

Own Initiative Investigation Report

Services Provided by the Northern Territory Department of Correctional Services

to

Don Dale Youth Detention Centre Alice Springs Youth Detention Centre

Final Investigation Report

August 2016

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EXECUTIVE SUMMARY

The aim of this own initiative investigation conducted by the Office of the Children's Commissioner (OCC) was to address the systemic issues emerging from complaints received from young persons in detention. During the course of the investigation several other issues were identified which were inherently connected to the three main issues named in the scope of the investigation because they reflect on the general management of young people in detention being placed 'at-risk'.

This report reflects investigations conducted and the analysis of information obtained and received by the OCC. On completion of the investigation a consultative process was conducted in order to reach the final report. This process is detailed in the Methodology of this report.

Since receiving responses from Department of Correctional Services (NTDCS) and Department of Health (DoH), I have learnt that NTDCS have updated the *At-Risk Procedures Manual* (hereinafter referred to as the updated Manual). The Commissioner of Corrections also issued a Directive attached to this updated Manual, directing staff of the NTDCS and DoH undertaking roles and responsibilities in youth detention centres to comply with the At-Risk Procedures Manual.¹

It is acknowledged that the DoH *Youth 'At-Risk' Procedures* (hereinafter referred to as the Procedure) have been agreed upon by Top End Health Service, Central Australian Health Service and the Principal Health Advisor at Corrections. I am encouraged to learn that both departments have recognised that the prevention and management of suicide and self-harm requires an integrated and collaborative approach. The principles of the Procedure states the NTDCS and DoH will work together to minimise the number of youth placed 'at-risk', using de-escalation strategies and minimise the time youth are held 'at-risk' through timely assessments.² Both departments are encouraged to up-hold these principles and welcome the updated versions of the Manual and the Procedure, which address several of the issues highlighted in the First Draft Report and the Extracted Report.

With respect to issues one and two, it is important to note that the findings are based on the previous 'At-Risk' Procedures Manual, issued March 2003. References to this Manual (hereinafter referred to as the Manual) have therefore remained in the report so that context can be given to the findings.

On 22 March 2016, the Commissioner for Corrections was provided with an overview of the issues, the consultative process then followed involving the OCC, NTDCS and DoH. As a result of that process 21 recommendations have been made (5 of those recommendations are relevant to DoH) and will be listed at the end of each issue. As per the *Children's Commissioner Act 2013*, monitoring of and reporting on the recommendations is required. This will be achieved by quarterly process reports provided by the relevant department.

¹ Department of Correctional Services, Directive NTDCSDOC16/5020, V.3, 16 June 2016.

² Department of Health – Youth 'At-Risk' Procedure.

INTRODUCTION

The Custodial Operations Division of the Northern Territory Department of Correctional Services (NTDCS) manages the youth justice facilities in the Northern Territory (NT). The Department is responsible for detainees, between the ages of 10 and 17, who have been sent to a detention centre by the Courts, either on remand, or on a sentence.

There are two youth detention centres: Alice Springs Youth Detention Centre (hereinafter referred to as ASYDC), a 16 bed facility located within the Alice Springs Correctional Precinct, and the Don Dale Youth Detention Centre (hereinafter referred to as DDYDC) which has a capacity to house 56 detainees. Both facilities house both male and female detainees.

DDYDC was formerly located in Tivendale Road, Berrimah, adjacent to the adult prison. This site was closed in September 2014 in response to a series of critical incidents at that centre; the detainee population at the DDYDC was transferred to the interim Holtze Youth Detention Centre facility. It was proposed that the detainees would be moved to the Berrimah Correctional Centre site once that facility had been totally decanted into the new Darwin Correctional Precinct. However, the detainees were moved prematurely following a further series of incidents. The current DDYDC was reopened at the site formerly known as Berrimah Correctional Centre on 23 December 2014.

NTDCS Youth Justice Officers are responsible for the day-to-day care of the young persons.

The detention centres have three fundamental roles:

1. Enhance community safety.
2. Provide a safe and secure environment for detainees, staff and visitors.
3. Provide a structured environment that supports the rehabilitation of detainees through a strengths-based approach to prepare them for reintegration into society and to reduce the risk of reoffending.³

The delivery of detention centre programs and services recognises that detainees:

- must be held accountable for their actions;
- have the ability to contribute to their rehabilitation and to make pro-social choices;
- have different criminogenic factors to those of adults;
- must be detained in a safe and supportive environment;
- have different developmental levels and needs;
- may have suffered trauma, including family trauma;
- may have specific cultural needs;
- may have religious beliefs and needs.⁴

The deprivation of the liberty of a young person should be a disposition of last resort. It has been widely reported that the detainee population has risen steadily over recent times and young persons on remand account for the majority of the detainee population. Trends in over-representation of Indigenous youth in detention in the Northern Territory have fluctuated to a greater extent than national trends.

³ NTDCS website, Youth Justice, Programs and Services.

⁴ Ibid.

The legislation that governs the operation of the detention centres is the *Youth Justice Act* and the *Youth Justice Regulations*. Standard Operating Procedures, some of which are site specific, and NTDCS Directives provide further governance.

Youth Detention in the NT has become a highly-publicised, debated topic over the past two years. The Vita Review commissioned by the NT Government and investigations conducted by the OCC have formed the basis for much discussion across the nation. The Youth Detention Reform Advisory Group (YDRAG) was formed to provide NTDCS with advice on detention centre reform consistent with the recommendations of the Vita Review. Since the establishment of YDRAG, the OCC has continued to receive complaints in relation to services provided to young people by NTDCS. Concerns have continued to be highlighted in the public arena.

One of the functions of the Children's Commissioner under the *Children's Commissioner Act 2013* is to conduct an investigation into a matter that may form a ground for making a complaint (irrespective of when the matter occurred and whether or not a complaint was made). The investigation therefore may not relate to any specific complaint and may include an investigation into systemic issues in relation to services provided to vulnerable children.

Following the receipt of a number of complaints emanating from young persons in detention, it was identified that many of the issues raised were systemic in nature. The OCC determined that the detainees were "vulnerable children" in accordance with section 7(1)(b) of the Act, and the Youth Detention Centres where the detainees were being housed were classified as a "responsible service provider" as per section 21(1)(a) of the Act. Therefore, an own initiative investigation was instigated as per section 10(1)(ii) of the Act.

The investigation was based on information that had been brought to the OCC's attention regarding services provided to young people by NTDCS involving the management of young persons who are 'at-risk', the use of restraints on young persons, and the decisions and actions of NTDCS to accommodate young persons in adult facilities.

The investigation identified seven issues of concern, all with a common connection of being relevant to the dealings with those young persons placed 'at-risk'.

FORMALITIES

There are a number of relevant legislative regimes that apply to the young persons referred to in this report. For the sake of convenience, and despite the terminology differing in each piece of legislation, including 'youth',⁵ 'child',⁶ 'vulnerable child'⁷ and 'youth detainee'⁸ or 'youth prisoner'⁹, this report will use the phrase *young person*.

⁵ Section 6, *Youth Justice Act*.

⁶ Section 13, *Care and Protection of Children Act*.

⁷ *Children's Commissioner Act 2013*, section 7(1).

⁸ Section 4, *Correctional Services Act*.

⁹ *Ibid*, read with sub-sections 5 and 6.

INVESTIGATION SCOPE

The decision to conduct this self-initiated investigation under section 10(1)(ii) of the Act was made by the former Acting Children's Commissioner, Ms Hilary Berry. This decision was based on events that occurred at both the ASYDC and DDYDC from 21 December 2014. These events became known to the OCC through complaints made by individual young persons and concerns raised by professional stakeholders on behalf of young persons, as well as information received independently by the OCC. Preliminary investigations were conducted and the complaints subsequently assessed and determined to have met the necessary legislative grounds, warranting an own initiative investigation. Whilst the issues highlighted by those complaints are to be addressed, the facts of those complaints will not be discussed in isolation. The outcome of those individual complaints have already been finalised and the complainants informed. On 12 May 2015 Ms Hilary Berry advised the then Commissioner of NTDCS, Mr Ken Middlebrook, of the intention to conduct this own initiative investigation.

Following the decision being made to conduct an own initiative investigation, two further complaints were received and assessed, and subsequently deemed relevant to this investigation, specifically the management of 'at-risk' episodes.

On further exploration, the OCC formed the view that these issues were flowing from higher level systemic issues affecting young people placed 'at-risk' in detention centres, including:

1. Insufficient management of young persons being placed 'at-risk' for extended periods.
2. Inadequate service intervention for young persons being placed 'at-risk' on repeated occasions.
3. Incidents where 'at-risk' clothing and bedding provided to young persons was torn by the young persons and used to self-harm.
4. Incidents where young persons placed 'at-risk' were restrained whilst their clothing was removed with the aid of a Hoffman Tool.
5. The use of restraints on a young person placed 'at-risk', including the use of an Emergency Restraint Chair.
6. Staffing and training issues.
7. Unsuitable infrastructure.

One of the three main issues referred to in the scope outlined to Mr Middlebrook was that of the decisions and actions of NTDCS regarding young persons being accommodated in adult facilities. An analysis of transfers occurring under the provisions of section 154 of the *Youth Justice Act* was conducted by the OCC. The results of the analysis identified an ancillary issue in regards to recording such transfers and will be addressed at the end of this report.

METHODOLOGY

As part of the methodology in conducting the investigation, the OCC:

- analysed all relevant information received or sourced by the OCC, including Integrated Offender Management System (IOMS) records, review of available closed-circuit television (CCTV), De-escalation journals, 'At-risk' journals, Supervisor (Block) journals, Use of Force Register, and Internal/External Handcuff Register;
- inspected the DDYDC facility, including the 'at-risk' cells within the High Security Unit (HSU);
- inspected the ASYDC and the Alice Springs Correctional Centre (ASCC);
- reviewed legislation, policies, standard operating procedures, guidelines and NTDCS directives relevant to the three main issues;
- reviewed Progress Notes on individual young persons' medical files;
- reviewed procedures of the Department of Health – Progress Notes (specifically regarding the notification and process of 'at-risk' episodes);
- reviewed incident reports on the Police Real Time Online Management Information System (PROMIS);
- conducted interviews with complainants;
- exercised the powers under section 35 (1)(b) of the Act to compel a total of 32 persons to attend before the OCC to give information and answer questions. These persons included senior NTDCS management, Youth Justice Officers (YJOs), Correctional Officers (COs), management from Department of Health - Correctional Services Health Centre (CSHC) and management from Top End Mental Health Service (TEMH).

Information yielded from the above mentioned sources will provide factual basis and underpin each of the issues.

In order to afford procedural fairness both departments were provided with an opportunity to respond prior to the report being finalised.

- 22 March 2016 - the Commissioner for Corrections was given an overview of the key issues being addressed in the Draft Investigation Report.
- 13 April 2016 - the Commissioner for Corrections was provided with the written First Draft Report.
- 16 May 2016 - NTDCS provided a response to the First Draft Report. In their response, NTDCS suggested that certain recommendations relevant to DoH be redirected to DoH for comment. An Extracted Report, specifically highlighting issues relevant to DoH was subsequently provided to the CEO of the Department of Health.
- 24 June 2016 - the response to the Extracted Report was provided by DoH.
- 29 June 2016 - notified that 'at-risk' procedures had been updated and ratified.
- 6 July 2016 - meeting with DoH management to discuss their response further.
- 28 July 2016 - a Second Draft Report was provided to both departments (an Extract for DoH), based on the responses and additional information gleaned since the First Draft Report was circulated. Commentary was provided regarding the responses and included 21 revised recommendations. A further opportunity for comment by both departments was afforded.

- 12 August 2016 – a response to the Second Draft Report was received from NTDCS and DoH on 15 August 2016. The commentary provided in these responses has been considered, however, the OCC is mindful that any further commentary may complicate the issues and confuse the reader. Therefore all of the responses are attached to this Final Report.

The 21 recommendations have been endorsed in this Final Report, with amendments made as necessary, considering the additional information gleaned since the First Draft Report was issued.

INVESTIGATION FINDINGS

This investigation identified systemic and departmental failings in dealing with those young persons placed 'at-risk'. The current approach is reactive, confronting and at times frantic. It is not cognisant of the complex, extremely vulnerable nature of those young persons and fails to apply a therapeutic or preventative approach in dealing with those young persons.

The Manual defines 'at-risk' as meaning a person detained in custody who a lawful authority may consider potentially harmful to themselves, is suffering from an actual or potentially harmful medical condition or is potentially subject to harm from another.¹⁰ Section 1 of the Manual states it has been designed primarily to help identify, assess and minimise the risk of young persons committing suicide and inflicting self-harm. The Manual provides clear processes that are to be followed by staff and include.

- (a) specific responsibilities and accountabilities;
- (b) risk identification and assessment;
- (c) communication and recording of events;
- (d) location/accommodation of detainees;
- (e) levels of supervision and observation;
- (f) processes for intervention;
- (g) detainee support strategies;
- (h) reporting and reviewing; and
- (i) follow-up and administration.¹¹

The processes listed above have been reviewed by the OCC in conducting the own initiative investigation. The OCC has identified numerous failures in following correct processes as outlined in the Manual which has led to the poor management of 'at-risk' young persons.

¹⁰ NT Correctional Services 'At-Risk' Procedures Manual – Don Dale Centre, Wilderness Work Camp & Alice Springs Juvenile Holding Centre, March 2003, page 4.

¹¹ NT Correctional Services 'At-Risk' Procedures Manual – Don Dale Centre, Wilderness Work Camp & Alice Springs Juvenile Holding Centre, March 2003, page 4.

Issue One – Ineffective management of young persons placed ‘at-risk’ for extended periods

Young persons who are considered to have the potential to harm themselves are placed in an ‘at-risk’ cell that contains a concrete platform which is used for sleeping, a toilet and hand basin, a CCTV camera and an intercom. A young person ‘at-risk’ is isolated from the rest of the centre, and given limited opportunity to exercise or interact with others. A young person placed ‘at-risk’ will be isolated until deemed by a Medical Practitioner to be no longer ‘at-risk’.

The relevant legislative and procedural provisions are set out below.

Section 162 of the *Youth Justice Act* states:

The superintendent of a detention centre must ensure that a detainee who is considered to be at risk of self-harm is dealt with in the manner prescribed in the Regulations.

Division 3 of the *Youth Justice Regulations* deals with young persons placed ‘at-risk’. Regulation 41 of the *Youth Justice Regulations* states:

- (1) If a member of staff considers a detainee may be at risk of self-harm, the member must:
 - (a) ensure the detainee is in view of a member of staff or a health professional at all times until:
 - (i) the Emergency Management Protocol prepared under regulation 42 is implemented; or
 - (ii) an individual management plan for the particular detainee is implemented; and
 - (b) notify the Superintendent or other person in charge of the detention centre at the time.
- (2) The Superintendent or person in charge must immediately:
 - (a) refer the detainee to a medical practitioner; and
 - (b) implement the Emergency Management Protocol or, if an individual management plan has been formulated for the particular detainee, that plan.

Regulation 42 of the *Youth Justice Regulations* deals with the Emergency Management Protocol, and states:

- (1) The Commissioner must ensure an Emergency Management Protocol is prepared in relation to the accommodation of at-risk detainees in an observation room.
- (2) The Emergency Management Protocol must address the following issues:
 - (a) the observation room must be thoroughly checked for potentially hazardous or unauthorised objects before the detainee is introduced into the room;
 - (b) the room must be furnished with a mattress and bedding made of rip-proof and non-flammable material;
 - (c) continuous monitoring of the detainee by closed-circuit television, or physical observation by a member of staff, and written recording of observations (including the date, time and name of the member of staff) at intervals not exceeding 15 minutes.
 - (d) the detainee to be clothed in rip-proof material and all potentially harmful items must be removed from the detainee’s possession;
 - (e) the detainee must be provided with adequate fluids and food suitable to be eaten without cutlery.

Regulation 43 of the *Youth Justice Regulations* refers to the Individual Management Plan, stating:

- (1) If a medical practitioner assesses the detainee as being at risk of self-harm, the medical practitioner must formulate and document an individual management plan for the detainee.
- (2) The plan must be culturally appropriate for the detainee.
- (3) The medical practitioner must consult, as practicable, with:
 - a. persons having relevant knowledge of the detainee; and
 - b. persons likely to play a key role in the management of the detainee.
- (4) The plan must be updated as appropriate after each time a health professional has contact with the detainee.

Regulation 44 of the *Youth Justice Regulations* refers to Cancellation of at-risk status, stating:

- (1) A detainee's at-risk status may be cancelled only on the recommendation of a medical practitioner after consultation with the Superintendent or a member of staff authorised by the Superintendent for that purpose.
- (2) After a detainee's at-risk status is cancelled, the detainee must be provided with appropriate follow-up attention by a medical practitioner or other appropriate health professional.

Section 4 of the Manual refers to the procedure to be followed when a young person is placed 'at-risk':

4.1 When any authorised person has grounds for believing that a young person is AT RISK of Self Harm, he or she must immediately:

- (a) notify the Nominated Officer, in accord with usual chain of command; and
- (b) complete a written Declaration to this effect. The writer must take care to correctly complete all sections of this form. On completion, it is to be submitted to the Nominated Officer for inclusion in the detainee's AT RISK file.

4.2 The Nominated Officer must immediately:

- (a) arrange for the detainee to be within view of a Youth Worker at all times until (d) has commenced;
- (b) notify Corrections Medical Services staff (unless they made the initial declaration);
- (c) commence an AT RISK of Self-Harm File
- (d) commence implementation of the Emergency Management Protocol, as defined in Section 6; and
- (e) inform the Delegate that the detainee is AT RISK of Self-Harm.¹²

Section 6 of the Manual refers specifically to young persons at risk of Self Harm. Section 6.1 refers to the Emergency Management Protocol when accommodating young persons in observation bedrooms. Section 6.3 stipulates that:

Throughout the implementation of this protocol, Youth Workers are, as far as possible, to maintain a humane and supportive attitude in their dealings with the detainee and should make active efforts to dispel the impression that any part of this protocol is being applied for punitive reasons.¹³

¹² NT Correctional Services 'At-Risk' Procedures Manual – Don Dale Centre, Wilderness Work Camp & Alice Springs Juvenile Holding Centre, March 2003, section 4, page 9.

¹³ NT Correctional Services 'At-Risk' Procedures Manual – Don Dale Centre, Wilderness Work Camp & Alice Springs Juvenile Holding Centre, March 2003, Section 6, page 11.

Section 6.4 of the Manual refers to preliminary procedures which state the following:

- (a) the detainee is to be observed continuously until placed in an AT RISK room;
- (b) all potentially harmful articles (e.g., pens etc.) are to be removed from the detainee;
- (c) the AT RISK room is to be thoroughly checked for hazardous and/or unauthorised items prior to the detainee being placed in the room;
- (d) all the detainee's clothing is to be removed and he or she is to be dressed in a non-rip gown. Female Youth Workers are to supervise the dressing of female detainees, whilst male Youth Workers are to supervise the dressing of male detainees;
- (e) the AT RISK room is to be furnished with a mattress and bedclothes made of rip-proof material, non-flammable material; and
- (f) the detainee is to be placed in the AT RISK room as soon as the above procedures have been completed and it is otherwise safe to do so. He or she is to be escorted to the bedroom by at least two Youth Workers.¹⁴

Section 7 refers to assessments by health professionals.

7.1 As soon as practicable after a detainee is declared AT RISK of Self Harm, Corrections Medical Services staff must notify Forensic Mental Health.

7.2 Within two hours of a detainee being declared AT RISK of Self Harm, Corrections Medical Services staff must carry out an initial assessment of the young persons. This assessment may be by telephone at the discretion of the Visiting Medical Officer.

Exception: Corrections Medical Services staff need not carry out their own assessment if Forensic Mental Health have already assessed, or made a commitment to assess, the detainee within the two-hour time-frame. This arrangement should be documented in the detainee's file by Corrections medical staff.

7.3 Forensic Mental Health is to assess the detainee as soon as practicable after being notified. Ordinarily, they will assess the detainee within 24 hours of notification. However, when there is a non-working day during this time frame, the response may be slower. In such circumstances, specialist expertise will be available from Mental Health Services through the Psychiatric Registrar On-Call. This service may be accessed at the discretion of the Visiting Medical Officer.¹⁵

The standard practice of notifying FMH that a young person has been placed 'at-risk' at DDYDC is for the YJO/Shift Supervisor to notify CSHC via the generic email and clinical manager's email addresses, but this is not monitored after-hours. The email therefore will not be acted on until the next working day. Upon receipt of the notification, CSHC then initiate a referral onto FMH.

The general theme of the Regulations and the Manual is the YJOs priority to isolate a young person to prevent the imminent threat of self-harm and to alleviate that threat. However, prolonged and often repeated episodes of isolation for extended periods of time were identified. This often led to further outbursts with the young person becoming increasingly more agitated and attempting self-harm. Chronologies of such incidents are contained in

¹⁴ Ibid, Section 6.4, page 11 & 12.

¹⁵ Ibid, Section 7, page 12 & 13.

Case Studies A, B, C and D, all of which highlight an ineffective response to young persons 'at-risk' events.

Case study A (at Attachment A) shows repeated incidents of a young person being placed in an 'at-risk' cell over a 6-day period. This period included several self-harm attempts, visits to the Royal Darwin Hospital (RDH) for treatment and psychological assessments and an eventual transfer to the adult correctional medical facility at Holtze where the young person could be closely monitored.

