provide a report. However, in this case DM [redacted] directly engaged with the prisoners on his arrival to the prison to establish their demands and to attempt to see if they would come down off the roof.

3.123 As investigators understand it, since the incident the GM has implemented a new approach to officer reporting. This is due to previous poor compliance issues; with the GM reporting he was continually 'chasing his tail' in having officers provide reports.[117] The new system involves the operational debrief now also including each person involved in the incident providing an overview of their role, with the GM or whoever is conducting the debrief identifying what is required in a report. The GM says this ensures accurate information is collected for decision makers, the QPS and prosecutors. He advised CSIU was complimentary of the information they were provided in a more recent incident.

[116] Interview with CCO [redacted], 18 March 2015
[117] Interview with GM [redacted] 10 December 2014

Comment

3.124 This incident occurred over three shifts and involved numerous officers undertaking various activities. It was a level 1 incident involving four prisoners and the use of force. The reporting by officers in relation to this incident was inadequate.

3.125 Whilst understandable, the new system used by MCC to identify those officers who are required to provide a report at the debrief of the incident may present some difficulties with information being filtered through the process, and the potential of information being missed if an officer is not in attendance at the debrief. Investigators are of the view there is an opportunity for the GM to further consider the issue of incident reporting compliance at MCC.

c) ***Whether there was any information (including intelligence) in existence prior to the incident which might have indicated any planning of the incidents, including any specific actions by any prisoner(s) or any behavioural, conduct or other issues that ought to have alerted staff to the potential risk of such incidents***

3.126 Investigators reviewed the IOM Case File notes for each of the prisoners in the month leading up to the incident. A précis of relevant entries has been prepared **(Attachment 7).**

3.127 The only relevant entries appear to be the reference to the death of [redacted].

3.128 On 1 October 2014 prisoners [redacted] and [redacted] received a postcard from [redacted]. Prisoner [redacted] had been released from prison in mid-September 2014. As investigators understand it, he died from an overdose on 29 September 2014. The prisoners were each taken into the interview room separately and provided the post card by Counsellor [redacted] and CLO [redacted]. The postcards were quite positive and upbeat.[118]

3.129 Counsellor [redacted] has advised the only prisoner who did not show any particular concern and even presented as a little annoyed at being taken into the interview room was prisoner [redacted] The others whilst subdued stated they were accepting of the news.

3.130 The prison psychologist was surprised prisoner [redacted] did not receive a postcard (the reference to the death of a friend in his case notes of 30 September 2014 was the death of [redacted][119]).

3.131 There were no issues identified with the prisoners and no further references to the death of [redacted] in the following days leading up to the incident.

[118] Confirmed by Counselor [redacted]
[119] Staff Briefing Notes

3.132 As a part of prisoner welfare, Prisoner Advisory Committee ('PAC') meetings are regularly conducted. The purpose of the meetings is to provide prisoner input into the facility's functioning and to promote positive communication between facility management and prisoners. There is evidence PAC meetings were conducted for the Secure Unit 6 mainstream secure accommodation block. At a meeting of 28 August 2014, amongst numerous other issues, a request was made for a Buprenorphine program. Prisoner [redacted] was present at the meeting.[120] The response provided by the Manager Offender Development ('MOD') was developed in consultation with the GM and Management team. The prisoners were advised, "*MCC does not have approval to run such a program and any future requests should be directed to QHealth*".[121]

3.133 The Official Visitor Reports of 1 September 2014 to 4 December 2014 were considered. There are no specific themes in the reports. There are no references to drug rehabilitation programs or transfer issues.

3.134 A review of blue letters sent by the prisoners in 2014 was undertaken by the Inspectors to determine if there was information available prior to the incident that could have alerted staff that these prisoners were going to be involved in a rooftop incident. Prisoner [redacted] had not sent any. Prisoner [redacted] sent a letter on 20 February 2014 requesting that QCS review the visit status of his partner [redacted]. Prisoner [redacted] sent two letters one on 10 March 2014 requesting reimbursement for shoes that he had missing from his property box and secondly on 5 May 2014 requesting an acquitance form which was signed back in March as the money had not gone into his account (this seemed to be related to the missing shoes). On 28 February 2014, prisoner [redacted] sent a letter requesting contact visits as his urine analysis tests always tested positive for medications he had been prescribed.

3.135 A review of the prisoners' telephone calls through ARUNTA did not reveal any information, which would have alerted QCS that the prisoners were planning a rooftop protest.

