CCC EXHIBIT

Department of Justice and Attorney-General
Queensland Corrective Services

OFFICE OF THE CHIEF INSPECTOR

Investigation into the management of Prisoner [redacted] at the Wolston Correctional Centre

August 2015

Queensland Government

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1 INTRODUCTION

1.1 On 22 June 2015, the Ethical Standards Unit (ESU), Department of Justice and Attorney-General, completed an investigation into the conduct of six officers from the Wolston Correctional Centre (CC). All six officers, namely Correctional Supervisor (CS) [redacted], and Custodial Correctional Officers (CCOs) [redacted], were stood down from duties during the period of investigation.

1.2 The investigation found that on [redacted] April 2015, CS [redacted] and CCO [redacted] used unnecessary/unreasonable force on Indigenous prisoner [redacted] and put his face in faeces after he defecated in his cell exercise yard within the Detention Unit (DU).

1.3 The ESU investigation findings included that:

- no aspects of the force used by the CCOs on Prisoner [redacted] were authorised, justified or excused by the *Corrective Services Act 2006* (the Act) or Queensland Corrective Services (QCS) policy or procedure;
- the act of forcing the prisoner's head into his own faeces represented a significant departure from the requirements of the Act and policy and procedure;
- there was a deliberate and substantial failure in meeting the requirements under the Act and Code of Conduct to respect the prisoner's dignity;
- there was a clear and deliberate failure to comply with QCS policy and procedure regarding the reporting of incidents involving the use of force on prisoners;
- the decision by CS [redacted] and the CCOs not to report the incident (to Wolston CC management or on IOMS) was instrumental in the incident being concealed from management for some four weeks;
- CS [redacted] failed to discharge his obligation under QCS policy and procedure to have Prisoner [redacted] medically examined following an incident involving the use of force; and
- despite Prisoner [redacted]'s head being forced into contact with the faeces (at approximately 1144 hours), he was not given access to the shower in his cell yard until 0837 hours the following morning.

1.4 The incident only came to the attention of the ESU and Wolston CC management after Prisoner [redacted] telephoned the Crime and Corruption Commission (CCC) and complained about his alleged mistreatment by the CCOs. On 5 May 2015, the CCC referred the matter to the ESU to deal with, subject to audit by the CCC.

1.5 On 13 May 2015, a Right to Information (RTI) request was made by the Aboriginal and Torres Strait Islander Legal Service (ATSILS), on behalf of Prisoner [redacted], in respect of the incident on [redacted] April 2015. In processing the request, CCTV footage of Prisoner [redacted]'s cell and exercise yard was reviewed by staff at Wolston CC, and the Intel officer reviewing the footage brought it to the General Manager's attention.

1.6 The CCTV footage is largely consistent with Prisoner [redacted]'s allegations of inappropriate behaviour by the CCOs. A copy of the CCTV footage was provided to the ESU on 14 May 2015.

1.7 On 14 May 2015, the matter was referred to the Corrective Services Investigation Unit (CSIU) for assessment.

1.8 On 24 June 2015, the Chief Inspector, QCS, appointed External Inspectors [redacted] and [redacted] and Internal Inspectors [redacted] and [redacted], to conduct an investigation into the matter pursuant to the *Corrective Services Act 2006* (CSA). Terms of Reference for same were issued (*Attachment 1*).

1.9 This is a report on the outcomes of the Inspectors' investigation.

2 EXECUTIVE SUMMARY

2.1 The Terms of Reference issued by the Chief Inspector included consideration of whether the policies and procedures in relation to the ongoing management of Prisoner [redacted] were adequate and complied with; and whether there were identifiable factors that may have contributed to the occurrence of the incident on 14 April 2015.

2.2 The investigation revealed a number of issues in relation to the ongoing management of Prisoner [redacted] and the manner in which he was treated leading up to and on [redacted] April 2015 relevant to these Terms of Reference.

2.3 Although Prisoner [redacted] had made ongoing complaints at Wolston CC since February 2015 that he was not being afforded adequate and appropriate medical treatment for pain management, the investigation did not reveal persuasive evidence that his medical needs were not being addressed. There was evidence that he was repeatedly reviewed by nursing staff and was transferred to the Princess Alexandra (PA) Hospital on more than one occasion. The prisoner was greatly dissatisfied in relation to the opinion held by various health practitioners that his symptoms (mostly back pain) did not warrant opiate based pain relief. The Inspectors are not in a position to make specific findings as to whether the opinion held by the health care practitioners in respect of the prisoner's medication regime for pain management was correct, however, as stated above, there appeared no persuasive evidence to the contrary. However, the Inspectors are satisfied that QCS staff did provide sufficient opportunity to Prisoner [redacted] for him to engage with those health care practitioners.

