



**Report to Secure Services,  
Department of Health and Human Services**

***Review of Parkville Youth Justice Precinct Incident  
on 31 October 2015***

**DRAFT: NOVEMBER 2015**

**FINAL: NOVEMBER 2015**

**COMMERCIAL IN CONFIDENCE**

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## EXECUTIVE SUMMARY

The chain of events that culminated in the incident under review commenced with an action that occurs almost every day at Parkville Youth Justice Precinct – a staff member attempting to restrain a client for non-compliant behaviour.

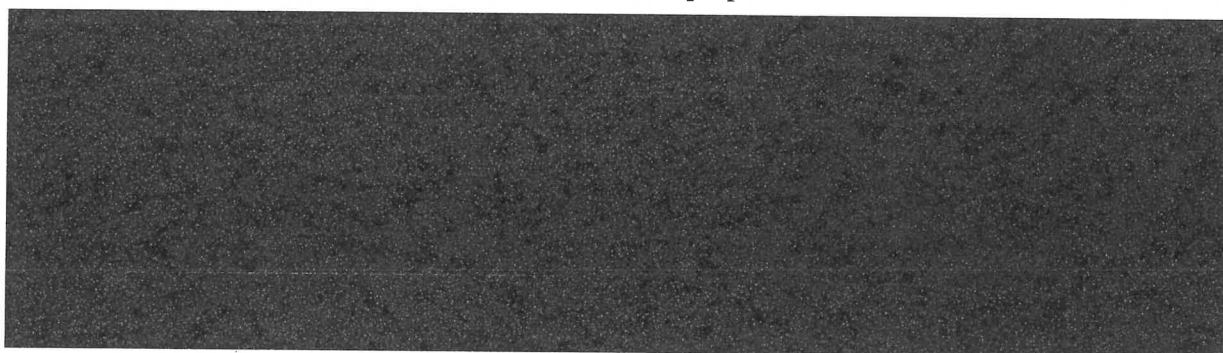
It is an issue that Secure Services has addressed strongly in its *Preventing Occupational Violence Program*. This program has delivered a framework, backed up by a rigorous training program. It is an issue that has been highlighted in Workplace Health and Safety statistics. It was addressed and highlighted in my recently completed Review of Occupational Violence in the Parkville and Malmsbury Youth Justice Precincts.

The incident at Parkville Youth Justice Precinct on 31 October 2015 had two primary causes and one aggravating factor.

Given that incidents involving client behaviour must be expected in any Youth Justice Centre, the most significant issue in my assessment is the failure of infrastructure to be able to contain and cater for the increasingly complex clients being housed in Victoria.

When all other systems fail, buildings must be able to safely contain those detained to allow for planned, emergency responses. Buildings must be able to be secured into zones that allow for the safe separation of clients. Lastly, infrastructure needs to cater for the complex and high needs of a growing number of clients.

The Parkville Youth Justice Precinct has significant limitations in all of the areas. For maximum-security clients, the current infrastructure is not fit-for-purpose.



The last factor was an aggravating but not causal factor: Staff shortages on the day of the incident.

It has to be stated the outset that the Eastern Hill Unit where the incident commenced had a full complement of staff at the time. Staffing shortages played no part in the commencing phase of the incident.

The two issues that I have identified are that shortages in the Safety Emergency Response Team (SERT) prevented its proactive and preventative functioning. If SERT was fully staffed it is possible that information on the Eastern Hill Unit that clients were unsettled may have been identified and acted upon. A SERT presence on the unit had the potential to assist to de-escalate the initial incident.

## DETAILED REPORT

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This issue was exacerbated by the failure of Eastern Hill Unit staff to report and act on information that clients were unsettled.

The second is that the staff shortages limited the response capability of the precinct once the incident had commenced.

The review was primarily carried out on the Parkville Youth Justice Precinct on 5 and 6 November 2015. A series of Operational De-briefing Sessions were carried out with Emergency Services personnel who were in attendance on 31 October; the staff of Eastern Hill Unit and the SERT and other responding DHHS staff.

I have reviewed the CCTV footage from the day in question and have conducted a number of individual interviews with key participants.

Many of the issues raised in this review are consistent with my previous review on Occupational Violence.

There are some additional issues raised as areas for improvement arising from the review process. These are detailed in the report and a summary of recommendations is found at **Attachment B**.



# DETAILED REPORT

## **BACKGROUND**

Peter Muir Consulting Pty Ltd has been engaged by Secure Services, Department of Health and Human Services to review the Incident that occurred at the Parkville Youth Justice Precinct (PYJP) on the afternoon of 31 October 2015 that lead to six clients positioning themselves on the roof of the Southbank Unit having assaulted staff and broken their way out of the Eastern Hill Unit. Terms of reference for the review are:

*The Department of Health and Human Services has commissioned a review of the incident with a view to implementing any identified practice, security or infrastructure improvements.*

*The review will be conducted by Peter Muir Consulting Pty Ltd, and will:*

- 1. Focus on the circumstances leading up to the incident, including any contributing factors and intelligence that might have been available;*
- 2. Examine the immediate response by staff to the behaviours of clients that then escalated.*
- 3. Consider the subsequent response of staff and management of the incident;*
- 4. The review will commence with an Operational Debrief of staff and agencies involved in the incident and a review of CCTV and documents and will deliver a report that identifies any required improvements to:*

- Operational procedures*
- Environment*
- Communication*
- Client management*
- Staff response(s).*

The chronology of this event is well documented in the incident report. A copy of the Incident Report is found at **Attachment A**.

Nothing in my review has caused me to conclude that this is not an accurate version of events.

For the purposes of this review, the sequence of events from approximately 13:20 until the conclusion at approximately 18:40 is regarded as the incident referred to in the terms of reference. The incident contains a number of phases. These are:

- The initial incident in Eastern Hill Unit where the client was restrained;
- The subsequent movement of a group of clients to the recreation area where they broke out of the Unit;
- Their movement to the roof of Southbank Unit; and
- The response phase by Management of DHHS and Emergency Services.

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Peter Muir Consulting Pty Ltd has previously completed a Review of Occupational Violence at Malmsbury and Parkville Youth Justice Precincts. The final report for this review was submitted in September 2015.

There are a number of themes from that review that are relevant to the incident that is now being reviewed. These will be highlighted in the report.

### **METHODOLOGY**

The review was carried out on site at PYJP on 5 and 6 November 2015.

In the course of this review, I have conducted Operational Debriefings with most key staff involved in this incident. Minutes of the group meetings are provided separately.

Three group debriefing sessions were carried out. Without the reviewer having a prior knowledge of the Department's Operational Debriefing Procedure they were carried out as closely as possible to the Department's procedure. A minute taker was provided by the Department. These minutes are provided back to the Department separately to this report.