3.136 From the Correctional Intelligence Reports there is only one reference to a potential roof access threat. [redacted] The threat was investigated. It was deemed that the allegation was unsubstantiated but to manage the risk prisoner

[120] Minutes of PAC Meeting, 28 August 2014
[121] Email [redacted] to [redacted], 12 December 2014,

[redacted] was housed in the DU for a short period.[122] There was no other intelligence substantiating the claim found prior to or after the incident.

3.137 Despite the regular monitoring by intelligence of the prisoners involved in this incident, there was no intelligence identified that would have alerted QCS that the prisoners were planning a rooftop protest prior to the incident.

Comment

3.138 Whilst [redacted] was one of the prisoners mentioned in relation to [redacted] information provided to intelligence in June 2014, the potential threat was investigated and not substantiated.

3.139 Whilst the death of prisoner [redacted] may have been a triggering factor for the roof top demonstration, there is no evidence that the prisoners were planning to take any action to attempt to highlight or avenge his death prior to the incident.

3.140 Investigators are of the opinion there was no material available to QCS, which would have alerted staff to a potential rooftop demonstration.

d) *The timeliness and effectiveness of both the management and staff in responding to the incidents, including whether or not appropriate contingency plans were in place and/or were implemented immediately following the incidents; whether or not the ongoing integrity/security of the centre was maintained following the incidents; and whether the QCS reporting requirements were complied with*

Incident Response

3.140 The response to the incident has been addressed above. Investigators have noted there appears to have been some confusion amongst staff concerning the application of both the QCS Incident Management System and the MCC CERT model.

Timeliness of Actions

3.141 As soon as the prisoners were identified climbing onto the walkway rooftop from the tennis court, the appropriate code alert was called and officers responded accordingly.

3.142 In accordance with the COPD Custodial Operations Practice Directive for Incident Management there is a timeline in which various actions are to be attended depending on the Incident level.[123] This incident was determined to be a Level 1 incident. The timeframes in reference to this incident are addressed in the table below.

[122] Interview with Intelligence Officer [redacted], 10 December 2014
[123] Custodial Centre Practice Directive – Incident Management, p19

Timeframe	Incident Level	Tasks	Comments
15 minutes	1A	Activate notification tree	The GM was notified at just after 1.30pm (the Code Silver was called at 1.15pm).
30 minutes	1A	Phone call to DC Email notification Completed Media Release	The DAGM contacted the DC when notified of the incident shortly after 1.30pm – the DC notified various members of Statewide Operations including the Commissioner at 2.05pm. Half hourly advice on the incident was requested. An email was sent at 3.42pm to the DC providing prisoner profiles and an update of the status of the incident. QCS media were alerted to the incident by the DC.
45 minutes	1A	Media release issued (by Commissioner or nominee)	A level 1 incident (which this incident was) only requires a media release at the discretion of the DDG or ADG. There is no evidence of a media release being required or completed concerning this incident.
60 minutes	1 & escalated 2	Phone call to DC Email notification	As above.
2 hours (after initially contained)	1 and 1A	Incident report completed Flash Brief completed and submitted to Statewide Operations	The incident occurred over approximately 19 hours. The incident report was completed on 13 October 2014. A flash brief was completed on 13 October 2013 (the time when it was completed is unclear).
4 hours (after initially contained)	2	Incident report completed	Not relevant.
12 hours (after initially contained)	3	Incident report completed	Not relevant.
9am the following business day	1 and 1A and 2	Flash Brief completed and submitted to Statewide Operations (for incidents that occur out of office hours) Flash Brief completed and submitted to Statewide Operations	A flash brief was completed on 13 October 2013 (the time when it was completed is unclear).

Comment

3.143 The centre security was not compromised throughout the incident. The centre was locked down in a timely manner and whilst visits proceeded, contingencies were implemented to manage the risk associated with the visits.