In the 4 days leading up to the self-harm incident on 7 April 2015, the young person was out of their cell for 3 hours and 40 minutes (aside from the visits to RDH). The young person appeared to be reacting to being isolated and was becoming more agitated upon being left in the 'at-risk' cell. The young person's view of being isolated and its impact is apparent when telling the YJOs:

"...I hate being in this room....why can't I just come out like a normal person...all I want to do is come off risk and be let out of here..."

A pattern of behaviour then developed. The young person would cover the camera and then attempt to self-harm. The YJOs would respond to the self-harm attempt and the young person would again be left in the cell and monitored via the CCTV camera. This behaviour continued for several days, and there were further events of the same pattern in late April/early May 2015.

Case Study B (at Attachment B) shows an event where a young person was placed 'at-risk' over a 3-day period where he continually attempted self-harm. Again, a pattern of behaviour developed. On this occasion the young person was isolated for 1 day and 15 hours (aside from a 15 minute visit to the medical centre). The ongoing episodes of attempted self-harm again show the ineffectiveness of the isolation and the need to consider other avenues. Attachment E shows video footage of a 'typical' operational response to this behaviour, failing to attempt to de-escalate the situation or negotiate with the young person.

The above events would suggest that isolating the young persons in an 'at-risk' cell for extended periods is not effective. Ongoing episodes of attempted self-harm, agitated and sometimes aggressive behaviour are evident. The majority of officers interviewed agreed. The Deputy Superintendent's views provide a potential alternative, even considering staffing constraints, stating:

"...Let him out of his room and you have an officer with him and if he carries on you go out and leave him but he's out of his room so he's not confined. I tried to get this implemented with Ken; I tried to get it implement with Vic. I'm happy to do it. I've seen the benefits of it but the other side of it is you've got to have the staff, but what's different, a kid consistently playing up and you got to keep opening the door, going in and shutting the door, opening the door..."

The OIC of ASYDC shared the same view, stating:

"...I find that a lot of the kids that threaten self-harm, it is best to just sit down with them and talk to them..."

The incident highlighted in Case Study C (at Attachment C) involves a young person being placed 'at-risk' for 4 days, 16 hours and 33 minutes without being seen by FMH. The young person was isolated in the 'at-risk' cell for the majority of the time, and was only taken from the cell to attend court and for one hour recreation time each day and shower time. It was established that there was a major break-down in communication between DDYDC, Department of Health - Correctional Services Health Centre (DoH - CSHC) and FMH staff. The process for making a referral to FMH was not followed. Although the initial 'Notification of Concern - At Risk/Self Harm/Suicide' was submitted to the Shift Supervisor, the next step as outlined in Division 3(2) of the *Youth Justice Regulations* was not completed, which had a knock-on effect leading to a breach of section 7.1 of the Manual. The nurse failed to enquire as to the whereabouts of the 'at-risk' Individual Management Plan on 18 September 2015, therefore it was not identified that one did not exist and that no referral to FMH had been made.

The consequence of a break-down in communication of this nature is made clear by a comment made on the Medical Progress Notes:

“...clients being placed in At-Risk cells for this amount of time without an assessment; over time, this could have an unhealthy negative impact on the client’s mental health and wellbeing...”

At interview, the Forensic Team Manager and District Manager of CSHC acknowledged that this could have been avoided and they have since taken steps to ensure the issue does not reoccur. One of the immediate steps introduced was a flowchart that has been distributed for all three agencies to comply with. This flow-chart is an uncomplicated diagram setting out the process of notifications in relation to a young person requiring medical services when they are placed 'at-risk'. This is a welcome development.

The HSU at DDYDC has been operating since May 2015. Young persons placed 'at-risk' are now accommodated in the HSU. The unit is staffed from 7am to 7pm. After this time the Communications Centre monitor the unit via the CCTV cameras. Several of the 'at-risk' episodes examined by the OCC have occurred after-hours. The incidents that pose the greatest risk to NTDCS occur when the HSU is monitored only by CCTV. The Communications Centre cannot adequately monitor and respond to any 'at-risk' behaviours or critical incidents when they are situated some distance away from the HSU. Physical observations are necessary in order to limit the period of 'at risk', if the staff member is not interacting with the young person this cannot be achieved.

All officers interviewed were asked about their own views on the way young persons 'at-risk' are managed. The general consensus was that they felt it was the most challenging part of their role and they had limited capacity to deal with it. Some of the more experienced officers detailed their thoughts on how they try to deal with each episode and how the processes need to be refined.

A shift supervisor provided this insight:

“...I don't think you can ride two ponies at once. You can be a YJO, but you can't be a mental health worker and you can't take all the individual elements and become good at all of them. Sure it's good to have an understanding and an appreciation but you're not mental health workers and you need to leave that to the professionals...but as far

as any broad scale intervention goes it must be left to the people, the experts in the field. I don't believe we're on the same page, needs to be more cohesive..."

This highlights the need for a collaborative approach for 'at risk' procedures to be effective. If such an approach is not taken, the procedures alone, as highlighted by the attached chronologies, can only be described as punitive as they offer no therapeutic assistance.

The 'at-risk' practices and procedures can only be productive and beneficial to the mental wellbeing of a young person when adequate medical intervention accompanies the isolation.

Such extended periods of 'at-risk' classification tend not to facilitate the YJOs in maintaining a humane and supportive attitude as required by Section 6.3. Such periods of isolation may prove detrimental and damaging to young persons in detention who are, by definition, vulnerable. This is highlighted by comments made by the same shift supervisor:

"...there's a vast majority of young people that come in detention that are suffering from a mental illness, or a pseudo mental illness. If you look at K for example, and the behaviours that escalate into the full on, full blown 'at-risk' episodes that we're talking about here, when they're prolonged over a period of time and yes, she might not be suffering from a mental illness, but anything that becomes a pattern and normal, after a while if its pattern and normal it's just as dangerous as if it was a full blown mental illness we need to look at those things quite more intensely, I believe, to get it right..."

The Article "*End Isolation Cells: Dutch NGO's*" by the International Detention Coalition highlights the negative consequences of isolation on the health of a young person. Suicidal thoughts, behaviour, emotional breakdown, chronic depression, uncontrollable anger, hallucinations and high blood pressure are among the negative consequences of a young person being isolated. Children with developmental disabilities or psychosocial problems should not be isolated; they may respond in unpredictable ways and be unable to convey how a period in isolation is affecting them. Periods of isolation stretching to 4 days cannot be justified and must be recognised as a failure to adequately care for a young person.

Rule 28 of the Havana Rules details the protective approach that should be taken to those young persons susceptible to 'at risk' periods:

"The detention of juveniles should only take place under conditions that take full account of their particular needs, status and special requirements according to their age, personality, sex and type of offence, as well as mental and physical health, and which ensure their protection from harmful influences and risk situations."

It further stipulates the reasons which can justify the separation of detainees as occurs when 'at risk':

"The principal criterion for the separation of different categories of juveniles deprived of their liberty should be the provision of the type of care best suited to the particular needs of the individuals concerned and the protection of their physical, mental and moral integrity and well-being."

The investigation found there was a need for a full review of the 'at-risk' procedures. The intention of providing case studies in this Final Report is to highlight that isolating a young person who is self-harming or threatening self-harm can be detrimental to their well-being if they are not managed appropriately and the response is not co-ordinated between the agencies. The recommendations are intended to address these issues.

The OCC acknowledges that prior to the First Draft Report being finalised, NTDCS were undertaking a full review of their 'at-risk' procedures. The OCC expected that any changes to the procedures would be implemented to ensure that periods of isolation are an absolute last resort and are replaced with therapeutic and preventative methods in dealing with those young persons who are placed 'at-risk'. This should include identifying a crisis ahead of time, taking remedial action, and maintaining close contact with the young persons during their 'at-risk' episode where it is necessary to isolate. This is to attempt to limit any period of 'at-risk' to the shortest period possible.

Recommendations re: Issue One – Management of young persons 'at-risk'

1. Northern Territory Department of Correctional Services and the Department of Health maintain collaboration in reviewing and updating the '*At Risk Procedures Manual*' and the '*Youth 'At-Risk' Procedures*' and associated service agreements to ensure operational effectiveness of managing young persons placed 'at-risk'.
2. Northern Territory Department of Correctional Services and the Department of Health examine alternative options, other than the de-escalation rooms, for young persons placed 'at-risk'.
3. Northern Territory Department of Correctional Services to give written notice to the Office of the Children's Commissioner, as soon as practicable, if a young person 'at-risk' has not been seen by a medical practitioner within 24 hours of being placed 'at-risk'.

Issue Two – Inadequate service intervention for young persons being placed 'at-risk' on repeated occasions

Following on from the above, the inadequate service intervention for young persons placed 'at-risk' was identified by the OCC.

Regulation 41 of the *Youth Justice Regulations* stipulates that an Emergency Management Plan (EMP) or an Individual Management Plan (IMP) **must** be put in place. The EMP and IMP were seldom completed in cases reviewed by the OCC. The plans that did exist on file contained generic, non-individualised responses; there was little consideration of the individual needs of each young person to appropriately address and limit the length of the 'at-risk' episode. This is highlighted in all chronologies attached.

The timeliness of the young person being seen by a Medical Practitioner is inadequate and therapeutic intervention provided by the Department of Health is limited to a risk assessment

of self-harm rather than an ongoing management plan to address and limit the need for ongoing 'at risk' classification.

Case Study A shows a clear lack of intervention from services provided by FMH. During the five day 'at-risk' episode, the young person was conveyed by ambulance to RDH for self-harm attempts on three occasions. On each visit to RDH, an assessment was conducted by the Crisis Assessment Triage Team (CATT). On each of those occasions a referral to FMH was made by CATT. FMH did not attend the DDYDC to follow up on those referrals until 7 April 2015, four days after the first referral was made. The young person's IMP was not reflective of the assessments made by CATT.

During the interviews the OCC conducted, it was conceded that the period during which the above situation occurred was a highly volatile one, with two other high-risk young persons being placed 'at-risk' and numerous incidents occurring over the Easter period where there was minimal intervention by Medical and FMH after-hours. The YJOs discussed a lack of consultation with the professional medical staff as to how best deal with those young persons, and they felt helpless and unsupported. The absence of such guidance will have an impact on the effectiveness of any 'at risk' period and will hinder a positive outcome.

The chronology of Case Study B again highlights the inadequate collaboration between providers in protecting the health of young persons. In this instance, a young person sustained an injury to their hand from striking his cell door during a period of isolation. The officers sought advice from CSHC in relation to the injury. The advice received was for the young person to be escorted to RDH for x-rays; however the Deputy Superintendent did not approve the escort to RDH due to the associated risks. This led to the young person being deprived of medical attention in contravention of Regulation 59(2) of the *Youth Justice Regulations*. At interview the Deputy Superintendent sought to justify his decision and stated that this could have been avoided if CSHC were able to attend and make a medical assessment, and administer pain relief. It is unacceptable that a young person in need is deprived of medical attention due to the lack of an alternative to attending RDH. Had this situation occurred at the DCC Holtze, medical staff would have, at least, been able to administer the young person with pain relief.

There is a lack of dialogue between the service providers which is hindering positive outcomes for the young persons. The services provided to DDYDC by the CSHC are limited, as they are only able to provide a nurse on site from 9.30am to 2pm at the latest. During these hours the nurse is limited in seeing the young persons due to school and court commitments, as well as the YJO staff having the capacity to escort the young persons to see the nurse. After these hours, the medical staff is based at DCC Holtze and can only provide a limited service until 9.30pm when the centre becomes reliant on the on-call nurse.

The Deputy Superintendent was of the view that CSHC's role is to provide a service and they have an on-call facility where they are contracted to attend DDYDC. All other officers interviewed agreed that having a full-time nurse on-site and better access to CSHC after-hours would be beneficial in avoiding incidents like the ones described. This would lead to a better response to and management of those 'at risk'.

The OCC received some feedback on potential remedies which are provided for your information. CSHC management believed that to improve communication, the Shift Supervisor could liaise with the on-duty nurse on a daily basis to discuss any incidents, such

as young persons being placed 'at-risk' overnight. Management of CSHC were of the opinion that having a full-time nurse at DDYDC would be a waste of resources as they are rarely used when they are there. They also believed it would require extra funding. The OCC suggests better collaboration and utilisation of available services together with more suitable servicing hours and the provision of on-call support.

CSHC management did believe there was a need for a full-time psychologist at DDYDC, one that could deal with the 'at-risk' situations. Adequate FMH services are fundamental to the successful care and management of such complex young people.

The importance of individualised management plans with attention given to the specific traits and circumstances of the young person cannot be understated. The obligation of service providers to ensure a young person is examined as soon as practicable by an appropriate health professional is paramount.

The recommendation that has been made is based on policy of the Queensland Department of Justice and Attorney-General which stipulates that:

'... the suicide risk assessment team will meet as soon as possible, but no later than the next business day, following the identification of an at risk young person to assess the young person to determine a level of risk and to finalise the management plan...'¹⁶

The policy further states:

'...interventions and management strategies must meet the individual needs of the young person and be provided in a timely manner...'

Recommendations re: Issue Two - Service intervention to young persons 'at-risk'

4. Explore options for continuously monitoring a young person 'at-risk' that complies with the Emergency Management Protocol in the *Youth Justice Regulations* and is consistent with the Northern Territory Department of Correctional Services *At-Risk Procedures Manual* and the Department of Health *Youth 'At-Risk' Procedures*.

Issue Three – Inadequate 'at-risk' attire and bedding

There is an issue with the adequacy of 'at risk' attire and bedding being provided to young persons. It is clear that they do not satisfy the requirements of Regulation 42 of the *Youth Justice Regulations* which refers to the Emergency Management Protocol that is prepared in relation to the accommodation of 'at-risk' young persons. Regulation 42(2)(b) states that the room must be furnished with a mattress and bedding made of **rip-proof** (emphasis added) and non-flammable material. Sub-regulation 2(d) states that the young person is to be clothed in rip-proof material and all potentially harmful items must be removed from the young person's possession. These provisions are echoed in the Section 6.4 of the Manual.

¹⁶ Queensland Department of Justice and Attorney-General Policy: Youth detention – Suicide and self harm risk management, YD-1-6, section 4.1, pg. 3.

The inefficiencies are highlighted by the ability of young persons to rip the clothing which has in the past been used as a ligature. This leads to situations where young persons are left without clothing and bedding during periods of 'at-risk'. This occurred in the event in Case Study B and the video footage at Attachment E where the young person covered the camera and attempted self-harm by tying material they ripped from the 'at-risk' sheet around their neck. The piece of material was removed by the YJOs. The YJOs returned six minutes later and physically restrained them while the mattress and bedding was removed from underneath them. The young person was left naked for a period of 10 hours and 55 minutes, and without any bedding for 12 hours and 18 minutes.

Interviews conducted with YJOs and COs revealed that the 'at-risk' attire and bedding was susceptible to tearing once a loose thread was found. The majority of officers interviewed had seen this occur. Many of the officers interviewed agreed that getting a young person into the 'at-risk' clothing was one of the challenging parts of their role but they had to follow the Regulations and the Manual, which stipulates they must put the young person into 'at-risk' clothing. The OIC for ASYDC shared his view of the 'at-risk' clothing, stating:

"...I don't like the policy of having to put 'at-risk' clothing on detainees...it's horrible; it's confronting for them and it's hard for the staff to achieve..."

The United Nations Convention on the Rights of the Child states:

16. No child shall be subjected to arbitrary or unlawful interference with his or her privacy...

37(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age.

The OCC are of the view that the stripping of a young person due to the inadequacies of the clothing provided is in breach of the above and that no young person, particularly in such a vulnerable state, should be left naked. As stated above, a child shall be treated in a manner which takes into account their needs and this practice fails to give due consideration to the trauma already experienced by many of the young persons in question.

Effective procedures and safety audit practices for the maintenance and replacement of 'at-risk' attire and bedding requires urgent implementation, not only to prevent young persons' self-harming, but also to prevent further breaches of the *Youth Justice Regulations* and the Manual. Whilst all occurrences of ripping 'at risk' clothing may not be preventable, some may be by regular audits and the replacement of those defected. The OCC believe that further efforts should be made to explore obtaining higher standard rip-proof clothing.

The recommendations involving audits of 'at-risk' clothing and bedding emanated from the case studies, which highlighted the susceptibility of these materials to be torn by young persons, causing further risk of self-harm. The purpose of the audit would be to ensure that the quality of clothing and bedding is to standard, to address issues of quality, quantity, appropriateness (i.e. suitable sizing) and condition. An audit would assist NTDCS to keep track of current stock, as the investigation found that any inspection of stock was on an ad-hoc basis, and was not adequate in identifying any loose threads that the young person could easily pick and ultimately tear the material, creating a further risk.

Recommendations re: Issue Three ('at-risk' attire and bedding)

5. Conduct and record regular internal audits of all 'at-risk' clothing and bedding held at both Youth Detention Centres to ensure each item to be issued to a young person placed 'at-risk' is in a sufficient condition (no loose threads) and there are appropriate stocks to cater for all sizes.

Issue Four – The use of the Hoffman Tool to remove clothing from young persons

Through the investigation the OCC identified a common practice of using the Hoffman Tool to cut clothing from young persons. This practice was prevalent when young persons had been placed 'at-risk' and reported as being "non-compliant" and subsequently restrained while their clothing was removed with the Hoffman Tool.

The Hoffman Tool is commonly referred to as the 'Hoffman Knife' by NTDCS staff; its correct name being the Hoffman 911 Rescue Tool. It is a tool designed to enable quick and effective release in hanging attempts. It is generally used by emergency services, particularly by first responders such as paramedics and police. This tool is well regarded as a useful tool in other trauma situations such as being suitable for cutting seatbelts etc. The tool cannot be used as a weapon to slash or stab yet it will safely and rapidly cut all clothing and material including leather rope or tubing. Its unique design enables it to be used to cut items from close to the skin without the danger of cutting the client.¹⁷ There is a degree of training required to use the tool effectively, without injuring any persons, in particular the persons using the tool.

A picture of the Hoffman Rescue Tool 911 is depicted below:¹⁸



¹⁷ Northern Territory Government Remote Health Branch – Best Practice Communique, 05-16.

¹⁸ Northern Territory Government Remote Health Branch – Best Practice Communique, 05-16.

One concerning aspect of this practice is the failure to consider other options available. There appears to be little by way of de-escalation and negotiation and an almost frantic approach is taken to the need for the removal of the clothes.

Several incidents of this nature were scrutinised by the OCC. CCTV footage of the event at Attachment F provides visuals of the practice where the young person had covered the camera with wet toilet paper. Four YJOs attended the cell and found the young person lying face down on the mattress, and non-responsive. The young person was immediately held down, handcuffed and stripped of his clothing (by the Hoffman Tool). All of the bedding was also removed from the cell. The young person was left naked and without bedding for 1 hour and 17 minutes. This response led to breaches of Regulation 42(d) of the *Youth Justice Regulations* and section 6.4(e) of the Manual, as the young person was left without 'at-risk' clothing or bedding.

At interview the YJOs involved stated they were following instructions to remove all items from the cell and the young person was not responding to them so they believed the young person was being non-compliant. No attempt was made to negotiate with the young person to remove their own clothing. This practice is akin to that of strip searching which is criticised where used other than as a last resort. The UN Convention on the Rights of the Child states children in detention should be treated appropriately having regard to their needs. Often children in detention have been physically, sexually or emotionally abused and this practice of stripping a young person of their clothes with an implement needs to cease immediately. No consideration is given to the consequences of this practice (i.e. on the emotional wellbeing of the young persons and the associated risks).

During the interviews the YJOs had varying accounts of where the Hoffman Tool was kept, who was authorised to use it and for what purpose, and the training they had received in the use of the tool. Some YJOs stated that they were not trained to use it and therefore not authorised, while others were of the belief that all YJOs had received training in its use.

Despite the purpose of this tool being to enable quick and effective release of material used in hanging attempts, comments made by YJOs during their interviews showed that a number were not aware of the Hoffman Tool's sole purpose, and in fact described the tool as the first option to use to remove the clothing of a non-compliant detainee. For example:

"...when a detainee is placed 'at-risk' it is appropriate to use the knife...if a detainee is non-compliant in removing their clothing and putting on the 'at-risk' clothing..."

"...if he was restrained on the ground his clothing would have been pulled off or cut off with Hoffman knife. No covering was provided, no-one could see his bits anyway...there was an immediate need to put on 'at-risk' clothing, because of previous episodes where he has used shorts to self-harm...it's a preventative measure..."

"...one is kept in each office. It's designed so you can get it under the clothing, cutting stuff off is pretty easy. It is used every time there is a self-harm episode. If the detainee is compliant, they stand at the back of the cell, a strip search, like a new admission, hand over their clothes and put on new 'at-risk' clothes. If the detainee is not compliant, then we have to cut their clothes off..."

“...it’s only used to remove the detainee’s clothing. If the young persons do comply, they hand over their clothing. If you can see that they won’t comply, then we use the Hoffman knife ...”

“...it is used to cut ligatures from detainees, and it can also be used to cut flexi-cuffs, and clothing if the situation is deemed that the young person must have their clothing removed (when they’re ‘at-risk’ and refusing to remove their clothing). I am inclined to try and draw that out (the time to remove clothing)...”

Other comments made during the interviews show some of the physical risks of the Hoffman Tool, in particular where there is an absence of training and guidance:

“...it is a straight out dangerous tool...it’s always risky...it’s not the best tool as it sometimes leaves material around the neck...”

“...there is a risk associated with the use of the Hoffman knife. A staff member snatched it out of another staff member’s hand and nearly cut his finger off. There is no official training on use of the Hoffman knife. Accidents can happen. It’s a pretty sharp tool...”