The first debrief of the day was conducted with Emergency Services and external service providers to allow them to return to duty as soon as possible. This session was attended by:

- [REDACTED] Health Commander, Ambulance Victoria
- [REDACTED] Incident Coordinator, Victoria Police
- [REDACTED] Liaison Officer, Metropolitan Fire Brigade
- [REDACTED] Incident Commander, Victoria Police
- [REDACTED] Operations Manager, G4S
- [REDACTED] Security Coordinator, G4S
- [REDACTED] General Manager, Parkville Youth Justice Precinct

A group debrief was held with the staff of Eastern Hill who were on Duty at the time of the incident. Only one staff member did not attend. This debrief included members of the Safety Emergency Response Team (SERT) and the Unit Supervisor on duty in Southbank at the time of the incident. Attendees were:

- [REDACTED] SERT Unit Manager (part meeting only)
- [REDACTED] A/Unit Manager Oakview Unit and Duty Manager on the day of the incident
- [REDACTED] Eastern Hill Unit Supervisor
- [REDACTED] Youth Justice Worker 1
- [REDACTED] Youth Justice Worker 1
- [REDACTED] Youth Justice Worker 1
- [REDACTED] Youth Justice Worker 1
- [REDACTED] SERT Team Leader
- [REDACTED] SERT - Youth Justice Worker 1
- [REDACTED] Southbank Unit Supervisor

The final group debrief was held with the two attending SERT members and the Southbank Unit Supervisor. These staff are listed in the previous debrief.

A range of individual sessions were carried out.

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CCTV of all relevant parts of the incident was provided and reviewed on 5 November.

Incident Controllers, [REDACTED] and [REDACTED] were individually interviewed.

The [REDACTED] who initiated the restrain on the client in Eastern Hill was individually interviewed.

I conducted a site inspection to some of the key sites in the incident including:

- Eastern Hill Unit
- Southbank Unit
- The Programs Centre.

In the course of the previous review conducted in June 2015, I undertook a full site inspection.

I was unable to interview the Parkville College Principal.

On 12 November 2015, I interviewed [REDACTED] the incident controller and acting Director for Secure Services on the day in question by telephone. He has provided me with three emails outlining his part in the management of the afternoon.

### ***INITIAL OBSERVATIONS***

There are two sets of observations that I will make at this point of the report to set the tone for the review.

The first is in relation to what has gone right.

The actions of the Team Leader of the SERT, [REDACTED] on duty on the day in question are to be highly commended. He demonstrated leadership and an extraordinary commitment to the safety of staff in the centre. His decision making was clear, reasoned and sound. He could articulate an awareness of what was happening at each point in the incident and his situational awareness was outstanding.

Reviewing his actions on CCTV, it is clear that these skills were supported by a well-designed system of work which he clearly understood and executed. The training and drills that are a part of the SERT operations came into play when they were most needed.

The second observation surrounds the actions of the Duty Manager [REDACTED] Whilst the SERT were actively managing the incident, the Duty Manager was managing the precinct which presented multiple and potentially serious risks to staff and other clients. She was managing the arrival of all alarms of the emergency services, the control room and injured staff. It is hard to overstate the complexity of what she was dealing with. This report will highlight some systemic failures or weaknesses but despite these occurring around her, she maintained her composure and effectively managed the complex series of challenges facing her.

It is my assessment that without the actions of these two staff members and the experience, training and systems that supported them, this incident could have taken a very different direction.

Once Emergency Protocols had been activated, there was a strong and coordinated response by DHHS staff and the branches of the Emergency Services in attendance.

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On the negative side there were three critical failure points which in my assessment were the major contributing factors to this incident. These are:

- **Building infrastructure that is no longer fit-for-purpose**
- **The decision of the [REDACTED] to attempt to restrain client [REDACTED]**
- **Staffing shortages on the day in question.**

No single aspect of these three contributed alone to the incident.

The most significant consideration in my assessment is that of infrastructure. Youth Justice Centres in Victoria are now accommodating a complex, challenging and at times dangerous cohort of clients. This has been clear now for the last number of years.

The most fundamental function of any detention centre is the ability to physically contain those who are incarcerated. Without buildings and infrastructure that meet this standard, every other objective will be compromised.

The failure of two units to be able to physically contain clients is in my mind the most significant system failure of all. If the buildings were able to contain those incarcerated, no matter what else was occurring in terms of the other two contributing factors; systems and responses could have been organised to respond safely and effectively to the situation. For example, despite the [REDACTED] if the building had contained the clients, a tactical withdrawal and later planned response could have been mounted.

The nature of those detained across Australia today is that they are presenting complex challenges to detention environments. The physical environment has to cater for this contingency.

The current buildings were constructed in the 1990's which were very different times. They contain design features and limitations that are not in line with contemporary standards and practice.

All of the contributing factors will be discussed in further detail in the body of the report.

## DETAILED REPORT

### 1. THE CIRCUMSTANCES LEADING UP TO THE INCIDENT AND ANY CONTRIBUTING FACTORS AND INTELLIGENCE THAT MIGHT HAVE BEEN AVAILABLE

#### *RELEVANT CIRCUMSTANCES LEADING UP TO THE EVENT*

In the Operational Debrief, staff indicated that in their view, the placement of client [REDACTED] was a significant precipitating factor given that he has a track record in manipulating other clients and leading subversive and defiant behaviour.

They indicate that in the week leading up to the event there was nothing untoward in his behaviour.

However, by contrast, the Daily Safety Advice (DSA) paints a different picture of the Unit.

On 26 October 2015 client [REDACTED] had threatened to kill staff. On 13 October 2015, he made threats to assault any staff member when he is let out of his room. On 23 October 2015, he was involved in assault of another client.

Staff did not discuss any of the other clients in the lead up. However, the DSA contains some critical insights into the histories of the clients involved in the incident:

**Client [REDACTED]** – 19 October 2015 Involved in incident in kitchen with staff where he refused to leave kitchen when directed, refused to put fork down which he used to brandish at staff and threatened to stab staff – (he was restrained and isolated.

**Client [REDACTED]** – 14 October 2015 – Refused lock down. Manager's warning given. 17 October 2015 – Managed on an IBMP due to his involvement in an incident the previous day. 19 October 2015 – tried to become involved in ES kitchen incident rose from seat in attempt to involve self. Tried to refuse lock down.

**Client [REDACTED]** - 14 October 2015 – Refused lock down. Manager's Warning given. 19 October 2015 – became very vocal and directed anger towards staff during and post incident with [REDACTED] in kitchen. Tried to refuse lock down.

**Client [REDACTED]** - 14 October 2015 – Refused lock down. Manager's warning given. 17 October 2015 – Given a supervisors warning. 19 October 2015 Involved in incident in kitchen with staff where he refused to leave kitchen when directed, refused to put fork down which he used to brandish at staff and threatened to stab staff – restrained and isolated.