3.144 Despite some confusion concerning who the incident controller was in the initial phase of the incident, the investigators are of the opinion the incident was responded to in a timely and effective manner.

e) *Application of relevant national or international research*

3.146 The *Investigation into circumstances surrounding the rooftop incident at the Brisbane Correctional Centre on 14 September 2013* report (the report) was considered by the investigators, in particular the research literature highlighted[124]. The literature identified contemporary best practice with respect to command and control structures for managing a negotiation incident. Recommendations 6 and 7 made in the report based on best practice incident negotiation were evidenced to be operationally implemented during the MCC rooftop incident. In particular, QCS senior managers did not directly participate in negotiations with prisoners once the QPS negotiation team was on site and an incident control centre was established in the administration block that provided a command and control structure, including coordination of incident response activities.

f) *A general history of the institutional management of the prisoners.*

3.147 Prisoner [redacted] was transferred to MCC on 30 April 2012 for his initial placement. He was transferred to BCC to facilitate Court appearances as required and remained at BCC between 16 May 2012 and 30 May 2012 and then again on 8 May 2013 to 22 May 2013. On 12 August 2014, prisoner [redacted] applied to transfer from MCC to Southern Queensland Correctional Centre ('SQCC') saying that he wished to be closer to his family. His mother provided a letter of support. The transfer request was considered by MCC Centre Management and was considered not suitable as a result of an incident that was continuing to be investigated.

3.148 Prisoner [redacted] was moved into MCC on 30 November 2012 from Court. Whilst an IOMS case note dated 19 August 2014 indicates that prisoner [redacted] attended the shop front and requested a transfer application, there is no record of him submitting such an application.

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[124] '*Crisis Negotiations – Managing Critical Incidents and Hostage Situations in Law Enforcement and Corrections*', 5th Edition, 2014, Anderson Publishing, USA and '*The Use of Negotiators by Incident Commanders*', 2011 published by the Association of Chief Police Officers and the National Policing Improvement Agency (UK)

3.149 Prisoner [redacted] was transferred from BCC to MCC on or around 3 September 2013. It appears prisoner [redacted] had applied to transfer to Arthur Gorrie Correctional Centre (AGCC) on at least two occasions. The transfer was stopped due to information provided by CSIU. There are three case notes separate to the previous two requests for transfer indicating that he was again applying for transfer to AGCC due to the location of his Court matters and family. The case notes include those of 23 September 2014, 30 September 2014 and 3 October 2014. The case note of 3 October 2014 indicates prisoner [redacted] attended the shop front and was provided with a transfer application. In his form he requested he be provided with something in writing in regards to his request for transfer. Prisoner [redacted] is currently a full remand prisoner or was so at the time of the incident. He has a number of outstanding Court matters for property related offences. They were listed to be mentioned in the Brisbane Magistrates Court on 6 January 2015. He also has a number of outstanding drug related offences resulting from a QPS operation concerning drugs in MCC, which are listed for mention on 16 February 2015.

3.150 Prisoner [redacted] was transferred from SQCC to MCC on 16 September 2013. Prisoner [redacted] was transferred due to intelligence information indicating he was a risk to the security and safety of the Centre. [redacted] did not indicate he had any issue with his transfer to MCC and there was no evidence [redacted] had requested to transfer from MCC to any other Centre prior to the incident.

Comment

3.151 There is no evidence to suggest the prisoners should not have been placed in MCC or that their request for transfers had been purposively obstructed. There was a major investigation going on in the prison concerning a significant drug problem, in which investigators understand all prisoners had some connection.

g) *The prisoners criminal history and particulars of current sentence*

3.152 Prisoner [redacted] criminal history commenced in 2003, when he was a juvenile of 12 years of age. The offences predominantly involve property, driving, contravention requirements and breach of conduct orders. This incident occurred during his first correctional episode in which he is currently serving a head sentence of four years imprisonment for offences including but not limited to unlawful use of motor vehicles, aircrafts or vessels – use, used /intended for an indictable offence wilfully destroyed, damaged, removed; six counts of enter premises and commit an indictable offence; eight counts of enter premises and commit indictable offences by break and two counts of stealing.[125]

3.153 Prisoner [redacted] has demonstrated behaviour not consistent with rules and regulations of the correctional centre. He has incurred or been a perpetrator in approximately four incidents, which have incurred four major breaches of

[125] QCC Administration Form information notice security classification

discipline.[126] Prisoner [redacted] has had several breaches of discipline and incidents as a perpetrator including positive drug tests during his current custodial episode.[127]

3.154 Prisoner [redacted] has a lengthy criminal history dating back to July 2004 when he was a juvenile of 17 years of age. He has many prior convictions for a range of offences including property; theft; driving; and drugs. This incident occurred during his fifth correctional episode in which he is currently serving a six year ten month and two day period of imprisonment for offences committed by him in the community. They include seven counts of driving related offences; seven counts of stealing, and five counts of entering a dwelling/ trespass.[128]