“...I’ve never been trained to use it but I’ve used it about 30 times...it’s always for a reason...justified and for safety...”

No reference is made in NTDCS policy or procedures to the use of the Hoffman Tool in removing clothing from a young person. Nor is there any reference to procedures in circumstances where a young person refuses to remove their clothing.

NTDCS use other legislative, non-specific means to govern the use of the tool. Section 153 of *Youth Justice Act* is the provision relied upon by the YJOs. This section describes when the superintendent of a detention centre may use force that is reasonably necessary to maintain discipline. Reasonable force may be used in an emergency situation and when a young person should be temporarily restrained to protect the young persons from self-harm or to protect the safety of another person. The force used in the circumstances explored by the OCC was justified (by the YJOs) as being reasonable to protect the young person from self-harm and/or to protect the safety of YJOs. Justifying the use of the Hoffman Tool with Section 153 of the *Youth Justice Act* when used as a first option is concerning as it fails to consider the ability of YJOs to alleviate any perceived existence of an “emergency situation”. The ability to justify something by legislative provision does not mean it is the most suitable approach and it undoubtedly fails to have regard for the young person’s dignity and self-respect as per regulation 73(2) of the *Youth Justice Regulations*.

This practice of stripping stems from regulation 42 of the *Youth Justice Act* and section 6.4 of the Manual which states that the young person placed ‘at risk’ must be clothed in rip-proof material. This is a mandatory requirement, however in the events reviewed by this office there was no clear negotiation with the young person to attempt to achieve compliance and have the young person change their clothing themselves. There is no evidence in the event detailed in Case Study B that the young person was non-compliant. It is apparent that there was minimal planning by the YJOs, and an absence of negotiation with the young person.

The OCC maintains that the practice of using the Hoffman Tool to strip a non-compliant young person is unacceptable. This is echoed in other jurisdictions, such as Queensland, their policy is very clear, stating:

'...under no circumstances can force be used to change a young person into suicide prevention garments. Such behaviour is not authorised under the Youth Justice Act 1992 and may result in staff being referred to the Department's Ethical Standards Unit and / or the Queensland Police Service as an alleged assault...'¹⁹

Section 6.3 of the same policy states the following:

'...If the suicide risk assessment team has recommended the young person be provided suicide prevention garments and the young person refuses to wear them, staff must provide continual visual observation of the young person until the young person agrees to wear the garment, encourage the young person to wear the garments and do not force a young person into suicide prevention garments...'²⁰

The OCC suggests the approach of other jurisdictions be followed: in a circumstance where the young person's clothing has to be removed for safety purposes, continual visual observation of the young person should be provided until they agree to change into the clothing. This course of action is adopted by other jurisdictions and is in compliance with the *Charter of Human Rights* and the *Havana Rules*. The suggestion to encourage the young person to wear 'at-risk' clothing is something that can be explored in de-escalation and negotiation training.

Recommendations re: Issue Four - Hoffman Tool

6. Immediately prohibit the use of the 'Hoffman Tool' to strip clothing from a young person who is refusing to change into 'at-risk' clothing.
7. Develop policy and operational procedures to address the appropriate use of the Hoffman Tool to remove ligatures in Emergency Management / Critical Incidents.

¹⁹ Queensland Department of Justice and Attorney-General, Youth Justice Policy: Youth Detention – Suicide and self harm risk management, YD-1-6, section 6.2, pg. 4.

²⁰ Ibid.

Issue Five – The use of restraints on a young person placed ‘at-risk’

Case Study D (at Attachment D and H) involved a young person who had been transferred to the adult facility on a Behavioural Management Placement (BMP), he was then placed ‘at-risk’ for threatening self-harm and placed in an Emergency Restraint Chair for almost 2 hours.

A still from the footage:



The OCC believes the use of restraint in this incident was likely unlawful, in addition the type of restraint used, namely an Emergency Restraint Chair, was also likely unlawful.

The *Youth Justice Act*, as it was at the date of the incident, allowed for the use of “handcuffs or similar device” as restraint. The OCC does not accept that an Emergency Restraint Chair falls within such a definition, in contradiction to the *Youth Justice Act*, NTDCS Directive 3.1.6 (which relates to the ‘Use of Restraints’) does permit the use of an Emergency Restraint Chair. It is unclear what legislative basis permits such restraint.

Section 1.1 of the above mentioned Directive outlines that YJOs are authorised to use approved instruments of restraint when deemed necessary for the maintenance of the security and good order of a detainee, a youth detention centre or other persons.

The authority to use restraints contained in Directive 3.1.6 has a lower threshold than that contained in section 153(3)(d) of the *Youth Justice Act*. Under the Directive, an approved instrument of restraint may be used where the maintenance of the security and good order of the centre requires such use, the legislation however sets the bar higher stating that handcuffing or use of similar devices to restrain normal movement can only be used where an emergency situation exists and (emphasis added) a detainee should be temporarily restrained to protect the detainee from self-harm or to protect the safety of another person. Therefore what is deemed reasonable under the Directive is likely to not meet the legislative threshold and was likely unlawful.

It was clear during the interviews that it was the Directive that was relied on to satisfy the use of restraints, therefore no assessment of the existence of an “emergency situation” was made by the staff.

Further guidance on the use of restraint is provided by Sections 6.6 and 6.7 of the NTDCS ‘at-risk’ Manual which refer to restraints being used on a young person who is ‘at-risk’:

- 6.6 Physical restraints may be used to reduce the likelihood or opportunity to self-injury or other behaviour tending towards self-harm. The use and duration [of use] of such restraints must be kept to a minimum and is to be closely monitored and documented.
- 6.7 Should the Delegate authorise the use of restraints, it must always be accompanied by urgent referral to Forensic Mental Health staff or Corrections Medical Services staff. It is preferable that this referral occurs before the use of the restraints is authorised.²¹

A review of CCTV footage revealed that the young person had been placed in an Emergency Restraint Chair for 1 hour and 55 minutes, with a spit hood placed over his head for the entire time. The lead up to the use of the Emergency Restraint Chair involved a transfer of the young person from the ASYDC to the ASCC for a BMP, and then transferred to an ‘at-risk’ cell after he threatened self-harm.

The young person had covered the camera with wet toilet paper and had been observed chewing on the mattress. When COs attended the cell the young person was restrained with hand-cuffs and held at the judas hatch²² while the COs removed all the items from the cell. When the COs were preparing to remove the handcuffs, the young person became agitated when he was informed that the mattress was not going to be replaced. The young person was vocal in stating that he was being punished for his ‘at-risk’ behaviour (contravening section 6.3 of the Manual).

The young person became agitated and threatened to spit at the COs. The OIC informed the young person that “...*once he had calmed down they would assess it...*” (being the return of his mattress). The CO proposed the “use of the restraint chair” to the young person as an apparent option in order to achieve compliance. The young person’s behaviour heightened with this and resulted in threats of self-harm. The young person was then placed in the Emergency Restraint Chair.

The OIC explained his reasoning for instructing that the young person be placed in the Emergency Restraint Chair:

“...he was already handcuffed, so as to prevent the detainee from self-harm and [give the young person] a chance to calm down and give him [the OIC] a chance to assess what was going on and contact the appropriate people...”

²¹ NT Correctional Services ‘At-Risk’ Procedures Manual – Don Dale Centre, Wilderness Work Camp & Alice Springs Juvenile Holding Centre, March 2003, Section 6.6 & 6.7, page 12.

²² Judas hatch – a hatch within the cell door which folds down to allow things to be passed through the hatch without the need to open the cell door.

The justification provided by the COs for placing the young person in the Emergency Restraint Chair was noted in the journal:

“...failed to comply with instructions and placed in restraint chair...”

The circumstances that existed at the time when the young person was placed in the Emergency Restraint Chair do not satisfy either the threshold of the Directive or legislation.

Upon viewing the footage the OIC conceded that the young person had not made any threats of self-harm when the restraint chair was first mentioned. The OIC maintained that he wasn't using the restraint chair as a threat and felt that he was justified in using it as per Directive 3.1.6.

The use and duration of the Emergency Restraint Chair was not justified nor was it kept to a minimum. No referral was made to FMH or CSHC staff relating to the use of the Emergency Restraint Chair as required by 6.7 of the Manual. The young person was not seen by FMH for another 9 hours.

There were broader concerns relating to the use of restraints highlighted in comments made by the COs who felt that there was no other option available to them in this particular case. The OIC summarised his thoughts in stating:

“...he wasn't out of control, medical don't like to sedate, once that threat was made I put him in the chair and then medical could have assessed it after that. I've used the chair before and I think it's the best option, compared to other restraints we've used in the past (i.e. hog-tied, put helmets on them etc.)...the chair poses the least risk to prisoners, and is heaps better than other options...”

Another CO involved with the use of the restraint chair informed investigators that even though the threat was considered to be 'flippant' they still needed to address it. He further stated:

“...it was the natural progression to use the restraint chair. We could keep an eye on him so he couldn't self-harm...”

This displays a clear misunderstanding of the internal and external framework authorising the use of restraints.

The use of restraints in such a way as the use of the Emergency Restraint Chair contravenes the *Charter of Rights for Children and Young People in Youth Justice Facilities*. The Charter provides that a young person has the right:

“not to have force used against you, or restraints used on you, unless absolutely necessary, and never as a punishment.”²³

Any use of force must be reasonable and proportionate; neither being apparent in this incident. Rule 64 of the *Rules for the Protection of Juveniles Deprived of their Liberty* states that force can only be used in exceptional cases “where all other control methods have been exhausted and failed”. The OIC concedes above that the young person “wasn't out of control”, he was already handcuffed and “the chair was utilised to give him a chance to calm down” and a

²³ JDL 63-64 – UN Rules for the Protection of Juveniles Deprived of their Liberty: the 'Havana Rules' (1990).

“chance to assess and contact appropriate people”, and as such no exceptional circumstances existed.

Case Study D also depicts the use of a spit hood. Spit hoods (also known as “spit masks”) are made of a breathable material of bacteria-filtering, medical grade fabric which helps contain contaminants. The spit hood is placed over the head and is held in place with elastic. They are used to prevent the transfer of diseases from spitting and biting. When improperly used, the risk of inadequate ventilation and eventual asphyxiation is dramatically increased.

Interviews conducted with YJOs revealed inconsistent application with regards to the use of spit hoods. Those interviewed stated they are generally used on young persons who continually and routinely spit on officers, but they were unable to identify the applicable policy or procedure for their proper use. None of the YJOs interviewed could recall being trained in applying the spit hood correctly. Policy and procedures relating to the use of spit hoods should be implemented; their use should also be documented on IOMS.

The use of the Emergency Restraint Chair in Case Study D highlighted the situation was not an emergency and therefore the use of this restraint was unjustified and contravened section 153(3)(d) of the *Youth Justice Act, the Charter of Rights for Children and Young People in Youth Justice Facilities*, the *Havana Rules* and NTDCS Directive 3.1.6 (issued 6 May 2015).²⁴

The OCC acknowledges that the ‘Use of Restraints’ Directive 3.2.1 re-issued January 2016 determined approved restraints were handcuffs, ankle cuffs and waist restraining belts, but did not include the Emergency Restraint Chair (as opposed to the previous Directive 3.1.6).

The introduction of the *Youth Justice Amendment Bill 2016* that came into effect on 1 August 2016 does provide for the use of mechanical devices of restraint, including the Emergency Restraint Chair.²⁵ The OCC has continuing concerns around any proposed use of an Emergency Restraint Chair; it is not accepted by this office that any circumstance would warrant such a response and the OCC continues to wholly disagree with its use.

Prior to the passing of the *Youth Justice Amendment Bill 2016*, the OCC provided comment on two occasions outlining its dissent for the Bill. The comments made relate to the OCC’s concerns in expanding the criteria for when restraints may be used, and disputed the merits of using restraints on young people. The OCC cannot support the use of an Emergency Restraint Chair irrespective of the development of standards of use. The recommendation has therefore been amended to the use of the Emergency Restraint Chair be strictly prohibited.

The divergence of opinion between the OCC and NTDCS regarding the ongoing use of the Emergency Restraint Chair cannot be resolved by this investigation. As such, the OCC has determined that informed public discussion would assist the promotion and understanding of the rights, interests, and wellbeing of vulnerable children. This is a function of the Children’s Commissioner under section 10(1)(h) of the *Children’s Commissioner Act*.

²⁴ Appendix A of Directive 3.1.6 issue date 6 May 2015 names the Emergency Restraint Chair as an Approved Instrument of Restraint.

²⁵ The *Youth Justice Amendment Bill 2016* inserted s151AB of the *Youth Justice Act*, where the Commissioner may approve a mechanical device (an **approved restraint**) for restricting the movement of detainees.

With regards to the use of restraints in general terms, the OCC acknowledges that the issue of the review of the 'Use of Restraints' Directive has been referred to the YDRPAG for consideration. The OCC is mindful that the existing directive and procedures are going to be reviewed and amended on the advice of the YDRPAG. It is hoped that the Advisory Group will develop evidence-based policy and procedures which allow for the use of restraints only in the strictest circumstances, as a last resort.

Whilst the spit hood may not be a restraint in the strict sense, its use will not always be in isolation and is most likely used in conjunction with another form of restraint. The spit hood is likely to cause discomfort and distress to the young person and as such, its use should be limited. The OCC acknowledges that the Chief Minister recently instructed that the use of spit hoods on detainees cease. For the sake of future potential amendments to that instruction, the OCC suggests that the use of the spit hood is governed by equally strict policy and procedures as those relating to the use of restraints. In regards to the training aspect of the spit hood, the OCC acknowledges that this is best dealt with under the training issue and a separate recommendation will be made.

Recommendations re: Issue Five – Use of Restraints

8. The use of the Emergency Restraint Chair is strictly prohibited.
9. Continue using 'Use of Restraints' Directive 3.2.1 until such point that the Youth Detention Restraint Practice Advisory Group develops evidence-based policy and operational procedures in restraint practices.
10. Develop policy and operational procedures to address the appropriate use of a spit hood.

Issue Six – Staffing and Training

Insufficient Staff necessary for managing 'at-risk' periods effectively

The responses provided to the young persons involved in this investigation who were placed 'at risk' were affected by both the level of training of the staff involved and demands on the staff at that particular time. Such variable factors result in inconsistent and at times disproportionate responses. The responses often lacked foresight, thought and any acknowledgement or consideration of alternatives as indicated by COs and YJOs during interview. The incidents referred to at Attachments B and D highlight this.

An example of this is the inability to utilise the option of having an officer sit outside the cell and have constant observation of the young person and/or constant engagement during periods of 'at risk'. The YJOs interviewed in relation to the events involving Case Study A all agreed that they felt that the only interim solution was to have a YJO with the young person for the entire period they was 'at-risk' but that was too labour-intensive and not feasible with their rosters, so they just "made do".

The OIC of the restraint chair incident stated:

“...in something like this, I could spend an hour trying but that still might not achieve anything, but we’re responsible for the whole gaol with 8-10 staff on. It’s just not a practicality...”

The Deputy Superintendent shared his views on the potential difference in having adequate staff when dealing with an ‘at risk’ young person:

“...At Holtze, if a prisoner goes ‘at-risk’ they go to a medical where the ‘at-risk’ cells are and there’s an officer watching them...but we can’t do that because there’s only a skeleton staff on after 7.00 pm...I’m a big believer in supervising them in an open area, I’ve seen it work down south but it’s labour intensive...”

Young persons placed ‘at risk’ should not be disadvantaged by staff shortages and practices should be as beneficial as those afforded to adults in DCC. Verbal and physical interaction with the young person ‘at risk’ is required to limit the period and facilitate their return to the general detention centre population.

Recommendations re: Staffing

11. Conduct a review of the High Security Unit to establish operational capacity to staff the unit 24 hours, 7 days a week.

Training of Youth Justice Officers

All officers interviewed had varying degrees of training. The issues highlighted were that there was insufficient ‘refresher’ training and a lack of consistency in the training provided.

In 2015 a revised course was introduced for YJOs. This training is described in the YJO ‘Recruitment Information Pack’ as an intensive off-the-job training course of eight weeks, which will incorporate a number of shifts in the Detention Centre.²⁶ YJOs initially enter into a temporary contract to successfully complete the Certificate III in Correctional Practice (Youth Custodial). None of the officers interviewed had undertaken this training.

Generally those YJOs that had been with the department for more than 3 years undertook very limited training, with some only receiving a 2-day induction and 3 days of PART²⁷ training. PART includes restraint techniques, the use of handcuffs and a brief overview regarding the restrictions on the use of force contained in the *Youth Justice Act*.

PART was the training method for YJOs during the period considered in this investigation. It was designed to equip officers with the skills to appropriately respond to challenging and aggressive behaviours or violence displayed by young persons. If properly applied, PART techniques provide a range of responses that can be legally, ethically and physically appropriate to challenging and/or violence behaviours. The PART training provider, MTU Training Concepts recommends annual refresher training.

²⁶ NTDCS Youth Justice Officer Recruitment Information Pack, page 5.

²⁷ PART – *Predict, Assess & Respond To Aggressive/Challenging Behaviour* (facilitated by MTU Training Concepts Pty.Ltd).

The YJOs completed some on-the-job training in the form of 'shadow shifts' when they were first employed, but subsequently relied on directions from senior YJOs or shift supervisors. The YJOs interviewed all agreed the training was not sufficient.

These officers had also recently been provided the opportunity to complete a workbook for the Certificate III in Correctional Practice (Youth Custodial), but only some had considered that option and sought the workbooks.

Generally, the view was that training for YJOs has evolved over the past few years and improved, but had left some inconsistencies in how things are done. The YJOs who had worked under the newly structured HSU were of the view that the training they received from COs was invaluable.

Three of the officers interviewed were undertaking training to become a CO, after being a YJO. All three officers held the view that the training they had received to become a YJO was insufficient and required improvement, particularly in the way critical incidents are dealt with. One officer believed that although the training for YJOs had improved, more training was needed to slow down, monitor and reassess the situation as it unfolds. He was of the belief that due to the lack of training, YJOs are too hasty to react to situations and they need to be trained to "*step back and assess the situation first before rushing in*".

Another officer believed that courses such as the 'Mental Health First-Aid' course would be beneficial for YJOs. Another officer stated there was no comparison between YJO training and CO training. He believed the CO training was far more extensive, thorough, and very comprehensive about legislation, policy and procedures. The officers agreed that refresher training would be helpful.

The YJOs that had undertaken the 3-day PART uniformly expressed the view they did not feel sufficiently trained to deal with the behaviours displayed by the 'at-risk' young persons. They explained a need to bring all YJOs in line with the training provided through the pathway of the Certificate III in Correctional Practice (Youth Custodial).

The Deputy Superintendent believed the new eight-week course has improved the training for YJOs but believed there was still room for improvement. He believed that scenario training and more practical training would assist in improving the training to make it more realistic.

A senior CO working in the HSU at DDYDC believed that he is constantly training and mentoring the YJOs working in the HSU and he is also of the belief that regular training days incorporating practical scenario training would be beneficial.

Such issues inevitably have implications on staff retention and wellbeing. Not only is training imperative in adequately dealing with young persons, it also provides a structured work environment for staff.

Mandatory regular refresher training must be undertaken at industry-accepted intervals.²⁸ The refresher training should be in-line with current training provided for new YJOs in completing the Certificate III in Correctional Practice and should include crisis de-escalation /

²⁸ For example, NT police officers must complete a two day defence tactics training 'refresher' package each year to maintain their qualification, and a one day firearms qualification is also mandatory.

negotiation / mediation training specific to young persons. Scenario training should be considered. A commitment to regular training days for all staff at DDYDC and ASYDC should be given in order to have staff trained in contemporary practice and to enable adherence to current legislation.

Given the complex needs of young persons in detention, it is important that those who work with them are well-equipped to support them. This includes guidance on effective behaviour management strategies.

Training of all YJOs needs to be consistent across the board. The OCC understands that several YJOs that did not undertake the Certificate III in Correctional Practice (Youth Custodial) have been provided with the workbooks for the Certificate III, with several units eligible for recognised prior learning (through workplace experience and an evidence portfolio). This negates the need to take those experienced YJOs completely off-line in order to complete the Certificate III.

It is understood that FMH are liaising with NTDCS training department in order to provide some input into the training schedule to address some of the gaps identified.

Recommendations re: Training of Youth Justice Officers

12. Conduct a review of staff planning processes to ensure that all current serving Youth Justice Officers have completed the Certificate III Correctional Practice (Youth Custodial) upon their confirmation of appointment.
13. Introduce mandatory training days to include operational safety and tactics training, (such as restraint techniques and scenario training) and updates upon changes to legislation, policy and/or procedures.
14. Identify an appropriate provider to incorporate training in complex trauma and its effect on young persons in detention.
15. Training to incorporate a more extensive focus on crisis de-escalation / negotiation / mediation training specific to young persons who are threatening self-harm, have attempted self-harm and/or have been subsequently placed 'at-risk'.

Correctional Officers lack of knowledge in dealing with young persons and the provisions of the Youth Justice Act

During the interviews with the COs of the ASCC it became apparent they were unaware of their obligations to young persons coming into an adult correctional facility, thereby breaching section 154 of the *Youth Justice Act*. COs were not instructed on legislative provisions of the *Youth Justice Act*.