Other information to emerge during the debriefing process was relevant in considering the circumstances leading up to the event.

The first is that the precinct was facing staff shortages on the day in question. I have been provided with two sets of figures in this regard. The first by Human Resources was that there should have been [REDACTED] rostered positions on in the centre on the day in question plus one staff member rostered on who was surplus to the establishment. Of these:

- [REDACTED] were covered by rostered shifts
- [REDACTED] were covered by casuals
- There were [REDACTED] agency staff
- One shift was cancelled on the morning of the event by a casual SERT staff member

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- [REDACTED] were vacant due to unplanned absences. [REDACTED]
- [REDACTED] vacant lines were not filled. (Two of these are SERT members)

This should have meant that [REDACTED] staff out of a possible [REDACTED] were present and on duty on the day of the incident.

The Duty Manager however believes that the actual figures on the day were different, so a roster for the day was produced. My count of this roster, once she had eliminated absences indicates a staff strength of [REDACTED] on the day of the incident; [REDACTED] below the establishment number. Once the [REDACTED] injured staff were sent home, this decreased to [REDACTED]

There were only two of the team of [REDACTED] SERT members on duty on the day of the incident.

Despite the shortages, there was a strong and active mix of programs occurring in the centre on the day in question. A high proportion of clients were actively engaged in programs. In my experience boredom, particularly on the weekend, is a significant risk factor. I strongly endorse the approach taken on the precinct and the fact that Parkville College provide programs that keep clients meaningfully occupied.

Staff identified a sense of unease in the centre on the morning in question.

The Duty Manager had made an assessment of the risks that the staffing shortages had posed. She believed that when staff took their lunch breaks that they did not have the capacity to respond to potential incidents. For this reason she made the decision to lock the precinct down for one hour from 3.00 to 4.00 pm. I cannot criticise this decision.

However, some staff report that this had the effect of unsettling the centre. Young people generally resent lock-downs in my experience, especially when it is in time that they believe they should be out of their rooms. In NSW, it was generally the practice of managers to offer some commensurate reward to clients for the period of lock-down. This may be something that was considered but I am unaware if it was noting that the General Manager had arranged for the delivery of pizza for clients the previous night for a similar purpose.

Staff also report a number of incidents and trends that I assess to be material to the risk profile of the day of the incident.

The first are two instances of non-compliance by residents in Eastern Hill. The first was in the Parkville College gym program between 10.30 and 11.00 am where the Unit Supervisor reports that he believes he dealt effectively with non-compliant residents through other tactics consistent with his training and deescalated the situation.

The next issue occurred in the programs area between 11.30 and 12.00. Again, non-compliance was the issue. The Unit Supervisor dealt with this without resorting to force.

In the de-briefing, staff indicated that on at least three occasions on the morning and in the programs that something was going to happen. One staff member commented in the de-brief that a client told them "It is going to go off today."

Others report that they were disengaged from staff throughout the morning and that in fact they were keeping their distance.

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Others report that they were 'looking for a fight'; that they were more aggravated than normal and that they saw changes in other clients.

They report that despite attempts to engage the clients, that the clients were "isolating" themselves from staff.

They had refused to perform some chores on the morning of the incident.

In the Unit itself, the CCTV footage indicates a continued level of conflict both between one particular client and the group in the upstairs area of Eastern Hill and with the staff members present.

i. ***Issue. Staff numbers on the day of the incident.***

Staff and the CPSU have been quick to assert that staffing shortages played a critical causal role in the incident.

**Eastern Hill had a full complement of staff of the day of the incident.**

It is my assessment that the staffing shortages in the precinct did not have a causal effect on the events in Eastern Hill.

It did have an effect on the response to the incident and this shortage is compounded by the limitations in the built environment.

The critical issue for me on the day in question (as it will be discussed later in the report) is that the staffing level provides for no margin of error. Key posts outside of the unit were not filled and the key risk is the lack of systemic redundancy.

The proposed lockdown was a direct consequence of the staffing issue.

I cannot establish a cause-effect between the client behaviour and the lockdown. Neither can it be eliminated as a contributing factor.

ii. ***Issue. Staff did not report available intelligence arising from the morning of the incident.***

I have reviewed a substantial number of critical incidents over the course of my career and staff possessing critical information and intelligence that is not then shared is one of the most consistent features in incidents of this nature.

Despite a number of comments in the de-brief that there was a sense that something was going on and that even a direct comment to that effect was made by a client, nothing was reported up the chain of command.

When I asked one staff member if they reported the direct comment, they replied that they were "too busy."

Even if the information was available to [REDACTED] it was not passed on to either SERT or the Duty Manager.

The situational awareness and dynamic risk assessment on the day was sub-optimal.

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My assessment is that this issue is caused by a number of factors:

- Busyness – Custodial Centres are environments that demand full attention.
- The constancy of the interactions tends to blunt staff awareness of the significance of some interactions and statements.
- Supervisors who are not sufficiently attuned to their role as managers and are too enmeshed in the day-to-day functioning of the unit.
- Human error.

### ***Recommendation***

1.1.	<b>RECOMMENDATION – See Recommendations 1.16 and 1.32 of the previous review.</b>
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### ***iii. Issue: Vacancies in the Safety Emergency Response Team (SERT)***

A fully functioning SERT is one of the critical safety features of this precinct.

Apart from the management of incidents, its proactive role in monitoring dynamic security and building rapport with clients is a strong feature of the centre environment.

When operating at capacity and as it was intended, they would most likely have been at the earlier trouble spots and may have picked up on the intelligence that was not escalated by at least three unit staff.

The diminished capacity eliminated its proactive function on the day in question.

With the failure of the unit staff to effectively escalate the information of emerging risks, this system of work is the next level of protection.

Its unavailability meant that the level of increasing risk was unknown to the Duty Manager and SERT.

Back-up SERT members were not requested from Malmsbury.

### ***Recommendation***

1.2	<b>RECOMMENDATION – Establish a minimum level required for daily SERT operations. If that number cannot be achieved, assistance should be sought from Malmsbury.</b>
	<b>PRIORITY RATING – Immediate</b>

1.3	<b>RECOMMENDATION – Review recruitment strategies for SERT to consider external recruitment from appropriately qualified and skilled individuals.</b>
	<b>PRIORITY RATING – Medium Term</b>

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### iv. *Issue: Daily Shift Planning*

There were differences of opinions as to the adequacy of this process.

One view is that the morning meetings focus too much on staffing rather than client related issues including the risk profile of the precinct and response capacity for the day.

Other supervisors/managers disagree with this assessment.