3.155 Prisoner [redacted] has an extensive and serious history of problematic institutional behaviour during his current correctional episode. He has been identified as the perpetrator of approximately 14 incidents. He has also incurred 13 breaches of discipline, ten of which were major breaches and three minor.[129]

3.156 Prisoner [redacted] has a significant criminal history, which commenced in 1999 when he also was a juvenile. He has many prior convictions for a range of offences predominantly related to property and vehicle offences. The incident occurred during his first correctional episode. On 2 June 2006, he had been sentenced in the District Court of Queensland to a period of eight years imprisonment for a number of offences including burglary; robbery with actual violence armed and in company; enter dwelling and commit indictable offence; unlawful use of a motor vehicle; enter premises and commit indictable offence by break; assault obstruct police; attempt to enter premises with intent; trespass; serious assault, breach of probation order; stealing and fraud.[130] It appears that prisoner [redacted] had been released from prison and was on parole when he committed offences whilst on parole. This resulted in his return to prison.

3.157 Prisoner [redacted] has a history of problematic institutional behaviour during his current correctional episode. He has been identified as a perpetrator in approximately 21 incidents, incurred 11 breaches of discipline of which 10 were major and one minor.[131]

3.158 Prisoner [redacted] has a lengthy criminal history dating back to 2001 when he was a juvenile of 16 years of age. He has many prior convictions for a range of offences including property; theft; breach of Court order; drug and violent offences. The incident occurred during his fifth correctional episode in which he is currently serving a three year four month and one day period of imprisonment for offences including but not limited to two counts of stealing; nine counts of enter premises and commit indictable offence for break; five counts of enter dwelling with intent; three counts of receiving tainted property; four counts of

[126] QCS Administration form – Sentence Management – Decision Making Record, 13 October 2014
[127] QCS Administrative Form – Sentence Management – Decision Making Record, 16 October 2014
[128] QCS Administration Form – Sentence Management – Decision Making Record, 16 October 2014
[129] QCS Administrative Form – Sentence Management – Decision Making Record, 16 October 2014
[130] QCS Administration Form – Information Notice Security Classification, 13 October 2014
[131] QCS Administrative Form – Information Notice Security Classification, 13 October 2014

unlawful use of motor vehicles aircraft or vessels – use; one count of dangerous operation of a vehicle and three counts of wilful damage.[132]

3.159 Prisoner [redacted] has an extensive and serious history of problematic institutional behaviour. He has been identified as a perpetrator in approximately 26 incidents during his current correctional episode. He has also incurred 15 breaches of discipline, 13 of which were major and two minor.[133]

Comment

3.160 The prisoners were all young men with significant criminal histories. They were all known drug users. Despite all having problematic institutional behaviour, there is no evidence that the staff of MCC had been put on notice or ought to have been aware that the prisoners were planning the rooftop incident.

h) *Any action taken by the Centre to respond to issues identified in any internal review/debrief*

Operational Factors

3.160 MCC had been undergoing significant change with the appointment of a new General Manager, [redacted] when the incident occurred. In addition, the prison was operating beyond its current prisoner capacity.[134]

3.161 Further, at the time of the incident, Secure Unit 6 had a high level of young impulsive prisoners.[135] It is also quite a transient population.[136] In recent times the prison had banned cigarettes and prohibited the purchase of certain categories of magazines as directed by a Deputy Commissioner's Instruction. Compounding this was the limited opportunities for employment.[137]

3.162 Secure Unit 6 had been unsettled for quite some time which had been identified. One of the issues was no consistency with the supervisor for Secure Unit 6 as there was no permanent correctional supervisor for this accommodation block.[138] Previously all correctional supervisors rotated through an eight hour day shift for Secure Unit 6. A residential correctional supervisor then took over the supervisor responsibility (in addition to the residential supervisor duties) when the Secure Unit 6 rotational supervisor concluded their eight hour shift. This has now been addressed with a discrete roster for the Secure Unit 6 correctional supervisor positions.

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[132] QCS Administration Form – Sentence Management – Decision Making Record, 16 October 2014
[133] QCS Administration Form – Sentence Management – Decision Making Record, 16 October 2014

[134] The built cell capacity is 500. As at 24 November 2014, there were 584 prisoners (MCC AG Fact Sheet 20141124)
[135] Interview with Accommodation Manager [redacted] 10 December 2014
[136] Interview with Accommodation Manager [redacted] 10 December 2014
[137] Interview with Accommodation Manager [redacted] 10 December 2014
[138] Interview with CS [redacted] 19 December 2014

3.163 The Chief Inspector undertook an assessment of the prison on 21-22 October 2014. A separate report concerning this assessment has been produced.