The issue of COs dealing with young persons whilst in an adult facility was explored at length with the SCO in charge of the incident with the restraint chair. He recalled being informed that once the young person is in the prison (adult facility) they are treated like an adult

prisoner, further stating: “...we are not trained in dealing with kids...” The SCO further stated that this issue had been raised with management and the union, stating:

“...I don’t know the *Youth Justice Act*. I’ve been told the juveniles are to be treated as adults...this issue was raised with the union...the issue of our COs doing escorts of juveniles...the question was asked where the COs fitted into this task but we were told by the powers-to-be that it was all good and to trust them...we have a Directive and a Standard Operating Procedure signed off by the Superintendent which covers juveniles held in an adult institution. These documents do not give a clear direction of guidance in the dealing of these juveniles...”

In addition to the training of YJOs, the curriculum for the training of COs needs to include provisions of the *Youth Justice Act* and *Youth Justice Regulations* that affect COs when dealing with young persons in adult facilities, or COs that work in the HSU at the detention centres.

Recommendations re: Training of Correctional Officers

16. Consult with the Correctional Officer Training Department to include training to include information on the obligations of Correctional Officers to young persons who are temporarily transferred to an adult correctional facility (with a focus on section 154 of the *Youth Justice Act*).

Use of the Hoffman Tool

The improper use of the Hoffman Tool has previously been addressed in Issue Four. However, it is more appropriate to address the training associated with the use of the Hoffman Tool under Issue Five. The First Draft Report identified a lack of instruction on the purpose of the Hoffman Tool and the operation of it, which was highlighted when a YJO sustained a serious injury when it was handled incorrectly. Aside from making a recommendation to prohibit the use of the Hoffman Tool to strip clothing from young people, a further recommendation will be made to incorporate the appropriate use of the Hoffman Tool into training.

Recommendations re: Training in the use of the Hoffman Tool

17. Incorporate into training the appropriate use of, and application of, the Hoffman Tool (to remove ligatures).

Use of Spit Hoods

The issue surrounding the lack of policy and procedure in the use of spit hoods has previously been addressed under Issue Five. However, the absence of instruction regarding its operational use is to be addressed as a training issue. As previously stated, interviews conducted with YJOs revealed that none of them could recall being trained in the appropriate use of and application of a spit hood.

Recommendations re: Training in the use of spit hoods

18. Incorporate into training the appropriate use of, and application of a spit hood.

Dispensing Medication

There is a current practice of YJOs dispensing medication after hours. All officers interviewed expressed concern in dispensing medication and the associated risks.

The YJOs interviewed had no formal training in dispensing medication, nor are there any procedures in place. YJOs dispensing medication are to make a log entry but it is unclear if this procedure is being adhered to.

The issue of dispensing of medications was highlighted in the incident involving an 'at-risk' episode of a young person outlined in Case Study B. Medical Progress Notes refer to a meeting between FMH and Youth Justice Manager who raises concerns about the YJOs dispensing medication (such as diazepam). A plan was eventually made for health to send a nurse to DDYDC between 7pm and 9.30pm to dispense the prescribed medication.

There is a need for CSHC to provide a service after-hours so that a nurse can attend to dispense medication to young persons.

Recommendations re: Dispensing medication

19. Northern Territory Department of Correctional Services and the Department of Health to develop a service arrangement for trained health practitioners to dispense schedule 4 and 8 medication to young persons.

Issue Seven – Infrastructure

The physical infrastructure of the 'at risk' cells at both ASYDC and DDYDC are incapable of adequately accommodating young persons displaying 'at-risk' behaviours and have the potential to heighten the risk of self-harm and mental health issues. The physical conditions in the 'at-risk' cells and de-escalation cells are inadequate. Young persons deprived of their liberty have the right to facilities and services that meet all the requirements of health and human dignity, as per article 31 of the UN Rules for the Protection of Juveniles Deprived of their Liberty: the 'Havana Rules'.²⁹

There is only one designated 'at-risk' cell at ASYDC. There is no window or natural light in this cell, and limited ventilation. There is no access to a toilet or running water in this cell either; if a young person needs to use the toilet then they have to rely on YJOs to escort them to a toilet. On occasions the OIC has utilised the de-escalation cell which has access to a toilet.

²⁹ UN Rules for the Protection of Juveniles Deprived of their Liberty: the 'Havana Rules' 14 December 1990 – Article 31

The 'at-risk' rooms used at the DDYDC are identical to the de-escalation rooms used for young persons placed on a Behaviour Management Plan. The only difference is that two 'at-risk' room doors consist of clear perspex which is shatter resistant and allows observation from outside the door without having to open the door or the judas hatch. On occasions the de-escalation rooms are used for 'at-risk' young persons. This again highlights the perception by young persons that they are being punished for their behaviour and mental health issues by accommodating those young persons in the same areas that they would be during times of bad behaviour.



'At-risk' cell

De-escalation cell

The 'at-risk' cell at the ASYDC does not meet standards of detention as outlined in the UN 'Havana Rules', in that it does not provide any sanitary installations, nor does it have drinking water available to the young person at any time.

The 'at-risk' cells at DDYDC are also deficient in satisfying the basic standards set out in the 'Havana Rules' in regards to the need for young persons to have sensory stimuli, opportunities for association with peers and recreation time.

All officers interviewed were questioned about the general set-up of 'at-risk' cells at both detention centres, and some officers were able to comment on those cells in comparison with the ones used at the adult facility at DCC. Those officers believed the set-up at DCC was far more suitable for 'at-risk' episodes, as the rooms were purpose built and within the medical centre where they can be monitored by the COs on-site and medical staff when they are on duty.

The presence of windows and light is a requirement of such importance that there needs to be an immediate effort made to cease the holding of young persons in cells that do not satisfy such basics.

The design of the 'at-risk' room and the physical environment should be in keeping with the rehabilitative aim of therapeutic treatment, with due regard to the need of the young person for privacy, sensory stimuli, opportunities for association with peers and participation in exercise/recreation and have direct access to services that can assist with their mental health wellbeing. To further reiterate the point made throughout this report, a failure to

therapeutically treat those young persons placed 'at risk' essentially nullifies any positive effect of that classification and such 'at risk' measures are punitive in nature.

It is acknowledged that since this investigation commenced several improvements to infrastructure at the DDYDC have taken place, with cells used for BMP and 'at-risk' now provided with running water and some natural light. However, on-going issues with natural ventilation and general maintenance are still occurring and the greatest concern remains, the nature of the 'at risk' cells and their inability to provide a therapeutic response to the young persons' mental health needs.

Article 31 of the UN Rules for the Protection of Juveniles Deprived of their Liberty: the 'Havana Rules', clearly articulates the standards of the physical environment that is required.

Recommendations re: Issue Seven - Infrastructure

20. Ensure that all cells are compliant with the minimum standards of detention outlined in the *UN Rules for the Protection of Juveniles Deprived of their Liberty* (i.e. the 'Havana Rules').

Ancillary Issue – Temporary Transfer of Young Persons to Adult Facilities

One of the three main issues referred to in the scope outlined to the Corrections Commissioner was that of the decisions and actions of NTDCS regarding young persons being temporarily accommodated in adult facilities. During the investigation, an analysis of transfers occurring under the provisions of section 154 of the *Youth Justice Act* was conducted. The analysis concentrated on transfers that occurred after September 2014 when the legislation was amended to no longer require Magistrate approval to temporarily transfer a young person to a custodial correctional facility. The Commissioner was given the ability to approve a 72 hour placement. This analysis showed the transfers that occurred during this period were justifiable; however it did reveal an ancillary issue in deficiencies of recording the decisions, and approvals, which was addressed in the final recommendation of the First Draft Report.

The recording of temporary transfers to adult facilities would address the concerns highlighted in the report. It was suggested by senior officers that this could perhaps be recorded on an incident report.

Recommendations re: Temporary transfer of young persons to adult facilities

21. Develop a reporting system to ensure decisions to transfer young persons temporarily to adult facilities are recorded appropriately.

CONCLUSION

Any period of detention must serve to support, educate and rehabilitate child offenders and seek to mitigate any factors that could exacerbate pre-existing vulnerabilities.

The previous 'at-risk' manual and procedures that the findings of the investigation were based on failed to minimise the risk of young persons inflicting self-harm. The recommendations focus on best practice, compliance with relevant legislation and adherence to national and international standards.

Periods of 'at risk' should be dealt with in a therapeutic and supportive way, the objective being the resolution of the behaviour and the return of the young person to the general detention centre population.

The review of the *NTDCS At-Risk Procedures Manual* and the *DoH Youth 'at-risk' procedure* are a welcomed update in addressing the issues identified. The OCC is acutely aware of the challenging role YJOs have in managing the behaviour of young persons in their care. The literature is clear that improving de-escalation techniques will lead to a reduction in the use of force, and critical incidents, thereby fulfilling their duty of care, minimising the number of young persons being 'at-risk' and minimising the time they are held 'at-risk' through timely assessments.

The 21 recommendations made are designed to serve as standards of reference and to provide structure and guidance to each of the departments that have a duty of care with regard to the safe custody of young people detained in its care. The recommendations will go some way in addressing many of the issues identified during this own-initiative investigation. Their implementation will be greatly enhanced by NTDCS and DoH making a concerted effort to work together to ensure adequate intervention is provided to vulnerable young persons in detention.

Colleen Gwynne
Children's Commissioner
24 August 2016

DATE	INCIDENT DESCRIPTION	MANAGEMENT	POLICY / PROCEDURE/ ISSUE
<p><u>2 April 2015</u></p>	<p><u>1900</u> - Female detainee climbed onto roof, became entangled in razor wire</p> <p><u>2300</u> - Cut from wire by Fire Brigade</p> <p><u>2330</u> - Conveyed to RDH for treatment of superficial wounds, including sutures to left arm-pit</p>	<p>Overall incident of rooftop managed adequately and followed relevant policy and procedure</p> <p>Evident that detainee was defiant to instructions and appeared to panic when she stepped into the wire, causing her to become further entangled</p>	
<p><u>3 April 2015</u></p>	<p><u>0355</u> - Detainee returned to DDYDC, placed 'at-risk' in C Block, Cell 2 Remained in Cell 2, monitored via CCTV camera</p> <p><u>1435</u> - Out of cell with staff for 15 minutes only Returned to Cell 2</p>	<p>Notification of 'at-risk' made to CSHC Management Plan – nil detail, except for 15 min observation checks No intervention from CSHC No intervention from FMH</p>	<p>Insufficient detail on plan to satisfy:</p> <ul style="list-style-type: none"> • Section 162 of YJA • Regulation 41 of YJR • Sections 7.1& 7.3 of 'at-risk' procedures contained in the Manual
<p><u>4 April 2015</u></p>	<p><u>1340</u> - Detainee moved from C Block, Cell 2 to B Block, Cell 30. Became agitated when the door was closed on her</p> <p><u>1351</u> - Detainee head-butting door</p> <p><u>1355</u> - Self-harm attempt (by tying cloth torn from 'at-risk' gown around her neck)</p> <p><u>1431</u> - Conveyed to RDH by ambulance & escorted by YJOs</p>	<p>Still no intervention from CSHC or FMH</p> <p>YJOs attended and cut cloth from detainee's neck with Hoffman Tool. Ambulance attended</p> <p>Seen by Resident Medical Officer who noted: "...CAT team want High Risk care for 48 hours. Continuous supervision and they are going to make a ref to Forensic team...Detention Centre team advised to look after her more closely..."</p>	<p>Contravention of section 7.1 of 'at-risk' procedures contained in the Manual</p> <p>'at-risk' clothing not fit for purpose</p>

	<p><u>2055</u> - Discharged from RDH. Escorted from RDH by YJOs</p> <p><u>2121</u> - Whilst in vehicle detainee attempted to strangle herself by wrapping both seatbelts around her neck</p> <p><u>2128</u> - Detainee appeared unconscious, bleeding from the mouth</p> <p><u>2148</u> - Arrived at RDH</p>	<p>Discharge letter given to YJOs</p> <p>YJOs administered first aid</p> <p>Ambulance attended and conveyed detainee to RDH</p>	
<p><u>5 April 2015</u></p>	<p><u>0100</u> - Detainee seen by CATT</p> <p><u>0215</u> - Detainee conveyed back to DDYDC Just prior to arriving detainee attempted to get out of the vehicle, still highly agitated</p> <p><u>0453</u> - Detainee returned to 'at-risk' cell and monitored via CCTV camera</p> <p><u>1415</u> - YJO took detainee out of cell for 35 mins (in recreation yard).</p> <p><u>1554</u> - CATT contacted DDYDC and noted: "...K is in an area that is under constant camera surveillance and has an intercom to speak to the communications centre..." Detainee remained in 'at-risk' cell and monitored via CCTV camera</p> <p><u>1645</u> - YJOs took detainee from cell so she could watch TV in recreation yard</p>	<p>Medical Progress Notes state: "...PLAN: K to be DC back to Detention Centre/to be closely monitored for next 24/24. Referred client back to Forensic MHT..."</p> <p>YJOs were left with the responsibility of caring for the detainee who was in a highly agitated state and at a very high risk of self-harm The Management Plan was unchanged, no detail except for 15 minute observations</p> <p>YJO had been involved in previous incidents & commenced duty early "...so he could check in on the detainee as he was so concerned about her..."</p> <p>YJOs attempted to engage with the detainee and keep her occupied</p> <p>Monitored via CCTV camera</p> <p>YJOs removed detainee from cell and taken to TV room to calm down</p>	<p>Ongoing failure to satisfy:</p> <ul style="list-style-type: none"> • Section 162 of YJA • Regulation 41 of YJR • Sections 7.1& 7.3 of 'at-risk' procedures contained in the Manual <p>Ongoing failure to update Management Plan No intervention or guidance provided from Health No visits from CSHC or FMH</p>

	<p><u>1735</u> - Detainee returned to 'at-risk' cell</p> <p><u>1842</u> - Detainee kicking and hitting wall</p> <p><u>2033</u> - Detainee returned to cell</p>	Monitored via CCTV camera	
6 April 2015	<p><u>1345</u> - Detainee tearing up magazines</p> <p><u>1357</u> - Detainee covered camera with wet magazines</p> <p><u>1415</u> - Camera still blocked</p> <p><u>1420</u> - Physical check conducted, detainee found to have material tied around her neck. Reported to be unconscious but breathing</p> <p><u>1455</u> - Conveyed to RDH by ambulance and YJO escort. Seen by ED staff at RDH</p> <p><u>2015</u> - Detainee discharged from RDH, escorted to DDYDC On return trip the detainee attempted to get out of the moving car through the window, and in the process smashed the window</p> <p><u>2039</u> - Arrived at DDYDC. Detainee continued to kick out and assaulted YJOs</p> <p><u>2130</u> - Detainee sat on footpath outside admissions</p>	<p>Noted on 'at-risk' log</p> <p>Noted on 'at-risk' log as "blocked camera"</p> <p>Notes on 'at-risk' log as "blocked camera"</p> <p>YJOs attended, cloth removed from detainees neck, on-site medical Nurse attended, as did ambulance</p> <p>Medical Progress Note: "...PLAN: Discharge to Don Dale as not mentally disordered. Refer to Mental Health Team..."</p> <p>Detainee restrained</p> <p>Detainee was removed from the vehicle safely and sat on the ground until she was calm</p>	<p>Contravention of:</p> <ul style="list-style-type: none"> Regulation 42(2)(c) of YJR (15 minute observations) <p>Failure to satisfy:</p> <ul style="list-style-type: none"> Section 162 of YJA Regulation 41 of YJR Sections 7.1& 7.3 of 'at-risk' procedures contained in the Manual <p>Failure to satisfy:</p> <ul style="list-style-type: none"> Section 162 of YJA section 41 of YJR section 7.1& 7.3 of 'at-risk' procedures

	<p><u>2230</u> - Escorted to B Block recreation yard, showered</p> <p>Placed in cell 29 of B Block</p>	<p>Monitored by staff on-site</p> <p>Monitored by CCTV camera</p>	
<u>7 April 2015</u>	<p><u>1030</u> - FMHT assessment conducted – 4 days, 6.5 hours since being placed 'at-risk' (with 3 visits to RDH for serious self-harm episodes)</p> <p><u>1045</u> - Detainee climbed onto gym equipment in recreation yard</p> <p><u>1245</u> - Detainee returned to cell</p> <p><u>1255</u> - Self-harm attempt (ripped 'at-risk' sheet, tied around her neck)</p> <p><u>1305</u> - Detainee turned on taps in cell and used other material left in cell and made a further attempt of self-harm by tying the cloth around her neck</p> <p><u>1330</u> - Detainee tried to self-harm by tightening collar of the 'at-risk' gown</p> <p><u>1335</u> - Detainee removed from cell and climbed onto gym equipment</p> <p><u>1418</u> - Email from Angeline Swan, Youth Justice Forensic Psychologist, requesting admission of detainee to forensic unit be reconsidered as an option</p>	<p>Noted on log as "HIGH RISK – NO IMPULSE CONTROL"</p> <p>Monitored by YJOs in recreation yard</p> <p>Monitored by CCTV camera</p> <p>YJOs attended and removed cloth from the detainee's neck, removed the mattress and bedding</p> <p>YJOs attended and cut cloth and left detainee in cell, water left running</p> <p>YJOs attended and removed detainee from cell</p> <p>Monitored by YJOs in recreation yard</p> <p>Medical Progress Notes refer to the possibility of a plan to transfer detainee to the DCC for close medical observation.</p>	<p>Management Plan not updated, breach of 'at-risk' procedures</p> <p>Lack of guidance to YJOs of interim measures to protect child</p> <p>Failure to utilise the provisions outlined in section 7.3 of 'at-risk' procedures – CSHC did not access Psychiatric on-call which is an option provided in circumstances where FMH were not available due to a public holiday period</p>

<p><u>1600</u> - 2 x Mental Health Nurses from FMH conducted assessment and administered medication to the detainee (diazepam)</p> <p><u>1615</u> - Detainee climbed back onto gym equipment</p> <p><u>1915</u> - Detainee climbing over mesh roof and climbed onto steel cupboard</p> <p><u>2015</u> - Detainee armed herself with 2 x steel doors that she had removed from an unlocked cupboard</p> <p><u>2100</u> - Detainee tied some material from her gown to the mesh and then around her neck, in an attempt to hang herself</p> <p><u>2145</u> - Detainee stabilised and on ground, ambulance called</p> <p><u>2200</u> - Ambulance arrived</p>	<p>FMH attended to provide “support”</p> <p>YJOs monitoring from recreation yard, attempted to negotiate YJOs monitoring from recreation yard</p> <p>YJOs monitoring from recreation yard, attempted to negotiate. Detainee kept saying to YJOs: “...I hate being in this room....all I wanted to do was come off risk...”</p> <p>YJOs used ladders to support detainee’s body (to prevent hanging) and cloth cut while the detainee was supported by YJOs</p> <p>Once on the ground the detainee was placed in the recovery position, concerns that the detainee had lost consciousness</p> <p>Whilst in the recovery position the detainee is restrained with hand-cuffs.</p> <p>One YJO then asks other officers: “Do you want me to take her clothes off guys?”</p> <p>Detainee conveyed to RDH by ambulance and YJO escort</p>	<p>First intervention from FMH to support YJOs in dealing with the detainee</p> <p>Breach of section 153 of YJA</p> <ul style="list-style-type: none"> • Detainee was contained on mattress within secure area • Detainee was unconscious, unable to self-harm whilst unconscious <p>Clothes not removed but comment made by YJO shows a lack of understanding of obligations and provisions of Regulation 73 of YJR</p>
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<p><u>8 April 2015</u></p>	<p><u>0005</u> - Detainee assaulted YJOs at RDH and had to be restrained</p> <p><u>0250</u> - Detainee returned to DDYDC</p> <p><u>0500</u> - Detainee returned to cell</p> <p><u>1119</u> - FMH assessment conducted</p>	<p>Detainee taken to isolation room within ED and monitored by YJOs</p> <p>Detainee seen by CATT</p> <p>YJOs sat with detainee in recreation yard while she had a meal, showered</p> <p>Monitored by CCTV cameras</p> <p>A 72-hour placement was approved for the transfer of the detainee to DCC where a plan to have constant observation (1:1 observation by a YJO) was enacted</p>	<p>Failure of FMH as trained professional to adequately support YJOs</p>
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DATE	INCIDENT DESCRIPTION	MANAGEMENT	POLICY / PROCEDURE/ ISSUE
<u>26 July 2015</u>	<p>Detainee received a 24-hour BMP for verbally abusing YJO</p> <p><u>2100</u> - transferred from K Block to HSU Placed in cell 4, Yard 2</p>	<p>Transfer authorised by DS</p> <p>De-escalation Log commenced, 15 minute observations logged</p>	
<u>27 July 2015</u>	<p><u>0015</u> - camera blocked with wet toilet paper SS & YJOs entered cell and found detainee to have piece of cloth tied around his neck Detainee found to be conscious and breathing Detainee became aggressive upon being restrained</p> <p><u>0037</u> - Hoffman Tool was used to remove detainees clothing whilst he was restrained. Detainee left naked</p> <p><u>0047</u> - camera obscured</p> <p><u>0054</u> - on-call nurse notified</p> <p><u>0154</u> - 'At-risk' clothing handed to detainee through judas hatch</p> <p>During the evening the detainee peeled the paint from a portion of the wall which exposed a 3cm x 3cm hole</p> <p><u>0710</u> - detainee moved to Cell 1, Yard 2 Detainee became agitated, punched and kicked door</p>	<p>YJO attended, unable to sight detainee Cloth around neck removed with Hoffman Tool</p> <p>Detainee restrained with handcuffs DS advised; instructed YJOs to put detainee 'at-risk' and remove items from the cell</p> <p>No 'at-risk' journal on record – 15 minute physical observations conducted from yard</p> <p>FMH referral sent at 0934 hrs</p> <p>Left naked & without bedding for one hour, 17 minutes</p> <p>Damage inspected by morning shift</p>	<p>Breach of Section 153 (use of restraints)</p> <p>Breach of Section 6.4(d)(e) of AT RISK Manual Breach of Section 4.2 of AT RISK Manual Breach of Regulation 42 of YJR, Section 6.4 of AT RISK Manual Insufficient facilities – paint easily peeled off by detainee which exposed a hole in the wall</p>