Staffing in Youth Justice Centres is a constant issue. Even on the best days, with the staff contingent the size of PYJP, decisions around the placement of staff and the strength of teams is a constant pressure on management and supervisors.

If the assessment that daily planning for the risks that are presenting for the day and how they are managed is less than optimal, the structure of this meeting needs to be reviewed.

I am unable to provide a clear assessment of this issue in the time available for the review. However there are differences in opinions amongst interviewees in the review.

Regardless of who is correct, my assessment is that this meeting would benefit from a more structured agenda that ensures clear planning for the day and activities that are structured around the availability of staff resources.

1.4	<b>RECOMMENDATION – Review the structure and functioning of morning meetings. The meeting should consider the response capacity of the shift when planning the day’s activities.</b>
	<b>PRIORITY RATING – Immediate</b>

### v. *Issue: The assessment, management and classification of risk*

One of the issues that has emerged for me in the previous review and has been reinforced in this incident is the manner in which information is used to assess and classify risk.

The collective staff psyche in the de-brief was that everything over the last week was stable. My reading of the DSA alone tells me that several of the detainees were far from that. There was in my assessment, no view of the static, dynamic and cumulative risks surrounding the cohort that the Eastern Hill Unit was managing on the day of the incident.

In my last review, I applied an objective detainee classification assessment against some of the clients in the case study. These indicated that most of the clients should be classified at a maximum security rating.

My suspicion is that at least some of these clients would also achieve that rating. It is unclear what systemic response if any was taken with the kitchen incident in which a client armed himself with a fork and another incident where one threatened to kill staff.

These incidents occurred in the fortnight before this incident, yet the system and the staff do not have a view of this. There is no effective system to manage this risk.

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DSA's contain good information, yet managers and staff do not appear to understand their importance nor do they appear to influence the manner in which staff manage clients. Despite the quality of information on the DSA's, this is not translating into an effective system of work.

More significantly, there does not appear to be a systemic response to the issues that they highlight.

I will re-state my position that I believe there needs to be a revision of the methods of classification and risk management.

I will foreshadow my complete position that all accommodation units need to be assessed to ascertain the classification of clients that they can safely accommodate. It is clear that in their current configuration, the units at Parkville are unsuitable for maximum security clients. Furthermore their presence compromises progress for all others on site.

Lastly, clients should be housed by classification and the entire asset portfolio and client flow rationale may need to be re-thought.

The risk of actually adopting this approach is that some detainees will aspire to a maximum security rating. These however will be in the minority.

The risks of not doing it are greater as risk information is not being adequately assessed and used to manage clients.

The mixing of classifications in the current system compromises the Department's objectives for the remaining group.

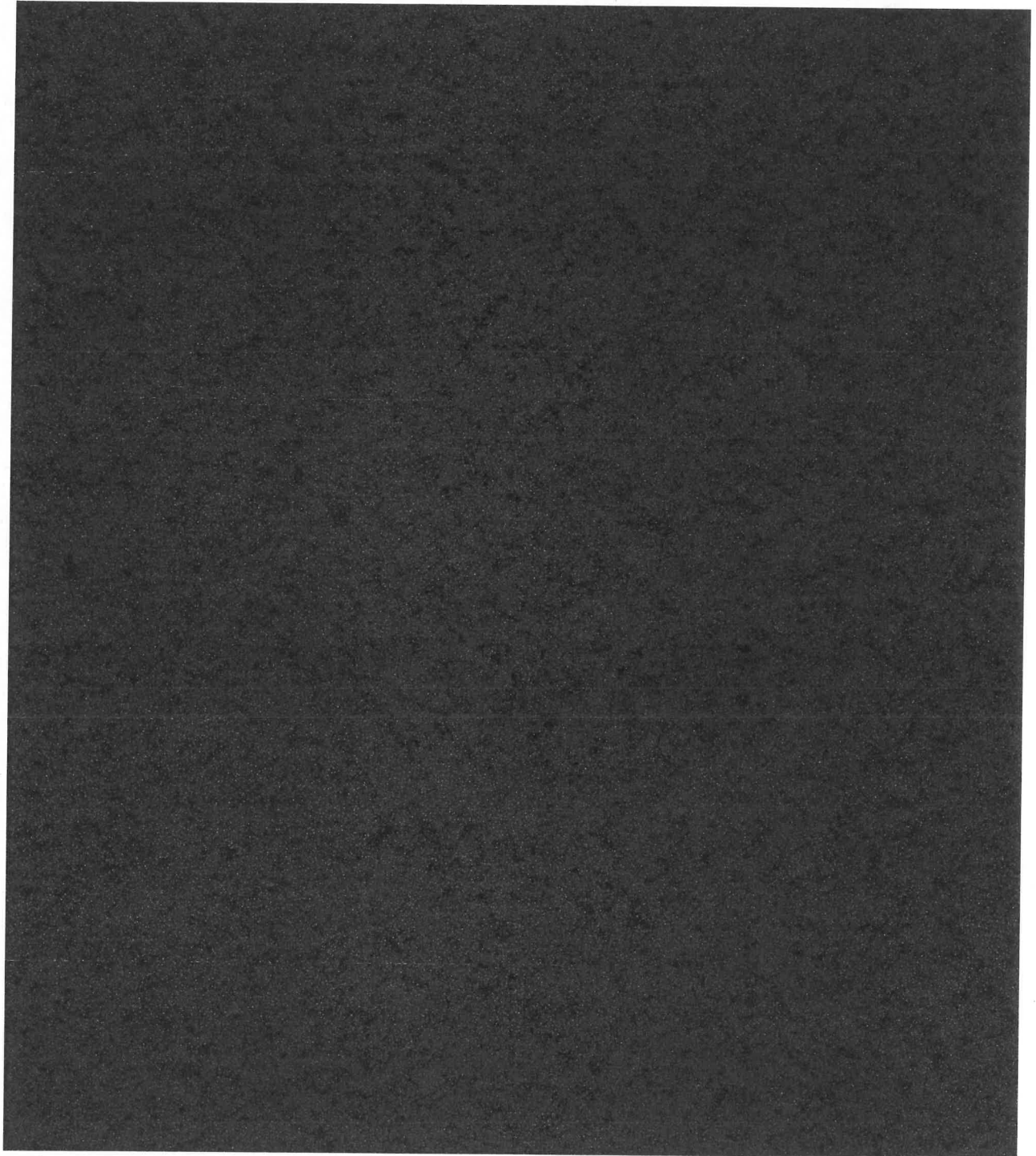
### ***Recommendation***

1.5	<b>RECOMMENDATION – See Recommendations 1.2; 1.10 and 1.12 of the previous review.</b>
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2. THE IMMEDIATE RESPONSE OF STAFF TO THE BEHAVIOURS THAT THEN ESCALATED