Comment

3.164 The GM and MCC have acknowledged the areas of concern at the prison and are actively undertaking measures to address those issues.

CERT Team Leaders Withdrawing from Team Leader Roles

3.165 CERT Team Leaders had withdrawn from their Team Leader roles at the time of the MCC rooftop incident as a result of a decision by the GM to leave the perimeter unattended by Dog Handlers due to the redeployment of staff and the decision not to backfill staff absentees in the Dog Squad. The concern was that the CERT 2 response would be without a Dog Handler should it be required. On 29 August 2014, the GM proposed an alternative model which involved nominating an alternative officer in the absence of the CERT 2 Dog Squad Officer.[139]

3.166 Despite proposing the alternative model, staff were concerned the model did not provide the same level of safety and security. On 2 September 2014, 16 MCC Team Leaders notified the GM they were unwilling to fulfil their roles as Team Leader.[140] This was concluded on 17 October 2014 with all Team Leaders returning to their normal duties.

3.167 The DGM has confirmed that team leaders continued to undertake 'hard' duties (control and restraint) that they were trained/accredited for during this period. They just withdrew from the leader role. The CERT response model provided for a supervisor to respond with a team leader and two accredited officers – therefore during the period there was still a supervisor and three accredited CERT officers responding. This resulted in the supervisor remaining as the leader for the response with the CERT accredited officers performing the 'hard' duties for which they were trained/accredited.

Comment

3.168 Some of the officers put the initial confusion concerning the management of the incident down to the CERT Team Leaders withdrawing from the leader role. That is, not having a CERT 2 team leader to direct the incident. However, the initial confusion really appears to lie in the officers not understanding the application of both the QCS Incident Management System and the MCC CERT model, and not having one specific person at the incident site providing direction. The Incident Controller should have been CS [redacted] until such time as DM[redacted] arrived to the prison.

[139] Email CM to DC and others, 29 August 2014
[140] Letter Team Leaders to GM, 2 September 2014

Infrastructure, Resources and Access to Rooftops

3.169 A number of QCS officers interviewed suggested razor wire be installed to a number of areas in the prison to prevent similar incidents occurring. The difficulty is the number of areas, which would require this intervention to prevent other future rooftop incidents.

3.170 The GM is of the opinion razor wire should only be installed on the top of the oval courtesy fence. He saw this area as a potential risk because of the number of prisoners who could be on the oval with two supervising officers. If one of the officers became distracted it would be relatively easy for a prisoner(s) to scale the fence and run off unseen.[141]

3.171 An additional risk identified by the GM, which was not related to the incident, is the potential for 210 unlocked residential prisoners to make their way directly to the front gate. He sees this as his biggest risk at MCC.[142]

3.172 As identified earlier, following the incident QBuild undertook an audit of the prison. The DGM advised QBuild reported the flashing to the roof had not been secured as tightly as it could have. They arranged for all roof flashing to be more firmly fixed to the rooftops in order to attempt to prevent future access to any plant areas.

3.173 The GM advised in his 25 years working in corrections, he has never seen prisoners smash windows to provide supplies to other prisoners.[143] He advised on one occasion a prisoner inside did not want to smash his window, so the prisoners on the rooftop smashed it and demanded he hand them materials. QPS Officer [redacted] advised the prisoners found items in the gutters to smash the windows.[144] Whilst, the GM sees it as a dangerous activity, it is a difficult risk to manage. He advised it may be that consideration is given to prisoner placement in relation to those cells adjacent to the roof.

3.174 CS Dog Handler [redacted] suggested the clearing of a prisoner's cell of all items and making a declaration to the prison that this would occur to any prisoner who attempted to smash a window was effective in this scenario when it was finally implemented. In specific terms, these measures were said to be effective because they discouraged other prisoners from supplying items to the demonstrating prisoners undertaking the rooftop protest.

3.175 CS [redacted] was of the view the thermal imaging camera borrowed from the rural fire brigade was very helpful as it allowed officers to keep track of the prisoners. He suggested it would be helpful in other incidents.

3.176 Investigators understand there has been no formal risk assessment or cost/benefit ratio undertaken in relation to changes of the infrastructure at MCC.