<p><u>1048</u> – FMH conducted assessment (conversed with detainee through judas hatch for 2 minutes)</p> <p>Although detainee was taken off ‘at-risk’ he remained in the ‘at-risk’ cell with ‘at-risk’ attire</p> <p>Detainee continued to cover camera with wet toilet paper</p> <p><u>1330</u> – detainee moved to Cell 2, Yard 2 Detainee punched the door repeatedly</p> <p><u>1356</u> – detainee intercoms Comms requesting medical (for his hand)</p> <p><u>1414</u> – CO attended, assessed detainee’s hand, took photographs</p> <p><u>1455</u> – CO received an email from Nurse of CSHC requesting detainee attend ED “...for further investigation...” CO advised detainee of DS’s decision</p> <p>Detainee in Cell 2 continues to cover camera throughout afternoon</p> <p><u>1922</u> – YJO noted in de-escalation journal that detainee “...is distressed...”</p> <p><u>1959</u> – detainee tore sheet with his teeth (for 25 mins)</p> <p>Detainee continued to cover camera with wet toilet paper</p>	<p>Detainee taken off ‘at-risk’ Medical Progress Note: “...D is likely to be placed at-risk in the near future; due to pattern of risky behaviours/non-compliance/low impulse control/poor insights...”</p> <p>No records on IOMS of detainee being taken off ‘at-risk’</p> <p>Monitored from outside the cell and CCTV camera</p> <p>Comms notified CO</p> <p>CO contacted CSHC</p> <p>DS advised “...due to D’s threatening behaviour and the fact that the injury is not life-threatening he would be escorted to RDH the following day....if his behaviour allows...”</p> <p>Camera was left obscured, YJOs conversed with detainee through door</p> <p>Comms monitor CCTV camera – no notation of this on logs</p>	<p>No Management Plan on record Lack of information or guidance to address issues raised on Medical Progress Note</p> <p>Breach of Regulation 59(2) of YJR</p> <ul style="list-style-type: none"> • Medical attention not provided to detainee • CSHC did not attend to provide medical attention • No pain relief given <p>‘at-risk’ clothing not fit for purpose</p>
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	<p><u>2047</u> – YJOs attend cell, found detainee lying face down on mattress and bedding Material tied around his neck, conscious & breathing Detainee continued to lay face down on the mattress, with a sheet over the top of him</p> <p><u>2053</u> – detainee covers camera</p> <p><u>2133</u> – 4 x YJOs return to cell, detainee remained lying face down on the mattress with the sheet covering him</p> <p>Detainee is left naked and without any mattress or bedding for the entire evening</p> <p>Detainee covered camera throughout the evening</p>	<p>Torn cloth removed from the neck of the detainee with Hoffman Tool</p> <p>YJO clears camera obstruction & inspect cell, then leave</p> <p>Detainee returned to 'at-risk' status</p> <p>YJOs physically restrain detainee while the mattress and bedding is removed from underneath him</p> <p>No negotiation with detainee attempted</p> <p>Detainee left naked for 10 hrs & 55 mins Detainee left without mattress or bedding for 12 hrs & 18mins</p> <p>YJOs conducted physical observations every 15 mins</p>	<p>Breach of section 153 of YJA</p> <ul style="list-style-type: none"> • force was not reasonable as per (3)(d) • was not an emergency situation • detainee was resting on mattress – no need to temporarily restrain to protect detainee from self-harm or protect others <p>Breach of Regulation 42 of YJR & section 6.4 of 'at-risk' procedures contained in the Manual</p> <ul style="list-style-type: none"> • detainee must be clothed in rip-proof material • room must be furnished with mattress & bedding made of rip-proof material <p>Failure to satisfy section 6.3 of 'at-risk' procedures</p> <ul style="list-style-type: none"> • impression of punitive reasons for 'at-risk' episodes
<p><u>28 July 2015</u></p>	<p><u>0932</u> – detainee provided with 'rip-proof' shorts & a sheet</p> <p><u>1035</u> – detainee escorted to medical room for injuries to hand</p> <p><u>1050</u> – detainee returned to 'at-risk' cell</p> <p><u>1511</u> – FMH assessment conducted</p>	<p>Noted on medical file about the need for the detainee to attend RDH for x-rays</p> <p>Detainee provided with a mattress</p> <p>Detainee taken off 'at-risk' & commenced 24-hour BMP</p>	<p>On-going breach of regulation 58 of YJR</p> <ul style="list-style-type: none"> • not provided with medical treatment <p>Insufficient follow-up of case management to deal with the issues cited throughout FMH assessments</p>

<u>29 July 2015</u>	<u>0920</u> – detainee escorted to RDH <u>1130</u> – detainee returned to DDYDC to continue BMP	X-rays performed on hand of detainee	
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DATE	INCIDENT DESCRIPTION	MANAGEMENT	POLICY / PROCEDURE/ ISSUE
<u>17 Sept 2015</u>	<p>Detainee given early lock-down for being non-complaint Upon lockdown detainee requested to be placed in another cell - request denied Detainee informed YJO that he would kill himself in the room he was in</p> <p><u>1745</u> - detainee was stripped searched and provided with rip-proof attire</p> <p><u>1802</u> - Notification of Concern - At Risk submitted</p> <p>Detainee placed in 'at-risk' cell</p>	<p>COs informed and attended & detainee placed 'at -risk'</p> <p>Notification made via chain of command - SS Johns</p> <p>Monitored via CCTV camera and 15 min observations logged</p>	
<u>18 Sept 2015</u>	<p><u>1143</u> - Nurse notes that detainee is 'at-risk' but informed he was at court</p> <p>Detainee remained 'at-risk' without being assessed</p>	<p>Documentary evidence confirms the Nurse did not notice IMP had not been initiated, therefore no FMH follow-up</p> <p>Monitored via CCTV camera and 15 min observations logged</p>	<p>Contravening 'at-risk' procedures</p> <ul style="list-style-type: none"> • FMH not notified • No IMP in place
<u>19 Sept 2015</u>	<p>Detainee remained 'at-risk' without being assessed</p>	<p>Monitored via CCTV camera and 15 min observations logged</p>	<p>Contravening 'at-risk' procedures</p>
<u>20 Sept 2015</u>	<p>Detainee remained 'at-risk' without being assessed</p>	<p>Monitored via CCTV camera and 15 min observations logged</p>	<p>Contravening 'at-risk' procedures</p>

<u>21 Sept 2015</u>	Detainee remained 'at-risk' without being assessed	Monitored via CCTV camera and 15 min observations logged	Contravening 'at-risk' procedures
<u>22 Sept 2015</u>	<p>Detainee remained 'at-risk' without being assessed</p> <p><u>0832</u> – CSHC Nurse noticed detainee had been 'at-risk' since 17 Sept 2015</p> <p><u>1021</u> – CSHC Nurse saw detainee</p>	<p>Monitored via CCTV camera and 15 min observations logged</p> <p>Email sent to DDYDC on-site Nurse</p> <p>Contacted FMH to see detainee as a priority. Social Worker conducted a mental health assessment of detainee and he was immediately taken off 'at-risk'</p> <p>Medical Progress Note: <i>"...clients being placed in At-Risk cells for this amount of time without assessment; over time, this could have an unhealthy negative impact on the client's mental health and wellbeing..."</i></p>	<p>Contravening 'at-risk' procedures</p> <p>Impact on detainee being placed in a small cell with limited interaction and no FMH intervention for in excess of 5 days</p>

DATE	INCIDENT DESCRIPTION	MANAGEMENT	POLICY / PROCEDURE/ ISSUE
<p><u>4 March 2015</u></p>	<p>Detainee transferred from ASYDC to ASCC following several incidents of non-compliance, aggression, violence</p> <p><u>1330</u> – detainee made intercom call asking for “a knife so he could slice his own throat”</p> <p><u>1450</u> – notification made to medical re: ‘at-risk’</p> <p>Detainee lay on mattress and watched TV until night-shift commenced and light of cell turned on</p> <p><u>2015</u> – detainee observed to be chewing on mattress</p> <p><u>2030</u> – detainee placed wet toilet paper on observation windows</p> <p>Detainee requested to remove toilet paper – nil response (spoken to by OIC through the judas hatch).</p> <p>Handy-cam commenced recording</p>	<p>72-hour BMP approved by Commissioner Detainee placed in cell GC51 at ASCC</p> <p>Detainee placed ‘at-risk’ and escorted to Remand Block, Cell GC01 (‘at-risk’ cell)</p> <p>Unclothed search conducted and ‘at-risk’ attire given to detainee</p> <p>15 min observations logged</p> <p>OIC notified and attended</p> <p>OIC instructed COs to remove articles from the cell (mattress, linen and toilet paper on window)</p> <p>Conversation between OIC and detainee recorded OIC directed detainee to place hands through judas hatch, handcuffs applied and held at hatch with baton while COs entered cell</p>	<p>Breach of regulation 42 of YJR & 6.4 of AT RISK Procedures contained in the Manual</p> <p>Breach of section 153 of YJA (use of restraints)</p>

	<p>Detainee threatened to spit at COs</p> <p>Detainee demanded mattress be returned</p> <p>Detainee informed COs he would “smash his hands to break bones so he could go to hospital” and continues to threaten to spit</p> <p><u>2050</u> - Detainee placed in restraint chair, spit hood remained on his head</p> <p><u>2110</u> - COs entered cell to check detainees circulation</p> <p><u>2245</u> - OIC assessed detainee and he was removed from the restraint chair (after 1 hr & 55 mins)</p>	<p>Spit hood applied and items removed from cell</p> <p>OIC informed detainee “once he had calmed down they would assess it”</p> <p>OIC replies: “no you’re not, just settle down eh...you can stay like that then...and we might get the restraint chair...well if you’re going to comply...you need to settle down...you need to prove yourself in there...”</p> <p>OIC instructed COs to retrieve restraint chair Notation on log: “...failed to comply with instructions and placed in restraint chair...”</p> <p>COs took turns in sitting outside cell to monitor the detainee while he was in the restraint chair</p> <p>Restraints loosened Monitoring continued by COs</p> <p>Mattress and ‘at-risk’ bedding provided to detainee</p>	<p>Failure to satisfy section 6.3 of AT RISK Procedures – impression of punitive reasons for ‘at-risk’ episodes (detainee ‘at-risk’ , not BMP)</p> <p>Breach of section 153(3)(d) of YJA (use of restraints)</p> <ul style="list-style-type: none"> not an emergency situation no need to temporarily restrain to protect detainee from self-harm (other options available) <p>Contravenes the <i>Charter of Rights for Children and Young People in Youth Justice Facilities</i></p> <ul style="list-style-type: none"> detainees right “not to have forced used against you, or restraints used on you, unless absolutely necessary, and never as punishment”
<p><u>5 March 2015</u></p>	<p>0755 – assessed by Nurse</p>	<p>Detainee taken off ‘at-risk’ and returned to Cell GC51</p>	

Legend

ASYDC – Alice Springs Youth Detention Centre
ASCC – Alice Springs Correctional Centre
DDYDC – Don Dale Youth Detention Centre
RDH – Royal Darwin Hospital
CSHC – Correctional Services Health Centre
CATT – Crisis Assessment Triage Team

YJO – Youth Justice Officer
CO – Corrections Officer
OIC – Officer in Charge
SS – Shift Supervisor
DS – Deputy Superintendent

YJA – Youth Justice Act
YJR – Youth Justice Regulations
BMP – Behavioural Management Placement
AT RISK Manual – NTDCS ‘At-Risk’ Procedures Manual

Video Footage

Attachment E Removal of mattress and bedding on 27 July 2015

Attachment F Stripping of clothing with Hoffman Tool on 26 July 2015

Attachment G Restraint Chair on 4 March 2015

Issue One – Management of young persons ‘at-risk’

1. Northern Territory Department of Correctional Services and the Department of Health maintain collaboration in reviewing and updating the *‘At Risk’ Procedures Manual* and the *Youth ‘At-Risk’ Procedures* and associated service agreements to ensure operational effectiveness of managing young persons placed ‘at-risk’.
2. Northern Territory Department of Correctional Services and the Department of Health examine alternative options, other than the de-escalation rooms, for young persons placed ‘at-risk’.
3. Northern Territory Department of Correctional Services to give written notice to the Office of the Children’s Commissioner, as soon as practicable, if a young person ‘at-risk’ has not been seen by a medical practitioner within 24 hours of being placed ‘at-risk’.

Issue Two - Service intervention to young persons ‘at-risk’

4. Explore options for continuously monitoring a young person ‘at-risk’ that complies with the Emergency Management Protocol in the *Youth Justice Regulations* and is consistent with the Northern Territory Department of Correctional Services *At-Risk Procedures Manual* and the Department of Health *Youth ‘At-Risk’ Procedures*.

Issue Three - ‘at-risk’ attire and bedding

5. Conduct and record regular internal audits of all ‘at-risk’ clothing and bedding held at both Youth Detention Centres to ensure each item to be issued to a young person placed ‘at-risk’ is in a sufficient condition (no loose threads) and there are appropriate stocks to cater for all sizes.

Issue Four – Use of the Hoffman Tool

6. Immediately prohibit the use of the ‘Hoffman Tool’ to strip clothing from a young person who is refusing to change into ‘at-risk’ clothing.
7. Develop policy and operational procedures to address the appropriate use of the Hoffman Tool to remove ligatures in Emergency Management / Critical Incidents.

Issue Five – Use of Restraints

8. The use of the Emergency Restraint Chair is strictly prohibited.
9. Continue using 'Use of Restraints' Directive 3.2.1 until such point that the Youth Detention Restraint Practice Advisory Group develops evidence-based policy and operational procedures in restraint practices.
10. Develop policy and operational procedures to address the appropriate use of a spit hood.

Issue Six re: Staffing

11. Conduct a review of the High Security Unit to establish operational capacity to staff the unit 24 hours, 7 days a week.

Issue Six re: Training of Youth Justice Officers

12. Conduct a review of staff planning processes to ensure that all current serving Youth Justice Officers have completed the Certificate III Correctional Practice (Youth Custodial) upon their confirmation of appointment.
13. Introduce mandatory training days to include operational safety and tactics training, (such as restraint techniques and scenario training) and updates upon changes to legislation, policy and/or procedures.
14. Identify an appropriate provider to incorporate training in complex trauma and its effect on young persons in detention.
15. Training to incorporate a more extensive focus on crisis de-escalation / negotiation / mediation training specific to young persons who are threatening self-harm, have attempted self-harm and/or have been subsequently placed 'at-risk'.

Issue Six re: Training of Correctional Officers

16. Consult with the Correctional Officer Training Department to include training to include information on the obligations of Correctional Officers to young persons who are temporarily transferred to an adult correctional facility (with a focus on section 154 of the Youth Justice Act).

Issue Six re: Training in the use of the Hoffman Tool

17. Incorporate into training the appropriate use of, and application of, the Hoffman Tool (to remove ligatures).

Issue Six re: Training in the use of Spit Hoods

18. Incorporate into training the appropriate use of, and application of a spit hood.

Issue Six re: Dispensing medication

19. Northern Territory Department of Correctional Services and the Department of Health to develop a service arrangement for trained health practitioners to dispense schedule 4 and 8 medication to young persons.

Issue Seven - Infrastructure

20. Ensure that all cells are compliant with the minimum standards of detention outlined in the *UN Rules for the Protection of Juveniles Deprived of their Liberty* (i.e. the 'Havana Rules').

Ancillary Issue re: Temporary transfer of young persons to adult facilities

21. Develop a reporting system to ensure decisions to transfer young persons temporarily to adult facilities are recorded appropriately.

Our Ref: OCC 2015/00149~4
Your Ref:

Mr Mark Payne
Commissioner
Department of NT Correctional Services
PO Box 1722
DARWIN NT 0801

Dear Mr Payne, *Mark*

RE: DRAFT INVESTIGATION REPORT

I am writing to advise the Office of the Children's Commissioner has completed the own initiative investigation regarding services provided to young people detained at the Don Dale Youth Detention Centre and the Alice Springs Youth Detention Centre.

The own initiative investigation was instigated pursuant to section 10(1)(ii) of the *Children's Commissioner Act 2014* (the Act) based on information that was brought to my attention following complaints made regarding the management of young people 'at-risk' of self-harm and/or suicide, the use of restraints and transfers to adult correctional facilities.

At our meeting on 22 March 2016 the issues to be highlighted in the investigation report were presented to you. Section 29 of the Act requires that a report of the investigation outlining the findings and recommendations must be prepared. Enclosed is a copy of the Draft Investigation Report and I invite you to provide a response on or before 6 May 2016.

Please do not hesitate to contact Ms Kira Olney, Manager of Investigations on telephone number 8999 6076 or via email at childrenscommissioner@nt.gov.au if you have any queries regarding this matter.

Yours sincerely



Ms Colleen Gwynne
Children's Commissioner
13 April 2016



16 May 2016

Ms Colleen Gwynne
Children's Commissioner
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CASUARINA NT 0811

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File Ref: DCSDOC26/004067

Dear Ms Gwynne,

RE: DRAFT INVESTIGATION REPORT

On the 13th April 2016, you wrote to the Department of Correctional Services (NTDCS) to advise of the completion of your own-initiative investigation into services provided to young people detained at the Don Dale Youth Detention Centre and the Alice Springs Youth Detention Centre and to provide the associated draft investigation report.

I am writing to advise you that NTDCS has considered the content of the draft investigation report and its recommendations and has provided an initial response which is summarised below; with a more detailed response and, where applicable, identified actions that NTDCS could take to achieve the recommended level of service (Attachment A).

Summarised response to recommendations

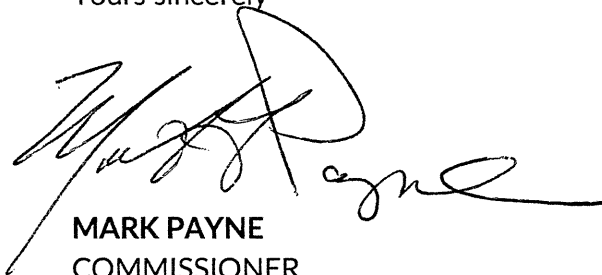
Recommendation		Response
1	Conduct a review of the 'at-risk' procedures, and where necessary implement changes to policies and procedures to ensure compliance with the requirements of the <i>Youth Justice Act</i> and <i>Youth Justice Regulations</i> , and most importantly to ensure the rights of the young person are upheld.	Supported
2	Conduct a review of operational practices surrounding the use of 'at-risk' isolation room as they currently stand.	Supported
3	Periods of 'at-risk' should be strictly limited. Section 28 of the South Australian legislation: <i>Youth Justice Administration Bill 2015</i> details such limits and could provide guidance for a similar structure to be implemented in the NT.	Partially supported
4	Inform the Office of the Children's Commissioner when a young person is placed 'at-risk'.	Not supported in current form
5	Amend the 'at-risk' procedures to reflect an immediate response from Forensic Mental Health whenever a young person is placed 'at-risk' - with a Forensic Mental Health Assessment to be conducted within 2 hours of the young person going 'at-risk'.	Refer decision

Recommendation	Response
6 Improve communication between service providers, may include: a. Universal flow chart for the notification process to be distributed amongst all service providers and included in training/induction; b. 24/7 service to be provided by FMHS (call-out system).	a. Supported b. Refer decision
7 Review the process of implementing the Individual Management Plans for 'at-risk' young persons to ensure a consistent and structured multi-disciplinary methodology is applied to each case.	Supported
8 Conduct a full audit of all 'at-risk' clothing and bedding issued to Alice Springs Youth Detention Centre and Don Dale Youth Detention Centre.	Supported in principle
9 Introduce an audit process of clothing and bedding issued to Alice Springs Youth Detention Centre and Don Dale Youth Detention Centre.	Supported in principle
10 'At-risk' procedures to include de-escalation, negotiation methods to be used where young persons are ripping clothing.	Supported in principle
11 Immediately prohibit any use of the 'Hoffman Tool' to strip clothing from young persons.	Supported in principle
12 Incorporate the appropriate use of the 'Hoffman Tool' into training.	Supported
13 Introduce options in the 'at-risk' procedures to deal with non-compliance.	Supported in principle
14 Immediately cease the use of the Emergency Restraint Chair.	Not supported in current form
15 Review of the Northern Territory Department of Correctional Services Directive 3.1.6 and the use of handcuffs and/or leg shackles to be limited to the provisions of the <i>Youth Justice Act</i> .	Supported
16 Development of policy and procedures to address the appropriate use of a spit hood.	Supported
17 Northern Territory Department of Correctional Services to gain a commitment from Correctional Services Health Centre to attend the Don Dale Youth Detention Centre to dispense medication.	Refer decision
18 High Security Unit to be staffed 24/7.	Supported in principle
19 Certificate III in Correctional Practice (Youth Custodial) mandatory for all current serving YJOs. Records of the completion of such training should be recorded for each staff member and attached to their personnel file.	Supported
20 Mandatory refresher training at industry-accepted intervals introduced for all YJOs.	Supported

Recommendation		Response
21	Regular training days on updates to legislation, policy and procedures and the inclusion of scenario training.	Partially supported
22	Training to incorporate a unit on complex trauma and its effect on young persons in detention.	Supported
23	Training to incorporate a more extensive focus on crisis de-escalation/negotiation/ mediation training specific to young persons in medium to high risk environments.	Supported in principle
24	Training for Correctional Officers incorporated into the Certificate III in Correctional Practice to cover information of their obligations under the <i>Youth Justice Act</i> .	Supported
25	Ensure that all cells are compliant with minimum standards of detention.	Supported
26	A reporting system on the Integrated Offender Management System to be developed to ensure decisions to transfer young persons to adult facilities are recorded appropriately.	Supported

NTDCS welcomes the opportunity to work with the Office of the Children's Commissioner to reach a resolution in relation to the above recommendations and I look forward to hearing from you regarding finalising this report.