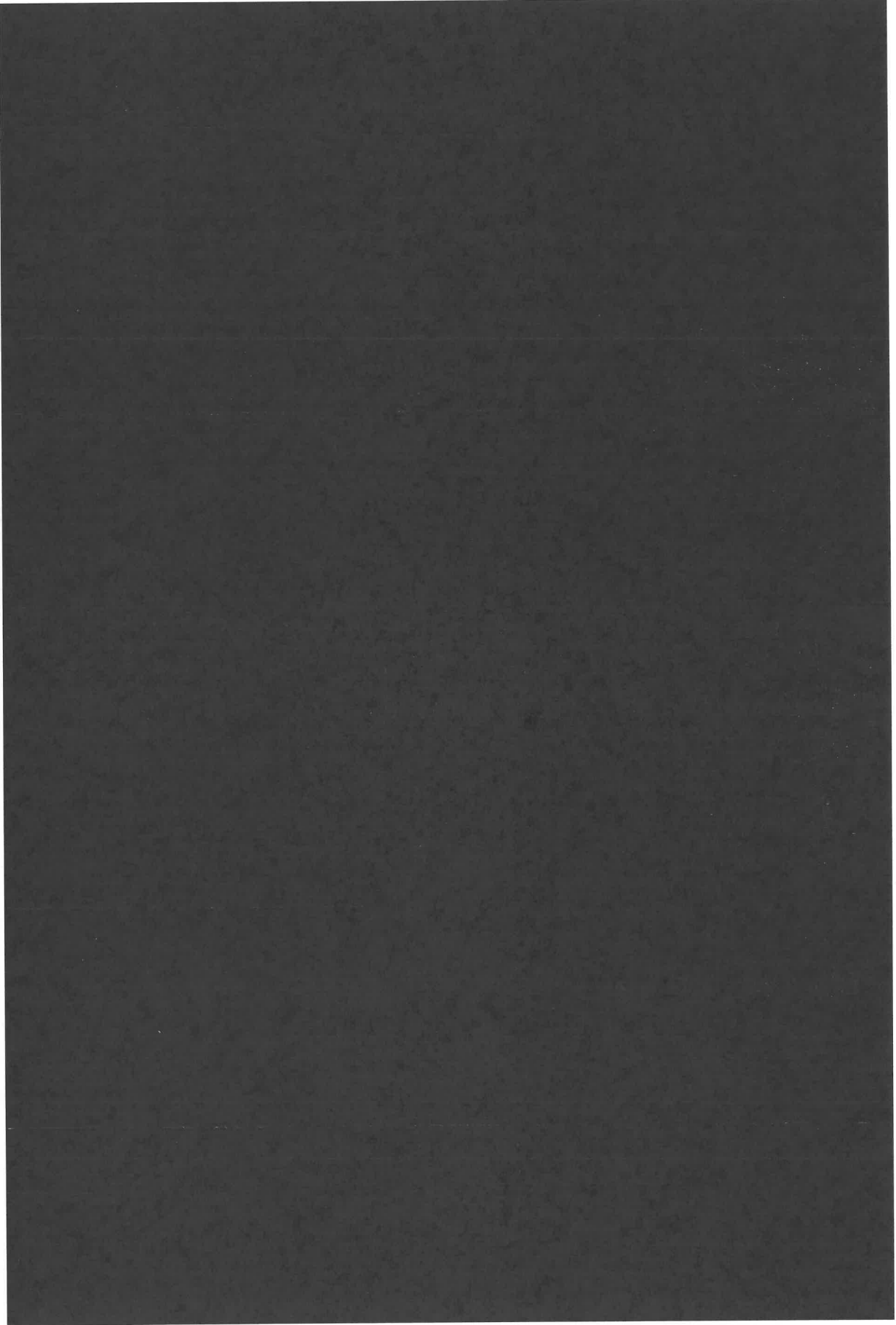
*RELEVANT CIRCUMSTANCES LEADING UP TO THE EVENT*

The chronology of events is outlined in the incident report and is largely consistent with the CCTV footage.