2.4 Prisoner [redacted] had a history of poor behaviour while at Wolston CC, including swallowing items or claiming to have done so. By his own admission, this was in order to attract attention to his self-reported medical needs. His behaviour was significantly resource intensive for those tasked with his management. It is acknowledged that Prisoner [redacted] presented significant challenges to staff however; it must be stated that it appears that insufficient consideration had been given to addressing the *cause* of his behaviour, and to put in place management strategies intended to address the cause/s and improve his behaviour.

2.5 It should also be acknowledged that such consideration would have likely to have been uninformed in a very material respect: those tasked with the prisoner's management would not have been privy to specific information about his mental health, even if they had sought access to such information. This lacuna arises because of the limitations on health sharing between QCS and the West Moreton Hospital and Health Service, the body responsible for offender health services at Wolston CC. The Inspectors consider that the Memorandum of Understanding (MOU) between QCS and QH, in its current form, does not make sufficient provision for the exchange of medical information relevant to a prisoner's behavioural management between from Queensland Health (QH) and QCS.

2.6 Prisoner [redacted] threatened staff with a broom handle on 6 March 2015 and he was placed on a Safety Order and moved to the Detention Unit (DU). Placing Prisoner [redacted] on a Safety Order at this time, in relation to this conduct, was appropriate.

2.7 An Intensive Management Plan (IMP) was completed on 31 March 2015. Its purpose was to place the prisoner on Level 2 of the 'Basic Regime' under the Wolston CC Incentives and Enhancements Program (IEP), in order to provide a regime of incentives and disincentives for the prisoner to work towards behavioural modification. The Inspectors have concerns that the Basic Regime within Wolston CC may be too austere, and recommend that further consideration by the Office of the Chief Inspector (OCI) should be given to this regime. Such consideration should, if possible, include an evidence based analysis of its effectiveness.

2.8 There was a delayed implementation date for the IMP of 21 April 2015. Reasons given to Inspectors as for that delay differed as between the relevant management staff. Whichever of those reasons was in fact the actuating reason for the continued placement of Prisoner [redacted] in the DU, the continued use of the Safety Orders in reliance on section 53 of the Corrective Services Act 2006 was, at best, problematic, and at worse, an invalid exercise of power.

2.9 There was insufficient clarity and consistency for DU officers in relation to allowable cell property for prisoners in the DU who were not on At-Risk observations. On the morning of the incident, a DU supervisor removed Prisoner [redacted]'s book and writing material, leaving him with nothing to do.

2.10 The investigation identified that there appeared to be a practice within the DU of removing items from prisoners as a punitive measure. The General Manager described the approach of giving and taking away property as basic positive and negative reinforcement directed at attempting to bring about behavioural change. The Inspectors' view is that it is likely that this is outside the legislative authority for, and stated justification within the, Safety Orders. Further, the removal of all cell property for prisoners in the DU (who were not on At-Risk observations) was inconsistent with policy/procedure. In that regard sections 53(4) and (5) of the CSA state:

> *(4) The chief executive may limit the privileges of a prisoner during the period of the safety order if the chief executive reasonably believes that during the period –*
>
> *(a) it will not be practicable for the prisoner to receive privileges to the extent the prisoner would otherwise have received them; or*
>
> *(b) having regard to the purpose of the safety order, it is not desirable that the prisoner receives privileges to the extent the prisoner would otherwise have received them.*
>
> *(5) …the safety order must also state the extent to which, as decided by the chief executive, the prisoner may receive privileges during the period of the safety order.*

2.11 The CSA defines privileges as privileges prescribed under a regulation for a prisoner. The CS Regulations, in section 19, defines privileges to include using library facilities and accessing the prisoner's property.

2.12 It appears, therefore, that the legislation contemplates that the extent to which a prisoner will have use of library facilities or access to property will be specified, by the chief executive (or delegate) within the safety order itself; and not something which can be varied by centre staff or management, in purported reliance on section 53(4)(b), when it is thought that this may moderate behaviour of the prisoner. Further:

- The *CPOD Detention Unit* (Privileges) states that the GM of a corrective services facility must provide for a prisoner's needs in accordance with the reason for his/her confinement in a detention unit. The removal of Prisoner [redacted]'s book did not relate to the reason for his confinement in the DU and was therefore not justified. According to the Appendix *DETENTION UNIT – AUTHORISED PROPERTY – SAFETY ORDER*, Prisoner [redacted] should have had access to a maximum of three books or magazines; and
- It is not appropriate, as was the case here, for the Safety Order to purport to empower the Accommodation Manager to make day to day decisions as to property entitlements.