Yours sincerely



MARK PAYNE
COMMISSIONER

16 May 2016

Issue One – Management of young persons 'at-risk'						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
1	Conduct a review of the 'at-risk' procedures, and where necessary implement changes to policies and procedures to ensure compliance with the requirements of the <i>Youth Justice Act</i> and <i>Youth Justice Regulations</i> , and most importantly to ensure the rights of the young person are upheld.	Supported	CP&S DoH <u>Partnership</u> CO	2016	<ol style="list-style-type: none"> 1. Finalise discussions with the Department of Health regarding compliance with the regulations. 2. Action decisions made and ensure the procedures reflect the agreed process. 3. Publish the procedures and advise staff of the change. 4. Ensure training incorporates the revised version of the procedures. 	The youth detention at-risk manual containing at-risk procedures have been reviewed for compliance with the <i>Youth Justice Act</i> and the Youth Justice Regulations. There are still some outstanding matters to resolve with the Department of Health to achieve full compliance with the Regulations.
2	Conduct a review of operational practices surrounding the use of 'at-risk' isolation room as they currently stand.	Supported	CP&S CO <u>Partnership</u> DoH	2016	TBA – see notes.	<p>An assumption is made that the purpose of this review is to examine alternative management options for at-risk detainees other than using de-escalation rooms.</p> <p>The response for this recommendation needs operational input (and comparative advice from other jurisdictions) to determine whether there are viable alternative options for managing young people at-risk other than the de-escalation rooms.</p> <p>The practice of containing at-risk detainees within a "safe room" until reviewed by a health practitioner is consistent with some of the other Australian jurisdictions, however there are additional processes applied by other jurisdictions that mean that this is either not the immediate response, that young people that need to be contained are not necessarily isolated during that containment and/or containment periods have a legislated limitation regardless of the advice of health practitioners.</p>
3	Periods of 'at-risk' should be strictly limited. Section 28 of the South Australian legislation: <i>Youth Justice Administration Bill 2015</i> details such limits and could provide guidance for a similar structure to be implemented in the NT.	Partially supported	CP&S CO	N/A	N/A	<p>It is currently the requirement that YJ staff place a young person on an 'at-risk' status as soon as there is an indication that the young person may be at risk of self-harm or suicide. This requirement is in place as a mitigation strategy recognising that the workforce responsible on a daily basis for a high-risk and vulnerable cohort of clients are not qualified in medical or mental health matters. Young detainees remain on an at-risk status until they are assessed by a health practitioner (required to occur within 24 hours) and the at-risk status is either to be removed or confirmed by a health practitioner.</p> <p>Whilst the principle of this recommendation is recognised by NTDCS, the time spent by at-risk detainees in the de-escalation rooms is reliant on the recommendation of health professionals. Removing this responsibility from a health professional and imposing pre-determined and generic time restrictions on periods of at-risk could jeopardize the safety of at-risk detainees; particularly as the de-escalation rooms are currently the safest option for at-risk detainees, given an absence of permanently co-located mental health professionals. In order to adopt this recommendation, NTDCS would be unlikely to introduce a legislative change to specify limitations on periods of isolation for at-risk detainees; however is willing to examine how current procedures and practice can be changed to reduce the time spent by young people in isolation.</p>

Issue One – Management of young persons ‘at-risk’						
4	Inform the Office of the Children’s Commissioner when a young person is placed ‘at-risk’.	Not supported (in current form – see Notes).	CP&S CO	N/A	1. Seek clarification from the Office of the Children’s Commissioner regarding the issues outlined in the Notes.	<p>The purpose of notifying the Office of the Children’s Commissioner when a young person is placed ‘at-risk’ is not clear and is likely not feasible or practical on a day to day basis. More information about what this recommendation would be aiming to achieve is required to determine whether we can meet the requirement operationally.</p> <p>It is currently a requirement for YJ staff to place a young person on an ‘at-risk’ status as soon as there is an indication that the young person may be at risk of self-harm or suicide. This requirement is in place as a mitigation strategy, recognising that the workforce that is responsible on a daily basis for a high-risk and vulnerable cohort of clients are not qualified in medical or mental health matters. Young detainees remain on an at-risk status until they are assessed by a health practitioner and the at-risk status is either removed or confirmed.</p> <p>If the mitigating practice followed by YJ officers is to be subject to additional scrutiny at the Children’s Commissioner level, NTDCS would need to be proactive in managing perceptions of staff in this regard to ensure that there are no unintended consequences where YJ staff are deterred from responding when identifying an at-risk young person. NTDCS could work with the Children’s Commissioner regarding advice of a medically confirmed ‘at risk’.</p>

Issue Two – Inadequate Service Intervention						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
5	Amend the ‘at-risk’ procedures to reflect an immediate response from Forensic Mental Health whenever a young person is placed ‘at-risk’ – with a Forensic Mental Health Assessment to be conducted within 2 hours of the young person going ‘at-risk’.	Refer decision to DoH	DoH	TBA	1. Refer this recommendation back to the Office of the Children’s Commissioner to re-direct to the Department of Health.	<p>There is currently no FMH service based at the youth detention centre. This arrangement makes it impossible for an “immediate” response to be provided, unless such a response was of an a medical examination nature only.</p> <p>Compliance with this recommendation would have to be based on the advice of Department of Health as to their capacity to provide an FMHS service within the youth detention centres.</p>
6	<p>Improve communication between service providers, may include:</p> <p>a. Universal flow chart for the notification process to be distributed amongst all service providers and included in training/induction;</p> <p>b. 24/7 service to be provided by FMHS (call-out system).</p>	<p>a. Supported.</p> <p>b. Refer decision to DoH</p>	<p>a. CO</p> <p><i>Partnership</i> CP&S NTDCS Training</p> <p>b. DoH</p>	<p>a. 2016</p> <p>b. TBA</p>	<p>a.</p> <p>1. Disseminate the existing flow chart (located in appendix of the at-risk procedures) to relevant service providers.</p> <p>2. Ensure its inclusion in YJO training and induction.</p> <p>b. Refer this recommendation back to the Office of the Children’s Commissioner to re-direct to the Department of Health.</p>	<p>a. A flow chart has been developed regarding the notification process and included in the at-risk procedures. This was developed by the Principal Health Advisor in consultation with detention centre staff and health staff. This flow chart can be distributed to any service provider that works with youth in detention.</p> <p>b. Compliance with this recommendation would have to be based on the advice of Department of Health as to their capacity to provide an FMHS service within the youth detention centres.</p>

Issue Two – Inadequate Service Intervention						
7	Review the process of implementing the Individual Management Plans for 'at-risk' young persons to ensure a consistent and structured multi-disciplinary methodology is applied to each case.	Supported	NTNTDCS DoH	2016	<ol style="list-style-type: none"> Following resolution to recommendation 1, consult with DoH to review the current process for implementing the ARMPs for detainees. Determine roles and responsibilities of all positions linked to detainees that may have a role to play in implementing the provisions under ARMPs. Revise the procedure for implementing ARMPs in the procedures manual. Ensure staff are adequately advised of their role and responsibility and receive training in this regard. 	The current responsibility for implementing Individual Management Plans (known as 'At-Risk Management Plans or ARMPs) lies with both the Department of Health and NTDCS as per the Youth Justice Regulations. Agree that the procedures could be more detailed in this regard.

Issue Three – At-risk' attire and bedding						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
8	Conduct a full audit of all 'at-risk' clothing and bedding issued to Alice Springs Youth Detention Centre and Don Dale Youth Detention Centre.	Supported in principle (See Notes)	CO	TBA	<ol style="list-style-type: none"> Establish what the standard for at-risk clothing and bedding is to determine the criteria of an audit to the adequacy of the clothing and bedding in the youth detention centres. Seek clarification from the Office of the Children's Commissioner regarding the issues outlined in the Notes. 	In order to complete this action plan, the purpose of the audit would need to be ascertained. An assumption is made that it would be trying to ensure the quality of the clothing and bedding is to standard however, it is unclear whether the audit is primarily trying to address issues of quantity, quality, appropriateness or condition of the at-risk clothing and bedding (or all of those things). Confirmation of the scope of the audit would be appreciated. Additionally, if the recommendation can clarify the level of independence required in the audit process (i.e. if this should be conducted internally or by an external party).
9	Introduce an audit process of clothing and bedding issued to Alice Springs Youth Detention Centre and Don Dale Youth Detention Centre.	Supported in principle (See Notes)	CO	TBA	<ol style="list-style-type: none"> Seek clarification from the Office of the Children's Commissioner regarding the issues outlined in the Notes. 	As above.
10	'At-risk' procedures to include de-escalation, negotiation methods to be used where young persons are ripping clothing.	Supported in principle (see "Notes" for this recommendation and recommendation 23).	CP&S <i>Partnership</i> CO DoH NTDCS Training	2016	<ol style="list-style-type: none"> Clarify that the de-escalation and negotiation methods can be used in a broader context in addition to when young people are ripping clothes. Conduct consultation with Department of Health to determine appropriate methods and techniques for staff to use in circumstances where young people are agitated and escalated while at-risk. Identify a training package or provider that would be suitable. Develop a procedure within the at-risk manual that outlines de-escalation techniques and methods. Finalise the manual. NTDCS training centre to provide or facilitate training for YJ staff in this regard. 	<p>An assumption has been made that this recommendation is in relation to preventing young people from ripping their clothing to avoid the need for removal of clothing/nakedness. Confirmation of this would be appreciated.</p> <p>It is the view of NTDCS that de-escalation, negotiation methods would be useful in a broader context. Therefore NTDCS suggests amalgamating recommendations 10 and 23 to reinforce training provided to YJ staff regarding techniques for negotiation, mediation and de-escalation in all circumstances where a young person is agitated/escalated, emphasising the procedures to use de-escalation techniques for at-risk young people to try and reduce the need for intervention and preserve their dignity and privacy.</p>

Issue Four – Use of the 'Hoffman Tool'						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
11	Immediately prohibit any use of the 'Hoffman Tool' to strip clothing from young persons.	Supported in principle (See Notes)	CP&S	2016	<ol style="list-style-type: none"> Cease use of the Hoffman Tool for the purpose of stripping clothing from young people. Research best practice, processes used in other jurisdictions to manage detainees when non-compliant, escalated or agitated. Engage professional service to develop training package 	Clarity is required within the report as page 17 contains a statement that reads as though the report is supporting the view of YJ staff that the Hoffman Tool should be used only in situations where there is non-compliance; however this would appear to be in contradiction to this recommendation.

Issue Four – Use of the ‘Hoffman Tool’						
					<p>specifically for de-escalating young people in a youth detention setting.</p> <ol style="list-style-type: none"> Develop a policy/procedure regarding de-escalation, mediation and negotiation. Develop a directive and procedure on stripping/removal of clothing from young people (for reasons other than a strip search – require clarity on query in Notes). Provide initial and refresher training including scenario-based training for YJ staff in de-escalation, mediation, and negotiation techniques and in the new procedures and directives. This should be linked to trauma training. 	If this recommendation stands and the recommendation is about ceasing the practice of using the Hoffman Tool to remove clothing in situations of non-compliance, it would be useful to know what might be recommended instead in situations of non-compliance where a detainee’s clothing poses a risk to their safety (or whether this would be up to us to determine in line with inter-jurisdictional practice, charter of human rights etc.).
12	Incorporate the appropriate use of the ‘Hoffman Tool’ into training.	Supported	CO <i>Partnership</i> NTDCS Training	2016 (following outcome of rec. 11)	1. Incorporate information around the use of the “Hoffman Tool” to remove ligatures in Emergency Management/Critical response procedures and training.	
13	Introduce options in the ‘at-risk’ procedures to deal with non-compliance.	Supported in principle (See Notes)	CP&S	2016	1. Seek clarification from the Office of the Children’s Commissioner regarding the issues outlined in the Notes.	<p>It is not clear whether this is recommending using the Hoffman Tool given the statement on page 17 stating “Comments made by YJOs in relation to the use of the Hoffman Tool show that it should only be used where non-compliant...”</p> <p>NTDCS would propose the following as a standard approach (to be implemented in line with the risk to the safety of the detainee and others):</p> <ul style="list-style-type: none"> Direct a detainee to change their clothing/submit any ripped clothing. If that does not result in compliance, use de-escalation techniques to prevent a young person from damaging their clothing or to accept at-risk clothing. If that is unsuccessful, intervention is required. [If the recommendation is intended that the Hoffman Tool not be used then NTDCS would appreciate suggestion as to what else might be acceptable in a circumstance where clothing has to be removed for safety purposes.

Issue Five – Use of restraints						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
14	Immediately cease the use of the Emergency Restraint Chair.	Not supported (in current form see “Notes”)	CP&S	N/A	N/A	<p>The Department of Correctional Services accords with this recommendation, as restraint chairs are not approved for use in relation to restraining youth detainees as per the Use of Restraint directive.</p> <p>The Commissioner of Correctional Services has commenced the establishment of the Youth Detention Restraint Practice Advisory Group to support the introduction of the <i>Youth Justice Amendment Bill 2016</i>. If the proposed amendment to the <i>Youth Justice Act</i> proceeds, the particular mechanical devices that may be approved for use in youth detention, and the standards of use for these devices are to be developed on the recommendation of the Youth Detention Restraint Practice Advisory Group.</p>
15	Review of the Northern Territory Department of Correctional Services Directive 3.1.6 and the use of handcuffs	Supported	CP&S	2016	<ol style="list-style-type: none"> Refer this matter to the Youth Detention Restraint Practice Advisory Group for consideration. Review any existing directives or procedures and/or develop new 	The Use of Restraints directive, reviewed January 2016, provides the following circumstances of use with respect to handcuffs or a similar device:

Issue Five – Use of restraints						
	and/or leg shackles to be limited to the provisions of the <i>Youth Justice Act</i> .				policy, procedure and directives in accordance with the decision of the Youth Detention Restraint Practice Advisory Group.	<p>The <i>Youth Justice Act</i> permits the use of approved restraints in the following circumstances:</p> <ul style="list-style-type: none"> • to restrain normal movement to be used when escorting a detainee outside a detention centre; or • if the Superintendent is of the opinion that: <ul style="list-style-type: none"> a. an emergency situation exists; and b. a detainee should be temporarily restrained to protect the detainee from self-harm or to protect the safety of another person. <p>The Commissioner of Correctional Services has commenced the establishment of the Youth Detention Restraint Practice Advisory Group to support the introduction of the <i>Youth Justice Amendment Bill 2016</i>. The Advisory Group will provide advice to the Commissioner of Correctional Services to inform decision making in relation to restraint practices, including the development and amendment of operational procedures and standards.</p>
16	Development of policy and procedures to address the appropriate use of a spit hood.	Supported	CP&S	2016	<ol style="list-style-type: none"> 1. Develop a policy position and procedures in accordance with National good practice guidelines. 2. Conduct training for staff in the use of a spit hood. 	Suggest moving this recommendation out of the “use of restraints” issue. It is the view of NTNTDCS that a spit hood does not constitute a restraint as it does not limit the normal movement of a detainee.

Issue Six – Staffing and Training						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
17	Northern Territory Department of Correctional Services to gain a commitment from Correctional Services Health Centre to attend the Don Dale Youth Detention Centre to dispense medication.	Refer decision to DoH	DoH	2016	<ol style="list-style-type: none"> 1. Refer this recommendation back to the Office of the Children’s Commissioner to re-direct to the Department of Health. 	Compliance with this recommendation would have to be based on the advice of Department of Health as to their capacity to provide an FMHS service within the youth detention centres.
18	High Security Unit to be staffed 24/7.	Supported in principle	CO	TBA	TBA – see Notes	NTDCS needs to conduct an exercise to ensure it has the operational capacity to meet this recommendation.
19	Certificate III in Correctional Practice (Youth Custodial) mandatory for all current serving YJOs. Records of the completion of such training should be recorded for each staff member and attached to their personnel file.	Supported	CO <i>Partnership</i> NTDCS Training	2016	<ol style="list-style-type: none"> 1. Liaise with the NTDCS training centre to determine the time commitment required by YJ staff to complete the Certificate III training. 2. Work with the NTDCS training centre to develop a calendar schedule for completion of this training. 3. Work with the NTDCS Training Centre to arrange for staff training days. 4. Ensure that the development of the staff roster considers dates for training. 5. Once completed, ensure the record of completion of this training is recorded in the staff member’s personnel files. 	<p>Adoption of this recommendation will require a concurrent review of staff planning processes and the rostering process to ensure there are considerations and allowances for any absences of experienced staff to attend training.</p> <p>There is also a requirement to consider available budget for this training.</p>
20	Mandatory refresher training at industry-accepted intervals introduced for all YJOs.	Supported	CO (Adult) <i>Partnership</i> NTDCS Training	2016	<ol style="list-style-type: none"> 1. Ascertain what the industry- accepted interval for refresher training is. 2. Work with the NTDCS Training Centre to develop a calendar schedule for refresher training in line with the industry-accepted interval. 3. Ensure that the development of the staff roster considers dates for 	<p>Adoption of this recommendation will require a concurrent review of staff planning processes and rostering process to ensure there are considerations and allowances made across the board for any mandatory refresher training.</p> <p>There is also a requirement to consider available budget for</p>

Issue Six – Staffing and Training						
					mandatory refresher training. 4. Deliver refresher training in accordance with the calendar schedule.	this training.
21	Regular training days on updates to legislation, policy and procedures and the inclusion of scenario training.	Supported in principle (see "Notes")	CO <i>Partnership</i> NTDCS Training	2016	1. When there is a change to any policy, procedure or legislation the NTDCS training centre is to be advised. 2. Work with the NTDCS Training Centre to arrange for staff training days to communicate these changes. 3. Ensure that the development of the staff roster considers dates for training.	Suggest amendment to the wording of this recommendation – in particular: <ul style="list-style-type: none"> Review the wording to remove the requirement for "regular" training in relation to this recommendation. Training for communicating updates would need to be conducted on an ad-hoc basis rather than a regular basis as it needs to be responsive to changes to legislation, policy and procedures.; and Review the inclusion of "scenario based training" in this recommendation. Suggest moving this to recommendation 20 as it seems more relevant there than to training for updates to policies, legislation and procedures.
22	Training to incorporate a unit on complex trauma and its effect on young persons in detention.	Supported	CO <i>Partnership</i> NTDCS Training	2016	1. Work with the NTDCS training centre to source an appropriate course or provider for this training. 2. Work with the NTDCS Training Centre to arrange for staff training days. 3. Ensure that the development of the staff roster considers dates for training.	An appropriate provider or course and budget for this would need to be sourced.
23	Training to incorporate a more extensive focus on crisis de-escalation/negotiation/mediation training specific to young persons in medium to high risk environments.	Supported in principle (see "Notes")	CO <i>Partnership</i> NTDCS Training	TBA	1. Conduct consultation with Department of Health to determine appropriate methods and techniques for staff to use in circumstances where young people are agitated and escalated while at-risk. 2. Identify a training package or provider that would be suitable. 3. Develop a procedure within the at-risk manual that outlines de-escalation techniques and methods. 4. Finalise the manual. 5. NTDCS training centre to provide or facilitate training for YJ staff in this regard.	It is the view of NTDCS that de-escalation and negotiation methods are useful in a broader context. Therefore NTDCS suggests amalgamating recommendations 10 and 23 to ensure that training provided to YJ staff recognises techniques for negotiation, mediation and de-escalation in all circumstances where a young person is agitated/escalated. The procedures to include using de-escalation techniques for at-risk young people to try and reduce the need for intervention and preserve their dignity and privacy.
24	Training for Correctional Officers incorporated into the Certificate III in Correctional Practice to cover information of their obligations under the <i>Youth Justice Act</i> .	Supported	CO (Adult) <i>Partnership</i> NTDCS Training	2016	TBA – See "Notes"	This relates to a decision regarding adult custodial training package. Would need to defer to CO adult custodial to determine the action plan.

Issue Seven – Infrastructure						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
25	Ensure that all cells are compliant with minimum standards of detention.	Supported	CO	2016	1. Develop a checklist of cell requirements based on the standards. 2. Review cells within youth detention centres against the checklist. 3. Provide results in report form to Commissioner.	An assumption has been made that the minimum standards of detention referred to in this recommendation refers to the "Havana Rules" and "Royal Commission in to Aboriginal Deaths in Custody".