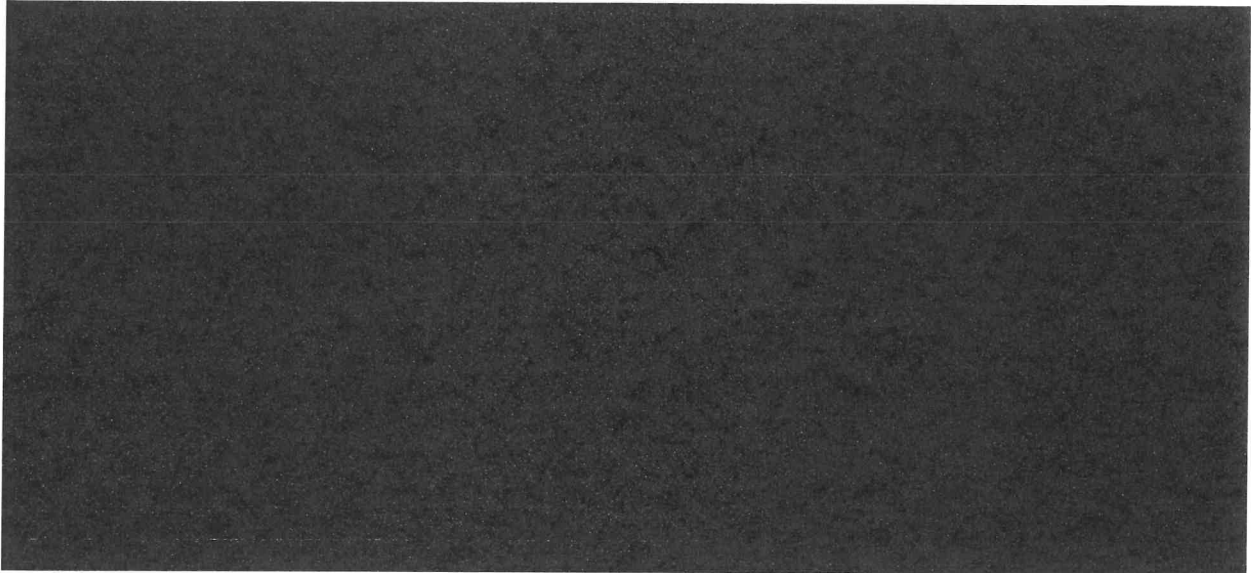
**DETAILED REPORT**

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## DETAILED REPORT

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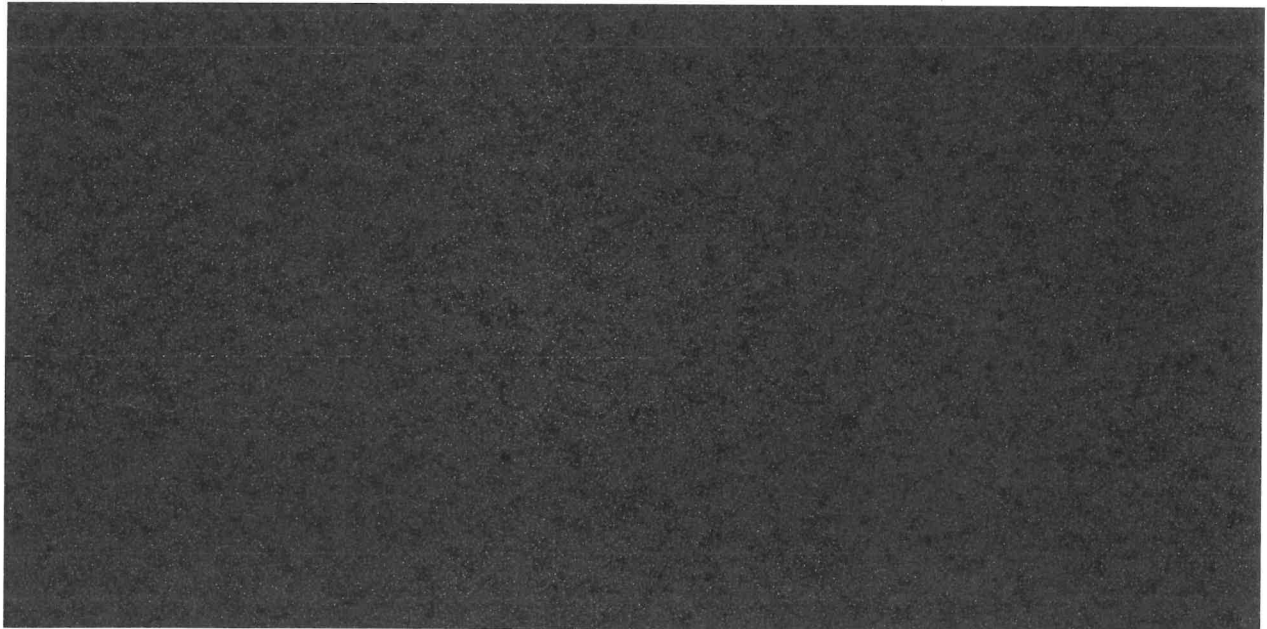


My advice is that change can only occur to this behaviour if staff are engaged in a process where they feel that their concerns are listened to and addressed. The Director commenced this process at the Town Hall meeting. I believe that this meeting needs to be followed up quickly by a process that seeks to build on the dialogue that was commenced.

I have discussed my views on the Behaviour Management System in my previous report. I have already made a recommendation on supervisor capability.

### *Recommendation*

2.1	<b>RECOMMENDATION – Commence a program of engagement with front-line staff in relation to Behaviour Management. I will not prescribe the form that this takes but it should seek to understand what is not working from a staff perspective and seek their input on improvements.</b>
	<b>PRIORITY RATING – Immediate</b>



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There are several possible solutions to this issue. For instance, spaces can be created as privileged areas. Routines can be written to suit the environment.

But, fundamentally doors must be able to be secured to create zones that are safe.

**Recommendation**

2.2	<b>RECOMMENDATION – Ensure that all internal doors can be locked and secured.</b>
	<b>PRIORITY RATING – Immediate</b>

2.3	<b>RECOMMENDATION – Review the legislation and practice surrounding Isolation and locked doors within Units.</b>
	<b>PRIORITY RATING – Immediate</b>

iii. *Issue: The Department’s Preventing Occupational Violence Program was not implemented*

There is not much about this phase of the incident that complies with the Department’s POV Program and Training.

The staff member moving into the client’s space; his lack of emotional regulation; no risk assessment or situational awareness and engaging in restraints that are not approved are just some of the non-compliant practices.

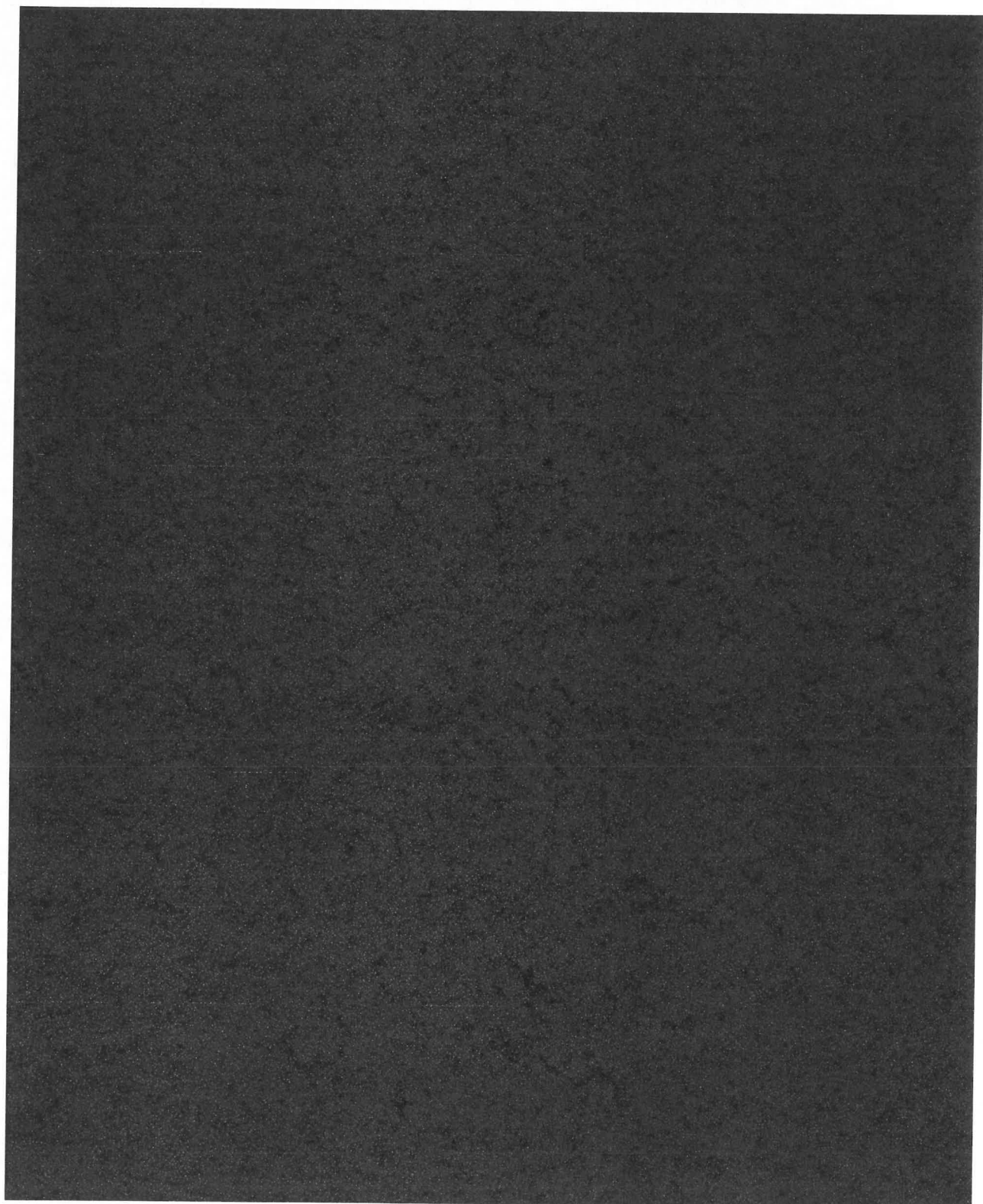
The previous review that I completed highlighted significant non-compliance with Reconnect Training and a lack of competence in restraint techniques. This incident underscores the importance of mandating this training and competency against its requirements.