[141] Interview with GM [redacted], 10 December 2014
[142] Interview with GM [redacted], 10 December 2014
[143] Interview with GM [redacted], 10 December 2014
[144] Interview with [redacted] (QPS), 19 December 2014

Comment

3.177 The tennis court allows access to the Secure Unit 1 and Secure Unit 6 roof walkway. A prisoner can move along the walkway roof to where it abuts the S6 accommodation unit building. The building is potentially scalable at this point via a downpipe and window sill and bars. However, a much easier option for a prisoner attempting a rooftop demonstration is to jump off the walkway and, as these prisoners did, run across the grounds to climb up the fence of an exercise yard. A prisoner on the oval could do the same.

3.178 Investigators are of the view there is an opportunity for QCS to further consider the infrastructure issues in attempting to avoid future incidents. This may involve QCS undertaking a cost/benefit ratio of strategically installing razor wire at specific locations throughout the centre to decrease the risk of roof top demonstrations and other future incidents. Further, investigators are of the view QCS has the opportunity to consider how future incidents of prisoners breaking cell windows in such incidents can be effectively and efficiently addressed. Particularly, in circumstances where there are no vacant cells available elsewhere in the prison. There is also an opportunity to consider the cost/benefit ratio of MCC purchasing a thermal camera to assist in future incidents or formalising an arrangement with the Rural Fire Brigade for the use of this equipment.

i) ***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.***

3.180 Investigators are of the opinion the rooftop demonstration by the prisoners was an essentially unplanned event. They identified an opportunity and took that opportunity. There is no evidence of any intelligence or other information that could have put MCC on notice or that they ought to have been aware of the intentions of the prisoners.

3.181 Whilst the prisoners referred to the death of [redacted], due to the many and various issues they promoted throughout the demonstration, his death may have been an excuse to protest but not necessarily the reason behind the protest.

4. CONCLUSION

4.1 Following the investigation, investigators have identified 10 key findings for consideration. They include:

Finding 1	There was no common specific key issue established for triggering the roof top protest.
Finding 2	There was no intelligence information or other relevant information that would have alerted correctional officers that the prisoners planned to undertake the rooftop protest.
Finding 3	There had been no formal risk assessment undertaken in relation to secure mainstream prisoners accessing the tennis court (prisoners first accessed the S1 – S6 walkway rooftop by scaling the tennis court mesh fence).
Finding 4	There was confusion at the outset of the incident as to who was managing the incident.
Finding 5	There was confusion concerning the application of both the QCS IMS Model and the MCC CERT Model.
Finding 6	There was no guideline for the use of a fire hose and no evidence a risk assessment had been undertaken concerning the use of a fire hose in a roof top incident.
Finding 7	This was the first time prisoners had smashed windows during a roof top protest.
Finding 8	There were difficulties in co-ordinating information between the QPS and the QCS in managing the incident.
Finding 9	The officer reports concerning the incident uploaded onto IOMS were inadequate.
Finding 10	Infrastructure of the MCC provides multiple points that enable a prisoner to access a rooftop.

5. ROOT CAUSE EVALUATION

5.1 Root cause analysis is a methodology that seeks to identify the underlying root causes of events as opposed to simply focusing on the immediately apparent causes of the event. This approach uses a series of structured methodologies to 'drill down' into problems until all the factors contributing to an event have been documented and the underlying or 'root' cause identified.

5.2 **Attachment 8** contains the relevant summary of the root cause analysis undertaken by the Office of the Chief Inspector. As well as a précis of the relevant root causes, **Attachment 8** encapsulates the outcomes of an assessment of the adequacy of existing controls for the relevant root causes, as well as a risk assessment against each root cause using the Department of Justice and Attorney-General's risk matrix and guide. It is hoped that the risk weighting will provide an indication about the level of priority that must be accorded to addressing each root cause.

5.3 Importantly, the Office of the Chief Inspector also conducted an environmental scan for the possible solution(s) or remedial options to root causes.

5.4 Lastly, when the Office of the Chief Inspector conducted the root cause analysis for this actual investigation, the existing controls for Findings 1 and 2 were assessed to be 'good' with no further actions required. The risk presented in Finding 6 was more immediate and, in this regard, was referred to QCS prior to the finalisation of this report. In relation to the remaining findings of this report, the root cause analysis process undertaken by the Office of the Chief Inspector identified a total of three likely root causes and one plausible root cause which requires further examination. In particular, the plausible root cause in relation to possible ineffective prisoner request/grievance/complaints management systems will be examined as a part of the Office of the Chief Inspector's proposed thematic review into rooftop incidents in Queensland Corrective Services.