Ancillary issue re: transfer to adult facilities						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
26	A reporting system on the Integrated Offender Management System to be developed to ensure decisions to transfer young persons to adult facilities are recorded appropriately.	Supported	CO <i>Partnership</i> IOMS team	2016	1. Consult with the IOMS team within NTDCS to determine whether this reporting could be incorporated in existing IOMS system. a. If so, develop a procedure for recording this in IOMS and issue to the Youth Detention Centre operations manual. b. Provide training for staff. c. If not, work with IOMS team to scope the work required and	An assumption has been made that this recommendation relates only to short-term temporary transfers to an adult facility as the reason for transfer as opposed to when a young person reaches age 18 as this is a clear rationale.

					request quote for development of the report. d. Consider quote in line with the procurement principles and available budget.	
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CO= Custodial Operations CP&S = Correctional Programs and Services DoH = Department of Health

Our Ref: OCC 2015/00149
Your Ref:

Mr Mark Payne
Commissioner
Department of NT Correctional Services
PO Box 1722
DARWIN NT 0801

Dear Mr Payne, *Mark*

RE: DRAFT INVESTIGATION REPORT

Thank you for your letter of 16 May 2016 in response to the draft investigation report of the own-initiative investigation into services provided to young people detained at the Don Dale Youth Detention Centre and Alice Springs Youth Detention Centre.

I will be reviewing your initial response and identified actions that NTDCS could take to achieve the recommendations, as well as reviewing the response from the Department of Health. Once I have considered both responses I would welcome the opportunity to work with NTDCS to reach a resolution to the recommendations.

Yours sincerely



Ms Colleen Gwynne
Children's Commissioner
20 May 2016

Mr Mark Payne
Commissioner
Department of NT Correctional Services
PO Box 1722
DARWIN NT 0801

Dear Mr Payne,

RE: DRAFT INVESTIGATION REPORT

Thank you for your response to the Draft Investigation Report of the own-initiative investigation into services provided to young people detained at the Don Dale Youth Detention Centre and Alice Springs Youth Detention Centre.

I understand that your department is consulting with the Department of Health at multiple levels across the agencies to enable provision of an appropriate service to 'at-risk' youth in correctional settings. I have also learnt that the 'At-Risk' Procedures Manual has also been updated and is due to be reviewed next month.

I have now reviewed the responses and identified actions that NTDCS could take to achieve the recommendations, as well as the response provided by the Department of Health. I have enclosed commentary on the responses provided. As the recommendations have been re-drafted, I would like to give each department further opportunity to comment on the Second Draft Investigation Report so that these comments can be taken into account in finalising the report.

It is acknowledged that the announcement of the Royal Commission into the Northern Territory Youth Justice System may impact the recommendations in this report. However, as this report relates to a point in time the recommendations remain valid and necessary in the interim and I invite you to consider them and provide a response on or before 12 August 2016. I acknowledge this is a short time-frame but given that no new findings have been made I would anticipate that it is achievable.

Please do not hesitate to contact Kira Olney, Manager Investigations, on 8999 6076 or via email at childrenscommissioner@nt.gov.au if you have any queries regarding this matter.

Yours sincerely,


Ms Colleen Gwynne
Children's Commissioner
28 July 2016

11 August 2016

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File Ref: DCSDOC16/6896

Dear Ms Gwynne, *Colleen*

RE: DRAFT INVESTIGATION REPORT

On the 13th April 2016, you wrote to the Department of Correctional Services (NTDCS) to advise of the completion of your own-initiative investigation into services provided to young people detained at the Don Dale Youth Detention Centre and the Alice Springs Youth Detention Centre and to provide the associated draft investigation report.

NTDCS provided an initial response to the draft report on 16 May 2016, with tabled feedback to each of the 26 recommendations. This has resulted in a second version of the investigation report which was provided for NTDCS feedback on 29 July 2016.

I am writing to advise you that NTDCS has considered the content of the second version of the draft investigation report and its 21 recommendations and has provided an initial response which is summarised below; with a more detailed response and, where applicable, identified actions that NTDCS could take to achieve the recommended level of service (Attachment A). In addition to feedback on the recommendations, NTDCS has identified several areas of the report that do not reflect accurately the position of the department, and therefore would like to seek resolution of these matters (Attachment B refers)

Summarised response to recommendations

Recommendation	Response
1 Department of Correctional Services and the Department of Health maintain collaboration in reviewing and updating the 'At Risk' Procedures Manual and the Youth 'At-Risk' Procedures and associated service agreements to ensure operational effectiveness of managing young persons placed 'at-risk'.	Supported
2 Department of Correctional Services and the Department of Health examine alternative options, other than the de-escalation rooms, for young persons placed 'at-risk'.	Supported
3 Department of Correctional Services to give written notice to the Office of the Children's Commissioner, as soon as practicable, if a young person 'at-risk' has not been seen by a medical practitioner within 24 hours of being placed 'at-risk'.	Supported
4 Explore options for continuously monitoring a young person 'at-risk' that complies with the Emergency Management Protocol in the Youth Justice Regulations and is consistent with the Northern Territory Department of Correctional Services At-Risk Procedures Manual and the Department of Health Youth 'At-Risk' Procedures.	Supported

Recommendation		Response
5	Conduct and record regular internal audits of all 'at-risk' clothing and bedding held at both Youth Detention Centres to ensure each item to be issued to a young person placed 'at-risk' is in a sufficient condition (no loose threads) and there are appropriate stocks to cater for all sizes.	Supported
6	Immediately prohibit the use of the 'Hoffman Tool' to strip clothing from a young person who is refusing to change into 'at-risk' clothing.	Supported
7	Develop policy and operational procedures to address the appropriate use of the Hoffman Tool to remove ligatures in Emergency Management/critical incidents.	Supported
8	Immediately cease the use of the Emergency Restraint Chair.	Supported
9	Continue using 'Use of Restraints' Directive 3.2.1 until such point that the Youth Detention Restraint Practice Advisory Group develops evidence-based policy and operational procedures in restraint practices.	Supported
10	Development of policy and procedures to address the appropriate use of a spit hood.	Not applicable
11	Conduct a review of the High Security Unit to establish operational capacity to staff the unit 24 hours, 7 days a week	Supported
12	Conduct a review of staff planning processes to ensure that all current serving Youth Justice Officers have completed the Certificate III Correctional Practice (Youth Custodial) upon their confirmation of appointment.	Supported
13	Introduce mandatory training days to include operational safety and tactics training, (such as restraint techniques and scenario training) and updates upon changes to legislation, policy and/or procedures.	Supported
14	Identify an appropriate provider to incorporate training in complex trauma and its effect on young persons in detention.	Supported
15	Training to incorporate a more extensive focus on crisis de-escalation / negotiation / mediation training specific to young persons who are threatening self-harm, have attempted self-harm and/or have been subsequently placed 'at-risk'.	Supported
16	Consult with the Correctional Officer Training Department to include training to include information on the obligations of Correctional Officers to young persons who are temporarily transferred to an adult correctional facility (with a focus on section 154 of the <i>Youth Justice Act</i>).	Supported
17	Incorporate training around the appropriate use of, and application of, the Hoffman Tool (to remove ligatures).	Supported
18	Incorporate into training the appropriate use of, and application of a spit hood.	Not applicable
19	Department of Correctional Services and the Department of Health to develop a service arrangement for trained health practitioners to dispense schedule 4 and 8 medication to young persons.	Supported

Recommendation		Response
20	Ensure that all cells are compliant with the minimum standards of detention outlined in the <i>UN Rules for the Protection of Juveniles Deprived of their Liberty</i> (i.e. the 'Havana Rules').	Supported
21	Develop a reporting system to ensure decisions to transfer young persons temporarily to adult facilities are recorded appropriately.	Supported

NTDCS welcomes the opportunity to work with the Office of the Children's Commissioner to reach a resolution in relation to the above recommendations and I look forward to hearing from you regarding finalising this report.

Yours sincerely



MARK PAYNE
COMMISSIONER

// August 2016

Issue One – Management of young persons 'at-risk'						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
1	Department of Correctional Services and the Department of Health maintain collaboration in reviewing and updating the 'At Risk' Procedures Manual and the Youth 'At-Risk' Procedures and associated service agreements to ensure operational effectiveness of managing young persons placed 'at-risk'.	Supported	CP&S DoH <i>Partnership</i> CO	2016	1. Continue to collaborate with the Department of Health regarding the management	This work will be an ongoing arrangement between the two departments and work has commenced to ensure a collaborative approach to managing at-risk detainees and in reviewing/updating practices and associated documentation is maintained.
2	Department of Correctional Services and the Department of Health examine alternative options, other than the de-escalation rooms, for young persons placed 'at-risk'.	Supported	CP&S CO <i>Partnership</i> DoH	2016	1. Conduct an assessment of operational facilities and resources, collaboration with the Department of Health and research to determine best practice approaches and practices used in other jurisdictions to determine viable alternatives for accommodating at-risk young people in the NT youth detention centres.	Associated action against this recommendation requires an assessment of operational facilities and resources, collaboration with the Department of Health and research to determine best practice approaches and practices used in other jurisdictions to determine viable alternatives for accommodating at-risk young people in the NT youth detention centres. In particular, the examination of and associated decision-making on any alternative management options or processes for monitoring youth at-risk in detention will be through collaboration between NTDCS and DoH. The practice of accommodating at-risk detainees within a "safe room" (such as the de-escalation rooms) until reviewed by a health practitioner is consistent with some of the other Australian jurisdictions, however there are additional processes or applied by other jurisdictions that could be considered including that placement in a de-escalation room is either: <ul style="list-style-type: none"> • not the immediate response; • in conjunction with the young people having the ability to participate in designated activities or interactions outside of that accommodation area; and/or • has a limitation on length of accommodation.
3	Department of Correctional Services to give written notice to the Office of the Children's Commissioner, as soon as practicable, if a young person 'at-risk' has not been seen by a medical practitioner within 24 hours of being placed 'at-risk'.	Supported	CP&S CO	2016	1. Develop a process for written notification to the Office of the Children's Commissioner. 2. Amend the "Northern Territory Youth Detention Centres At-risk procedures manual" to reflect a process for written notification to be made to the Office of the Children's Commissioner in instances where a young person 'at-risk' has not been seen by a medical practitioner within 24 hours of being placed 'at-risk'. 3. Provide training for the relevant officers.	

Issue Two – Inadequate service intervention for young persons being placed 'at-risk' on repeated occasions						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
4	Explore options for continuously monitoring a young person 'at-risk' that complies with the Emergency Management Protocol in the Youth Justice Regulations and is consistent with the Northern Territory Department of Correctional Services At-Risk Procedures Manual and the Department of Health Youth 'At-Risk' Procedures	Supported	NTDCS DoH	2016	1.	Associated action against this recommendation requires an assessment of operational facilities and resources, collaboration with the Department of Health and research to determine best practice approaches and practices used in other jurisdictions to determine viable alternatives for accommodating at-risk young people in the NT youth detention centres. The exploration and associated decision-making on any alternative management options or processes for monitoring youth at-risk in detention will be through collaboration between NTDCS and DoH.

Issue Three – Inadequate ‘at-risk’ attire and bedding						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
5	Conduct and record regular internal audits of all ‘at-risk’ clothing and bedding held at both Youth Detention Centres to ensure each item to be issued to a young person placed ‘at-risk’ is in a sufficient condition (no loose threads) and there are appropriate stocks to cater for all sizes.	Supported	CO	2016	<ol style="list-style-type: none"> 1. Establish what the standard for at-risk clothing and bedding is to determine the criteria of an audit to the adequacy of the clothing and bedding in the youth detention centres. 2. Develop an internal audit process and associated supporting documentation. 3. Implement training for relevant staff responsible for conducting audits for the at-risk clothing and bedding. 	

Issue Four – The use of the Hoffman Tool to remove clothing from young persons						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
6	Immediately prohibit the use of the ‘Hoffman Tool’ to strip clothing from a young person who is refusing to change into ‘at-risk’ clothing.	Supported	CO CP&S	2016	<ol style="list-style-type: none"> 1. Cease use of the Hoffman Tool for the purpose of stripping clothing from young people. 2. Research best practice, processes used in other jurisdictions to manage detainees when non-compliant, escalated or agitated. 3. Engage professional service to develop training package specifically to inform youth justice staff in effectively and safely de-escalating young people in a youth detention setting. 4. Develop a policy/procedure regarding de-escalation, mediation and negotiation. 5. Develop a policy position, and associated directive and procedure on what to do regarding incidents where a young person refuses to change into non-rip clothing. This should be in consideration of the <i>Youth Justice Act, Youth Justice Regulations, UN Convention on the Rights of the Child and the “Havana Rules”</i>. 	
7	Develop policy and operational procedures to address the appropriate use of the Hoffman Tool to remove ligatures in Emergency Management/critical incidents.	Supported	CO CP&S	2016	<ol style="list-style-type: none"> 1. Develop a policy/procedure regarding the appropriate use of the Hoffman Tool in emergency situations. 	

Issue Five – The use of restraints on a young person placed ‘at-risk’						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
8	Immediately cease the use of the Emergency Restraint Chair.	Supported	CP&S	N/A	N/A	<p>The Department of Correctional Services accords with this recommendation, as restraint chairs are not approved for use in relation to restraining youth detainees as per the amended Directive 3.2.1 Use of Restraint – Youth Detention, which came into force 1 August 2016.</p> <p>The Youth Detention Restraint Practice Advisory Group has been established to support the introduction of the <i>Youth Justice Amendment Bill 2016</i> which will recommend the particular mechanical devices that may be approved for use in youth detention, and the standards of use for these devices.</p>
9	Continue using ‘Use of Restraints’ Directive 3.2.1 until such point that the Youth Detention Restraint Practice Advisory Group develops evidence-based policy and operational procedures in restraint practices.	Supported	CP&S	2016	<ol style="list-style-type: none"> 1. Refer this matter to the Youth Detention Restraint Practice Advisory Group for consideration. 2. Review any existing directives or procedures and/or develop new policy, procedure and directives in accordance with the decision of the Youth Detention Restraint Practice Advisory Group. 	<p>The Youth Detention Restraint Practice Advisory Group (the Advisory Group) has met four times since its establishment in May 2016. The Advisory Group provided advice in relation to the development of a Restraint Practices – Standards of Use document. The Standards of Use are awaiting formal ratification by the Commissioner of Correctional Services (all members of the Advisory Group endorsed ratification of the Restraint Practices – Standard of Use document). This document has been used to inform the development of an</p>

Issue Five – The use of restraints on a young person placed 'at-risk'

						amended Directive 3.2.1 Use of Restraint – Youth Detention, which came into force 1 August 2016. The Advisory Group will continue to meet to address restraint practice in youth detention.
10	Development of policy and procedures to address the appropriate use of a spit hood.	N/A	N/A	N/A	N/A	The current NTDCS policy position with regard to the use of spit hoods on detainees accords with instructions from the Chief Minister: that is, that NTDCS has ceased the use of spit hoods in relation to detainees.

Issue Six – Staffing and Training

No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
11	Conduct a review of the High Security Unit to establish operational capacity to staff the unit 24 hours, 7 days a week.	Supported in principle	CO	2016	1. Conduct a review of the staffing model in comparison with the detainee needs and operational procedures for the High Security Unit to determine whether there is operational capacity to staff the High Security Unit 24 hours, 7 days a week.	
12	Conduct a review of staff planning processes to ensure that all current serving Youth Justice Officers have completed the Certificate III Correctional Practice (Youth Custodial) upon their confirmation of appointment.	Supported	CO <u>Partnership</u> NTDCS Training	2016	1. Review processes to ensure there is one that will capture the confirmation of current serving Youth Justice Officers' completion of Certificate III Correctional Practice (Youth Custodial). 2. Once completed, ensure the record of completion of this training is recorded in the staff member's personnel files.	
13	Introduce mandatory training days to include operational safety and tactics training, (such as restraint techniques and scenario training) and updates upon changes to legislation, policy and/or procedures.	Supported	CP&S CO <u>Partnership</u> NTDCS Training	2016	1. Work with the NTDCS training centre to develop a calendar schedule for this training. 2. Work with the NTDCS Training Centre to arrange for staff training days. 3. Ensure that the development of the staff roster considers dates for training. 4. Once completed, ensure the record of completion of this training is recorded in the staff member's personnel files.	
14	Identify an appropriate provider to incorporate training in complex trauma and its effect on young persons in detention.	Supported	CP&S CO <u>Partnership</u> NTDCS Training	2016	1. Conduct a process to source an appropriate course or provider for this training. 2. Work with the NTDCS Training Centre to arrange for staff training days. 3. Ensure that the development of the staff roster considers dates for training. 4. Once completed, ensure the record of completion of this training is recorded in the staff member's personnel files.	
15	Training to incorporate a more extensive focus on crisis de-escalation / negotiation / mediation training specific to young persons who are threatening self-harm, have attempted self-harm and/or have been subsequently placed 'at-risk'.	Supported	CP&S CO <u>Partnership</u> NTDCS Training	2016	1. Conduct consultation with Department of Health to determine avenues for appropriate training for staff to use in circumstances where young people are agitated and escalated while at-risk. 2. Identify a training package or provider that would be suitable. 3. Develop a procedure within the at-risk manual that outlines de-escalation techniques and methods. 4. Ensure relevant staff within the youth detention centres receive training in this regard.	
16	Consult with the Correctional Officer Training Department to include training to include information on the obligations of Correctional Officers to young persons who are temporarily transferred to an adult correctional facility (with a focus on section 154 of the Youth Justice Act).	Supported	CO <u>Partnership</u> NTDCS Training	2016	1. Notify the Executive Director of Custodial Operations and the Manager of the Training Centre of this recommendation. 2. Request that consideration be made to the training of Correctional Officers who manage youth detainees when transferred to an adult correctional facility.	

Issue Six – Staffing and Training						
17	Incorporate training around the appropriate use of, and application of, the Hoffman Tool (to remove ligatures).	Supported	CO <i>Partnership</i> NTDCS Training	2016	1. Provide training for Youth Justice Officers around the use of the Hoffman Tool for its intended purpose.	
18	Incorporate into training the appropriate use of, and application of a spit hood.	N/A	N/A	N/A	N/A	The current NTDCS policy position with regard to the use of spit hoods on detainees accords with instructions from the Chief Minister: that is, that NTDCS has ceased the use of spit hoods in relation to detainees.
19	Department of Correctional Services and the Department of Health to develop a service arrangement for trained health practitioners to dispense schedule 4 and 8 medication to young persons.	Supported	CP&S CO DoH	2016	1. Work with the Department of Health to develop a service arrangement and procedure regarding health practitioners dispensing schedule 4 and 8 medication to detainees.	

Issue Seven – Infrastructure						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
20	Ensure that all cells are compliant with the minimum standards of detention outlined in the <i>UN Rules for the Protection of Juveniles Deprived of their Liberty</i> (i.e. the 'Havana Rules').	Supported	CP&S CO	2016	1. Develop a checklist of cell requirements based on the standards. 2. Review cells within youth detention centres against the checklist. 3. Provide results in report form to Commissioner.	

Ancillary issue re: transfer to adult facilities						
No.	Recommendation	Supported/Not Supported	Responsibility	Commence	Action Plan	Notes
21	Develop a reporting system to ensure decisions to transfer young persons temporarily to adult facilities are recorded appropriately.	Supported	CO <i>Partnership</i> IOMS team	2016	1. Consult with the IOMS team within NTDCS to determine whether this reporting could be incorporated in existing IOMS system. a. If so, develop a procedure for recording this in IOMS and issue to the Youth Detention Centre operations manual. b. Provide training for staff. c. If not, work with IOMS team to scope the work required and request quote for development of the report. d. Consider quote in line with the procurement principles and available budget.	

CO= Custodial Operations CP&S = Correctional Programs and Services DoH = Department of Health IOMS = Integrated Offender Management System

NTDCS comments regarding content of the Draft Investigation report

Page	Current content	NTDCS comment
4	<p>The Youth Justice Division of the Northern Territory Department of Correctional Services (NTDCS) manages the youth justice facilities in the Northern Territory (NT).</p>	<p>The current name of the division responsible for the management of youth detention centres in the Northern Territory is the Custodial Operations division. The Youth Justice division does not exist anymore.</p>
21	<p>However, the procedure states that a member of staff (i.e. YJO) will remain with the youth at all times</p>	<p>NTDCS wishes to clarify that this content (sourced from the Department of Health 'At-risk' procedure) is inconsistent with the "NT youth detention centres at-risk procedures manual" which states that a staff member will remain with the youth until the Emergency Management Plan is enacted. This inconsistency has now been clarified with the Department of Health, with the health procedure now reflecting the same process as the NTDCS procedure.</p> <p>In relation to the management of a young person in the time between the enactment of the at-risk procedure and the individual at-risk management plan being developed, NTDCS intend to include the presence of a Youth Justice Officer or case management team member with the detainee for the first hour of their placement and to conduct physical observations every 15 minutes rather than CCTV observations. The Department of Health is supportive of the proposal however it is acknowledged that training for youth detention staff in de-escalation techniques and responding to young people at-risk of suicide and self-harm is required before implementation of these practices. NTDCS anticipates commencing this training in the near future.</p> <p>NTDCS requests that the content be amended to reflect the correct procedural information.</p>

Page	Current content	NTDCS comment
32	... and as such NTDCS are unwilling to accept the recommendation going forward”.	<p>This does not accord with the information provided by NTDCS.</p> <p>As advised, at the time the recommendation was provided to NTDCS, the restraint chair was not approved for use in relation to detainees.</p> <p>Further, NTDCS advised that it had established an Advisory Group to provide advice and oversight in relation to the development of restraint practice in youth detention, to complement the amendment of the <i>Youth Justice Act</i>. NTDCS advised that it would act on the advice of the Advisory Group.</p> <p>NTDCS therefore requests a retraction of this statement and/or an amendment to the content to reflect the above information.</p>
32	The OCC acknowledges the response of NTDCS to the First Draft Report, and the fact that NTDCS does not support (in the current form) the immediate cessation of the use of the Emergency Restraint Chair.	<p>This is a misrepresentation of NTDCS’ response. As advised, at the time the recommendation was provided to NTDCS, the restraint chair was not approved for use in relation to detainees. Practice was not authorised or occurring at that time, therefore could not be ceased.</p> <p>NTDCS therefore requests a retraction of this statement.</p>

Mr Mark Payne
Commissioner
Department of NT Correctional Services
PO Box 1722
DARWIN NT 0801

Dear Mr Payne,

RE: FINAL INVESTIGATION REPORT

Thank you for your letter of 11 August 2016 in relation to the Draft Investigation Report, the Office of the Children's Commissioner welcomes your support of 19 of the 21 recommendations.