**Recommendation**

2.4	<b>RECOMMENDATION – See Recommendation 5.1 of the previous review.</b>
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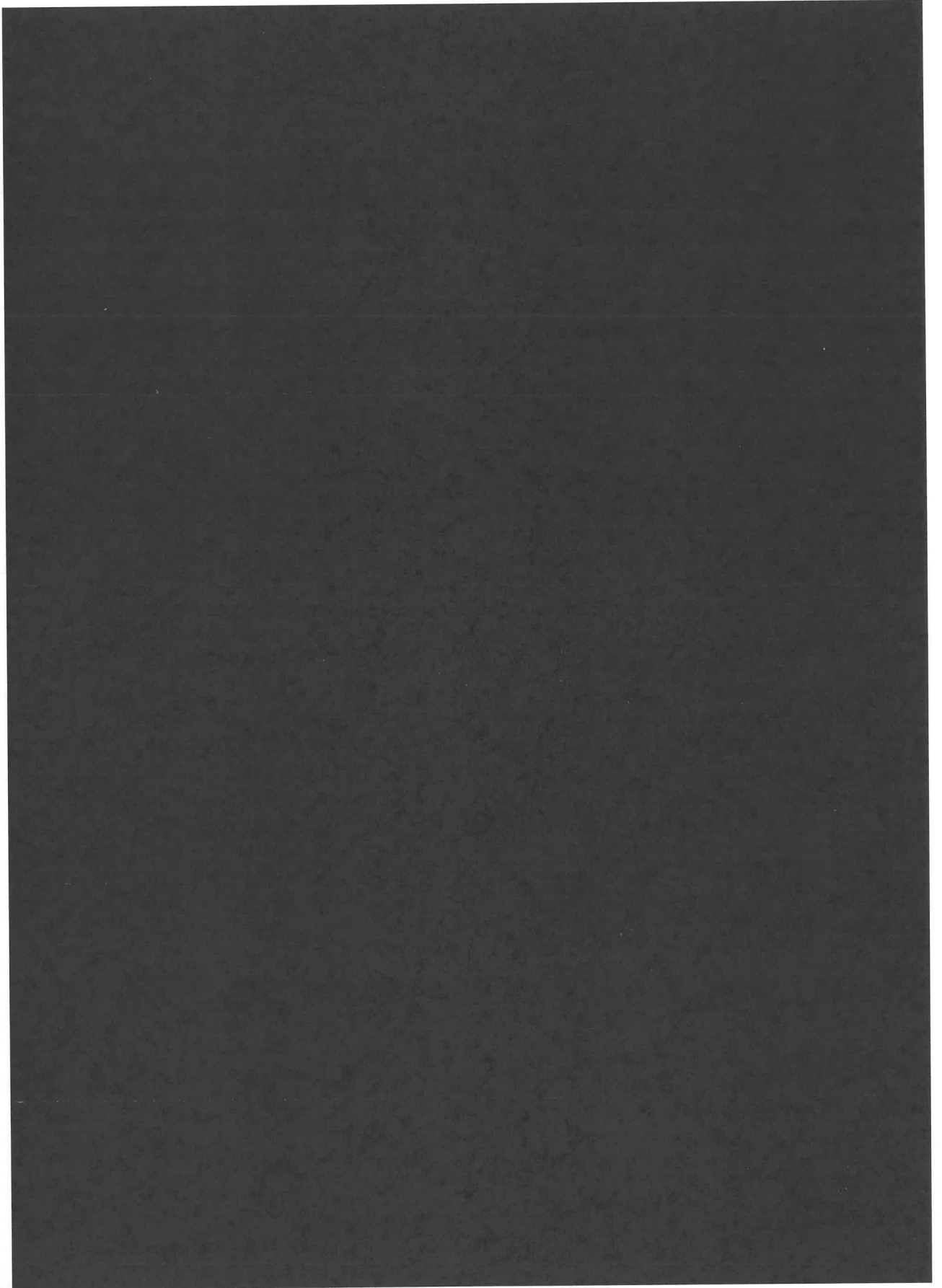
3. THE SUBSEQUENT RESPONSE OF STAFF AND MANAGEMENT OF THE INCIDENT