2.13 Certainly, there was no evidence that the manner in which Prisoner [redacted] was managed in the DU (i.e. locked in his cell and a small adjoining exercise yard 24 hours per day with limited or no cell possessions) was having any positive effect on his behaviour. To the contrary, his behaviour was deteriorating, as clearly demonstrated by the incident on 14 April 2015 when he defecated in his cell yard.

2.14 CCTV footage indicated that he, and the other prisoners within the DU who had no cell possessions, paced their small cells/exercise yard for much of the time.

2.15 Inspectors recommend that further consideration be given to the treatment of prisoners in the DU under safety orders.

2.16 Prisoner [redacted] stated that the unexplained and unjustified removal of his cell property was the catalyst for him defecating in his cell yard (in protest). As to the actual incident, in which CS [redacted] and CCO [redacted] put the prisoner's face so close to the faeces that it was all but inevitable that his face would come in contact with them, the Inspectors accepted the findings of the ESU that there was unjustified use of force. Further, the Inspectors accept the findings of the ESU that there was a failure to report the incident by officers who were involved. These failures are departures from the officers' obligations under the CSA, QCS policy and procedure and the Code of Conduct.

2.17 As stated above, the decision by the five CCOs (subordinate to CS [redacted]) not to report the incident was found to be a combination of an incorrect belief that this was not necessary because their supervisor had the situation in hand and was an experienced and respected officer and the practice of completing an officer report only if asked to do so by a supervisor. This "chain of command" mentality is problematic particularly if coupled by a culture of fear of reprisal and/or cover-up within the prison. In that regard, there was some (although certainly not comprehensive) evidence of both. The Inspectors are also of the view that with respect to some of the officers involved, their failure to report was influenced by a fear of reprisal for reporting the wrongdoing of colleagues. For some others, the failure to report was motivated, at least in part, by wanting to protect their colleagues.

2.18 There was some evidence that some staff, in an approximately 12 – 18 month period prior to 14 April 2015, had raised with concerns with management about the behaviour of CS [redacted], in respect of such matters as short temperedness and volatility. Both the General Manager and the Deputy General Manager were firmly of the view that although complaints had been made about CS [redacted], none of the complaints gave rise to any concerns about the way in which he would behave towards prisoners or his ability to carry out his job as a Correctional Supervisor well. They described him as an officer with very good prisoner management skills, and one who would go so far as to almost advocate for prisoners. They expressed concern that information received by the OCI from some of the staff may have been somewhat agenda driven due to their disaffection for CS [redacted]. It is not appropriate for the Inspectors, in this investigation, to make specific findings as to the wisdom or appropriateness of appointing CS [redacted] as the Supervisor in Secure, against the background of staff complaints concerning him. To do so would be outside the Terms of Reference, and would also be to express a finding on the basis of incomplete evidence. In any event, it is tolerably clear that what occurred with respect to Prisoner [redacted] on 14 April 2015 was not an act of volatility or loss of control, but rather a CS acting quite deliberately within an intentional framework of what he (wrongly) considered to be an appropriate response to the prisoner's conduct, both in the act of defecation and in his behaviour to the staff when challenged about it and asked to clean it up. It is that framework which drove the behaviour of CS [redacted] on the day in question, and which is the immediate cause of the incident. That CS [redacted] still maintains that his behaviour was acceptable reveals core beliefs which are inconsistent with agency expectations.

2.19 A number of further systemic issues were identified as warranting further consideration and/or exploration by the OCI in their continued role, including:

- The consequences and impacts of Wolston CC being overpopulated
- The consequences and impacts of the changes to the prisoner profile/demographic
- That there appears to be very limited training in mental health issues, for the CCOs and supervisors tasked with their management
- The consequences of there being no in-house nursing staff available within Wolston CC after 9.30pm each night

2.20 The investigation did not raise any evidence of broader mistreatment of prisoners in Wolston CC.

2.21 However, the investigation did raise evidence tending to indicate some insufficiencies and inadequacies in at-risk management practices, and that incident oversight practices were in need of improvement.

2.22 A Provisional Psychologist raised a number of concerns about the treatment of prisoners within the DU and on the Basic Regime. As noted above, the Inspectors considered that these issues raised warranted further investigation by the OCI during the upcoming full announced inspection.