In relation to Recommendations 10 and 18 which deal with the use of the spit hood, we note that the Chief Minister has directed that they are to no longer be used. In light of that direction we have placed both recommendations on hold. Our rationale for not removing them from the report is to ensure that if there is a change to the direction in the future the recommendations remain and can be implemented. We do not require any reporting against those recommendations as things stand.

Recommendation 8 has been amended to reflect the position that the Emergency Restraint Chair is not currently in use as per Directive 3.2.1, however the recommendation is to address the possibility that the Emergency Restraint Chair be reintroduced as an outcome of the Youth Detention Restraint Practice Advisory Group. We maintain our position that there is no circumstance that can justify the use of the Emergency Restraint Chair.

For ease of the reader we have removed the extracts of correspondence from the body of the report and have attached them to the Final Investigation Report in their entirety in order to articulate the process engaged in by this office and your department.

As this is now the Final Investigation Report, I am required by law to monitor and report on responses made by service providers to the recommendations made as a result of an investigation. In order for me to monitor the progress of your implementation of the 19 recommendations, I request that you provide progress reports over the next twelve months, with the first of these to be provided on or before 25 November 2016.

Yours sincerely,


Ms Colleen Gwynne
Children's Commissioner
24 August 2016

Dr Len Notaras
Chief Executive
Department of Health
PO Box 40596
Casuarina 0811

Dear Dr Notaras, 

RE: EXTRACTED DRAFT INVESTIGATION REPORT - FINDINGS AND RECOMMENDATIONS

I am writing to advise that I have completed my own initiative investigation regarding services provided by the Northern Territory Department of Correctional Services (NTDCS) to young people detained at the Don Dale Youth Detention Centre (DDYDC) and the Alice Springs Youth Detention Centre (ASYDC).

As you are aware, my office interviewed staff from your department regarding incidents involving young people who were determined to be 'at-risk'. A draft investigation report has been completed in accordance with Section 29 of the *Children's Commissioner Act* (the Act). This report includes findings and recommends specific actions that apply to the Department of Health (DoH).

Section 29 (3) of the Act states that if the Children's Commissioner proposes to make specified findings or recommend specified actions in the report about a responsible service provider or responsible Agency, the Commissioner must:

- a) Give the service provider or Agency a reasonable opportunity to comment on those findings or recommendations; and
- b) Take into account those comments in finalising the report.

Given this, I have enclosed extracts from my draft report, as well as the recommendations that require input from your department, and if accepted, a commitment to formalising a partnered approach with NTDCS to implement.

I invite you to provide a response to my office on or before 17 June 2016.

Please do not hesitate to contact Kira Olney, Manager Investigations, on 8999 6076 or via email at childrenscommissioner@nt.gov.au if you have any queries regarding this matter.

Yours sincerely,


Ms Colleen Gwynne
Children's Commissioner
19 May 2016

A/Chief Executive Officer
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Our Ref: DD20164705
Your Ref: OOC2015/00149

Ms Colleen Gwynne
Children's Commissioner
Office of the Children's Commissioner
PO Box 40598
CASUARINA NT 0811

Dear Commissioner

**RE: EXTRACTED DRAFT INVESTIGATION REPORT – FINDINGS AND
RECOMMENDATIONS**

I refer to your letter of 19 May 2016, attaching extracts of your draft own-initiative investigation report (Draft Report) on services provided by the Northern Territory Department of Correctional Services (NTDCS) to young people detained at the Don Dale Youth Detention Centre (DDYDC) and the Alice Springs Youth Detention Centre (ASYDC).

The Department of Health (DoH) thanks you for providing the Draft Report and recommendations (Recommendations), and for the opportunity to comment.

The DoH response (Response) to the Draft Report and Recommendations is at **Attachment A** to this letter. The Response deals with the content of the Draft Report and the substantive issues underlying the Draft Report, including providing clarification / correction around certain aspects. This response has been contributed to by both Health Services and the DoH.

As detailed in the Response, the DoH is presently consulting with NTDCS at multiple levels across the agencies to enable provision of an appropriate service to detained youth. Resource constraints have proven to be a challenge to date. DoH is committed to working within the legislative framework and ensuring that appropriate oversight, assessment and treatment is provided by Health staff to 'at risk' youth in correctional settings.

The DoH is cognisant of the significant complexities, risks and sensitivities in relation to youth justice services. We undertake to fully support the health services and NTDCS in exploring viable options, and welcome the opportunity to work collaboratively with NTDCS towards improving outcomes for detained youth, stakeholders and the community.

Yours sincerely



JANET ANDERSON PSM
24 June 2016

Attachment A

Northern Territory Department of Health

Response to the May 2016 draft report (Draft Report) and recommendations of the Children's Commissioner into services provided by the Northern Territory Department of Correctional Services (NTDCS) to young people detained at the Don Dale Youth Detention Centre (DDYDC) and also the Alice Springs Youth Detention Centre (ASYDC)

Response to the Draft Report

The DoH agrees¹ that a collaborative inter-agency approach is essential for 'at risk' procedures to be effective in Youth Detention Centres. The DoH is now working with NTDCS to review and improve the At-Risk Procedures Manual and associated documents. It remains a challenge to ensure that services available to these young persons are appropriate, sufficient, in line with current best practice models and seamlessly co-ordinated between the agencies. The fundamental human rights of detained young persons must be respected and protected, and this includes access to health care at a standard equal to that of the non-detained population.

Introduction, Formalities

No specific comments. For ease of review, this Response adopts matching terms to the Draft Report and Recommendations. Namely the DoH Response will also use the term 'young person'.²

Investigation Scope, Methodology, pages 5-6, and Investigation Findings, page 6

Point three of the methodology of the investigation is as follows:

- *reviewed legislation, policies, standard operating procedures, guidelines and NTDCS directives relevant to the identified issues;*

The DoH has concerns (of which NTDCS is aware) about elements of the NTDCS 'At-Risk Procedures Manual' (the Manual) and the 'Youth At-Risk Procedure' (covering after hours service provision). These documents do not fully align with legislative provisions, current service arrangements or resourcing capabilities. Relevant practical and procedural issues are now being addressed constructively between the agencies at multiple levels, and we are hopeful improvements will flow in the near future.

Issue One - Ineffective management of young persons placed 'at-risk' for extended periods, pages 7 - 12

It is inaccurate to state that Forensic Mental Health (FMH) "deems a young person to no longer be 'at risk'". The Regulations are explicit as to operational requirements for managing 'at-risk'

¹ This sentence is in reference to the first and final paragraphs on page 12, particularly.

² Noting that the terminology differs in various applicable legislation (including 'youth'², 'child'², 'vulnerable child' and 'youth detainee' or 'youth prisoner').

young persons from time of being assessed as 'at risk' through to the requirement for a medical practitioner to be involved in cancellation of 'at risk' status:

44 Cancellation of at-risk status

(1) A detainee's at-risk status may be cancelled only on the recommendation of a medical practitioner after consultation with the Superintendent or a member of staff authorised by the Superintendent for that purpose.

This is an area where the Manual is inconsistent with the Regulations, particularly in relation to the duties of medical practitioners. It seems that the Manual was adapted from a model used in the adult correctional facility, which likely contributed to the use of terms which do not correlate with the Act / Regulations and to service arrangements which are not in place or possible within current FMH resourcing.

The DoH acknowledges that compliance with the regulatory requirements (around medical practitioner involvement particularly) is difficult to achieve under current service arrangements. It is nonetheless the case that it is highly desirable for a medical practitioner to provide assessment, oversight and review of at-risk young persons to ensure that good clinical care is provided and that risk is appropriately managed. The processes set out in the Regulations largely correlate with those set out in the *Mental Health and Related Services Act (NT)* around management of analogous situations i.e. in providing mandatory minimum standards for monitoring and protection of basic human rights of an 'at risk' individual.

DoH agrees with the insights offered by the NTDCS officer as set out on page 11 of the Draft Report:

"...I don't think you can ride two ponies at once. You can be a YJO, but you can't be a mental health worker and you can't take all the individual elements and become good at all of them. Sure it's good to have an understanding and an appreciation but you're not mental health workers and you need to leave that to the professionals ..."

This comment captures the importance of utilising the right expertise to deal with detained young persons. While NTDCS staff should be appropriately trained and fully supported in all of their dealings with detained young persons, it is not reasonable to expect or request NTDCS staff to be able to fulfil functions they are not trained, experienced or qualified in. All clinical assessment and interaction with detained young persons should be performed by appropriately qualified health professionals. DoH is committed to working with NTDCS to achieve service level arrangements where clinical staff are available in person and by telephone to fulfil the legislative requirements, and to support NTDCS staff in performing their core duties.

Further, DoH agrees with the importance of ensuring that processes are in line with legislative requirements and that both NTDCS and Health staff are well-informed about how to access appropriate and readily available resources to manage at risk situations safely.

Issue Two – Inadequate service intervention for young persons being placed 'at-risk' on repeated occasions, pages 13-14

The summary provided in this section appears critical of the FMH service, in terms of a lack of response and intervention provided to a particular at risk individual.

While FMH has historically provided gratis assistance (on the ground and by telephone) and support to the NTDCS in relation to at risk young persons, this is not FMH's role, nor is FMH funded for this function. The Manual provides misleading information in this regard.

Under the existing service structure, the Primary Healthcare Service employs medical practitioners who are qualified to fulfil the obligations under the Regulations. However, as noted at page 14 of the Report, the Primary Healthcare Service is situated at the Holtze Corrections centre and so there are logistical difficulties around attendance by a medical practitioner.

DoH is working with NTDCS to undertake a review of operational practices surrounding the use of the 'at-risk' isolation rooms and to explore possible alternatives for management of youths 'at risk'.

Ancillary Issue - YJO's Dispensing Medication, page 14

Medication dispensing is a task that should be undertaken by appropriately trained health practitioners. After hours dispensing of medication by Youth Justice Officers (YJOs) introduces avoidable risks.

Conclusion, page 15

No specific comment.

DoH Response to the Draft Recommendations

Issue One - Management of young persons 'at-risk', page 16

The DoH agrees with all of the recommendations set out on page 16. The collaborative work currently underway has been referred to above. DoH (in conjunction with the Health Services) is working with NTDCS to set up a protocol around notifications of young persons placed 'at risk' to the Office of the Children's Commissioner.

Issue Two - Inadequate Service Intervention, page 17

- 5. Amend 'at-risk' procedures to reflect an immediate response from Forensic Mental Health whenever a young person is placed 'at-risk' - with a Forensic Mental Health assessment to be conducted within 2 hours of the young person going 'at-risk'.*

DoH agrees with the need for an expert, timely response when a young person is placed 'at-risk'. In principle DoH is willing to consider this recommendation as part of the broader review of services provided to young persons 'at risk' in detention centres, with a view to improving timely communications around such cases and decreasing response times for assessments to be conducted.

Use of the term 'Forensic Mental Health' should be replaced by the broader 'Health' in this recommendation. Ongoing review will consider the role of all health professionals involved in the assessment of young persons at risk, not solely FMH personnel. The FMH team is an adult team, trained in the provision of care to those aged 18 years over, and not resourced or trained to service 'at risk' young persons in the way contemplated in the Manual.

A Primary Health employed nurse, psychologist³ and / or medical practitioner would be better placed to respond in the first instance. This would be a suitable first tier assessment arrangement, and the attending health practitioner could contact FMH as / when required and depending on the outcome of the initial assessment. As per Regulations, the Medical practitioner would then conduct a comprehensive assessment with support as required by FMH or other mental health specialist clinician.

DoH notes that the 'at-risk' procedure is an endorsed NTDCS document. DoH will work in collaboration with NTDCS to develop an agreed process and aligned procedures for both Agencies.

6. *Improve communication between service providers, may include:*
 - a. *Universal flow chart for the notification process to be distributed amongst all service providers and included in training/induction;*
 - b. *24/7 service to be provided by FMH (call-out system).*

This recommendation requires comprehensive discussions involving both DoH and the two Health Services. DoH considers that the term 'Forensic Mental Health' should be replaced by 'Health' in this recommendation. The review will look at the role of all health professionals involved in the assessment of young persons at risk, not solely Forensic Mental Health personnel.

As set out above, the service and assistance provided by FMH to NTDCS to date has been an interim gratis / goodwill arrangement while permanent solutions are found. Additional and specific resources would be required if FMH were to be involved in this service provision, including extra resourcing to provide 24 hour coverage.

7. *Review the process of implementing the Individual Management Plans for 'at-risk' young persons to ensure a consistent and structured multi-disciplinary methodology is applied to each case.*

The DoH agrees in principle with a structured multi-disciplinary approach to each at risk youth episode. DoH is working with NTDCS to review the process of implementation for Individual Management Plans for young persons 'at risk'.

Ancillary Issue - Dispensing of Medication

As set out above, the DoH considers that medication administration should be undertaken by appropriately trained health practitioners. DoH and NTDCS will need work together on servicing arrangements, and additional resourcing will be required.

³ Noting again that the current Regulations require a medical practitioner to deal with 'at risk' youth.

Dr Len Notaras
Chief Executive
Department of Health
PO Box 40596
Casuarina 0811

Dear Dr Notaras,

RE: EXTRACTED DRAFT INVESTIGATION REPORT - FINDINGS AND RECOMMENDATIONS

On 24 June 2016 Ms Janet Anderson provided a detailed response to the First Draft Investigation Report of the own-initiative investigation into services provided to detained youth. I thank you for the input your department afforded.

On 6 July 2016 I welcomed the opportunity to meet with the Chief Operating Officer of Top End Health Service, Mr Michael Kalimnios, General Manager, Primary Health Care, Dr Christine Connors and the Acting General Manager, Top End Mental Health Service, Mr Richard Campion to discuss the findings and recommendations outlined in the First Draft Report. I understand that your department is consulting with NTDCS at multiple levels across the agencies to enable provision of an appropriate service to 'at-risk' youth in correctional settings.

I have reviewed the response provided by your department, in conjunction with the response and identified actions provided by the Northern Territory Department of Correctional Services (NTDCS). I have enclosed commentary on the responses provided. As the recommendations have been re-drafted, based on the responses received, I would like to give each department further opportunity to comment on the Second Draft Investigation Report so that these comments can be taken into account in finalising the report.

It is acknowledged that the announcement of the Royal Commission into the Northern Territory Youth Justice System may impact the recommendations in this report. However, as this report relates to a point in time the recommendations remain valid and necessary in the interim and I invite you to consider them and provide a response on or before 12 August 2016. I acknowledge this is a short time-frame but given that no new findings have been made I would anticipate that it is achievable.

Please do not hesitate to contact Kira Olney, Manager Investigations, on 8999 6076 or via email at childrenscommissioner@nt.gov.au if you have any queries regarding this matter.

Yours sincerely,



Ms Colleen Gwynne
Children's Commissioner
28 July 2016

Deputy Chief Executive
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Our Ref: DD2016/6175
Your Ref: OCC2015/00149

Ms Colleen Gwynne
Commissioner
Office of the Children's Commissioner
PO Box 40598
CASUARINA NT 0811
Via email: Colleen.Gwynne@nt.gov.au

Dear Commissioner

RE: SECOND DRAFT INVESTIGATION REPORT INTO SERVICES PROVIDED TO DETAINED YOUTH - OPPORTUNITY TO COMMENT

Thank you for your letter dated 28 July 2016 requesting that the Department of Health review a Second Draft Investigation Report into services provided to young people in detention at the Don Dale Youth Detention Centre and Alice Springs Youth Detention Centre. The Department and the Health Services welcome this opportunity, and acknowledge that the updated Report takes into account both the written feedback on the previous draft and information provided through your meeting with Mr Michael Kalimnios, Dr Christine Connors and Mr Richard Campion from Top End Health Service.

The Department in collaboration with relevant Top End Health Service and Central Australia Health Service personnel has reviewed your commentary on the response provided and the re-drafted recommendations. A response to each of the five recommendations is provided in the attachment to this letter.

I am pleased to report that significant collaboration between Northern Territory Department of Correctional Services (NTDCS) and the Department of Health is already underway to ensure that our respective protocols are aligned. I am also aware that Dr Christine Connors has discussed Recommendation 3 and Recommendation 4 with you, and that it is likely that the Department will be asked to consider an additional recommendation relating to reporting occasions when a medical practitioner is not available to assess a young person within the 24 hour time-frame of NTDCS staff identifying the youth "at risk". We look forward to this communication.

DEPARTMENT OF HEALTH

Thank you again for this opportunity to provide further comment and responses to the Commission's draft report. The Department of Health and the two Health Services are committed to working collaboratively with the Department of Correctional Services and exploring viable options that will achieve improved outcomes for detained youth, stakeholders and the community.

Yours sincerely

J. M. Anderson

Janet Anderson PSM
15 August 2016

DEPARTMENT OF HEALTH RESPONSE TO SECOND DRAFT RECOMMENDATIONS**Issue One – Management of young persons ‘at-risk’**

1. **Northern Territory Department of Correctional Services (NTDCS) and the Department of Health maintain collaboration in reviewing and updating the ‘At Risk’ Procedures Manual and the Youth ‘At-Risk’ Procedures and associated service agreements to ensure operational effectiveness of managing young persons placed ‘at-risk’.**

Agree. Collaboration is well underway to align these documents.

2. **Northern Territory Department of Correctional Services and the Department of Health examine alternative options, other than the de-escalation rooms, for young persons placed ‘at-risk’.**

Agree. The Department of Health has offered to provide education and advice that may reduce the need for use of de-escalation rooms. Examples include mental health de-escalation strategies, including training through the established P3 (Prevent-Plan-Protect) Program, which has a focus on risk minimisation. We have also offered to provide information to relevant Correctional Services staff regarding the internationally recognised ‘Safewards strategy’ program that has been successfully implemented within mental health settings to reduce aggression and violence.

3. **Northern Territory Department of Correctional Services to give written notice to the Office of the Children's Commissioner, as soon as practicable, if a young person ‘at risk’ has not been seen by a medical practitioner within 24 hours to provide a medical practitioner to assess a young person that has of being placed ‘at risk’**

Agree. It is understood that as this recommendation relates to the reporting responsibilities of Correctional Services officers, there are further considerations in regards to Health providing reports to the Commissioner.

Issue Two – Service Intervention to young persons ‘at-risk’

4. **Explore options for continuously monitoring a young person ‘at-risk’ that complies with the Emergency Management Protocol in the *Youth Justice Regulations* and is consistent with the Northern Territory Department of Correctional Services *At-Risk Procedures Manual* and the Department of Health *Youth ‘At-Risk’ Procedures*.**

Agree. The Department of Health has consulted with the Department of Correctional Services to establish that this recommendation relates to on-site monitoring of youth in preference to CCTV when youth are initially identified as “at risk” by Youth Justice Officers, and that such changes would be incorporated in NTDCS’s At-Risk Procedures Manual. The education, information and advice offered by the Department of Health (as per above) may assist with preparing Youth Justice Officers for such a change in procedure.

The implications for the Department of Health Youth ‘At-Risk’ Procedures will be examined and addressed.

5. **Northern Territory Department of Correctional Services and the Department of Health to develop a service arrangement for trained health practitioners to dispense schedule 4 and 8 medication to young persons.**

Agree. The Top End Health Service is exploring strategies to facilitate the additional resources that are required in order for this change to occur.

Dr Len Notaras
Chief Executive
Department of Health
PO Box 40596
Casuarina 0811

Dear Dr Notaras,

RE: FINAL INVESTIGATION REPORT

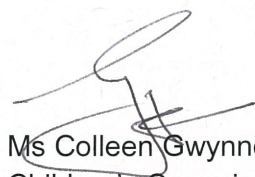
Thank you for your department's letter of 15 August 2016 in relation to the Extract of the Draft Investigation Report, the Office of the Children's Commissioner welcomes your support of the 5 recommendations relevant to the Department of Health.

Recommendations 3 and 4 are provided for information only; the NT Department of Correctional Services (NTDCS) is solely responsible for their implementation. I apologise for the confusion caused in providing those to your department without proper explanation. The rationale for their inclusion in the Extract Draft Report was to provide information to your department on those recommendations impacting on practices of 'at risk'. This will assist your department and the two Health Services to work collaboratively with the NTDCS in exploring viable options that will achieve improved outcomes for young persons detained.

For ease of the reader we have removed the extracts of correspondence from the body of the report and have attached them to the Final Investigation Report in their entirety in order to articulate the process engaged in by this office and your department.

As this is now the Final Investigation Report, I am required by law to monitor and report on responses made by service providers to the recommendations made as a result of an investigation. In order for me to monitor the progress of your implementation of the 3 recommendations (namely recommendations 1,2 and 5), I request that you provide progress reports over the next twelve months, with the first of these to be provided on or before 25 November 2016.

Yours sincerely,



Ms Colleen Gwynne
Children's Commissioner
24 August 2016