*RELEVANT CIRCUMSTANCES TO THE EVENT*



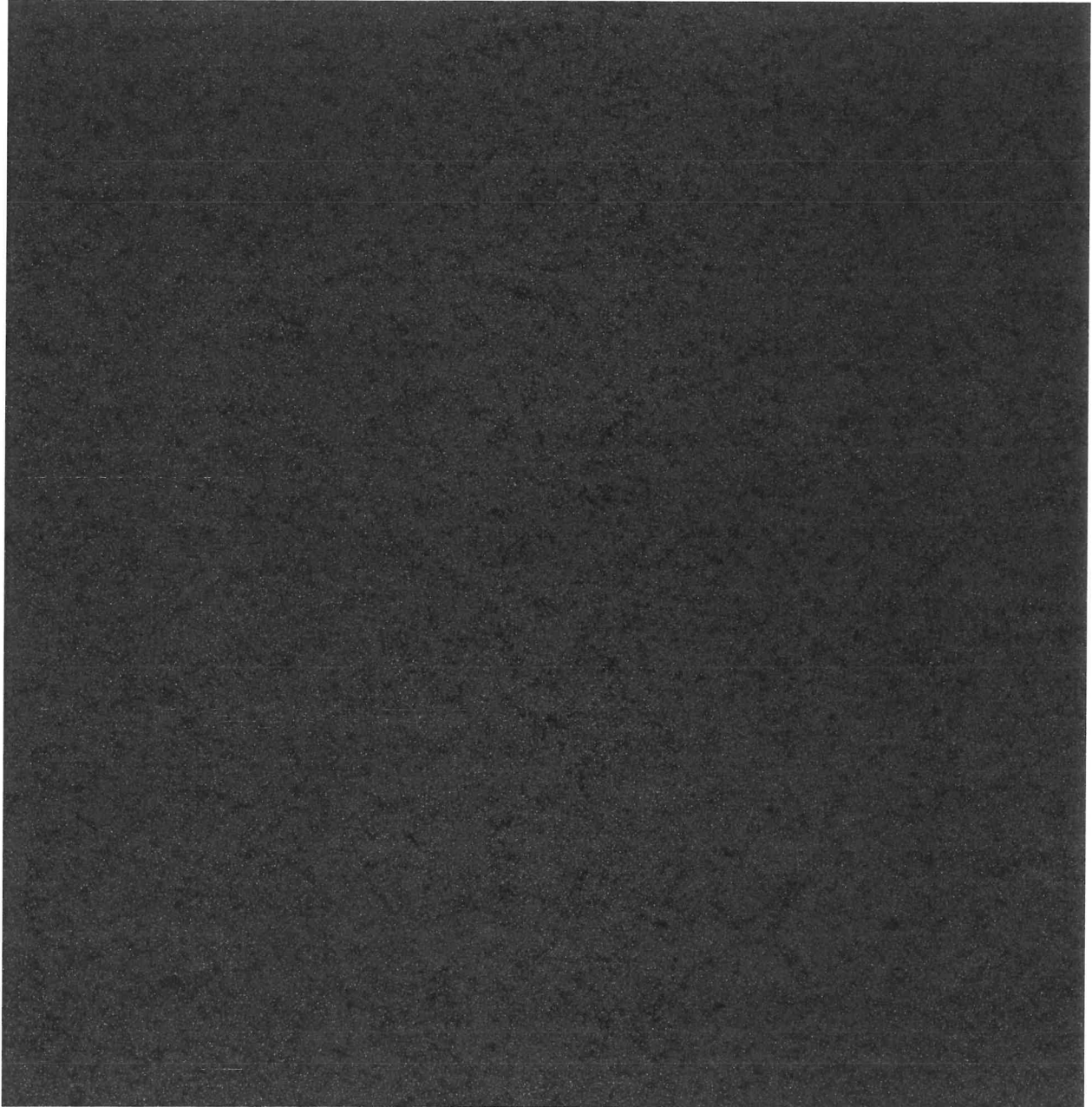
**DETAILED REPORT**

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## DETAILED REPORT

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### *Special Commendation*

I want to make note of two aspects of staff actions at this point.

The first is to commend the actions of the Duty Manager. She was dealing with a series of events that were quickly unfolding around her. She faced multiple and serious challenges any one of which could have demanded her full time attention.

She demonstrated leadership and resilience.

The second are the staff who managed clients from Oakview outside of their unit for a four-hour period and other staff who kept the remainder of the centre under control.

## DETAILED REPORT

I was not able to spend any time reviewing this aspect of the day but their roles were made clear by other staff.

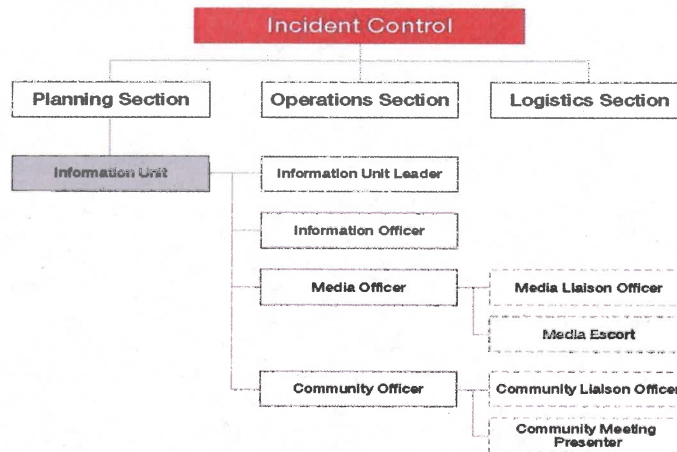
i. **Issue: Command and Control Structures**

Operationally, both the SERT Team Leader and the Duty Manager, supported by the back-up Duty Manager did outstanding jobs at managing the initial phases of this incident.

What has not been clear to me in the review is that an incident control structure was established consistent with the Department's procedures and the Australasian Inter-Service Incident Management System (AIIMS) from the beginning of the incident in Eastern Hill until the arrival of [REDACTED]

Each of the key personnel performed their roles well but in interviewing them both, it is clear that they did not have visibility of each other's actions and without knowing the role played by [REDACTED] I do not have the picture of a clear incident control process in the first two hours of the incident in particular.

The full AIIMS structure as indicated below was implemented on the arrival of [REDACTED] but there are opportunities to improve the Department's response as arising from the incident.



Source: Exhibit 131 – Mapping Information Flow During Critical Incidents (TEN.033.001.0001) at 0024<sup>26</sup>

The Emergency Services De-briefing indicated that the availability of information across the site was one area that could be improved. This was raised by both VicPol and G4S.

Whilst a liaison officer appears to have been appointed, it is not clear that the role was effectively carried out.

My assessment is that in the first few hours of the incident, both the Duty Manager and the SERT Team Leader were involved in operationally managing the incident and there was no one aside from the pressure of the incident making the command decisions inherent in that role.

Staff shortages left no redundancy in other staffing roles.

## DETAILED REPORT

### *Recommendation*

3.1	<b>RECOMMENDATION – Review Incident Command and Control Structures in the Precinct to ensure that incident management structures reflect best practice. Bi-annual drills should be carried out in incident control and management.</b>
	<b>PRIORITY RATING – Medium Term</b>

#### ii. *Issue: Staff Shortages*

Whilst staff shortages did not play a role in precipitating this incident, they did in the response phase.

Instead of [REDACTED] SERT staff, there were only two.

[REDACTED]

There was insufficient staff to operate the Control Room. [REDACTED]

There was no staff member in Admissions.

Once the [REDACTED] staff members in the initial Eastern Hill incident were sent home, the on-site staff contingent was reduced to [REDACTED]

It is clear that staffing capacity both on the day in question and over the last period of time is an ongoing issue.

I am aware that the FBG Group has delivered a report on this issue.

I have no knowledge of the content of this report.

Staffing in detention is a constant issue. The nature of 24 hour; 7 days operations means that replacing staff is a constant challenge. This is not isolated to Parkville.

It is significant that there was a shortage of staff on the day.

Despite whatever strategies are pursued, there is a need to urgently increase the supply of staff.

### *Recommendation*

3.2	<b>RECOMMENDATION – Conduct an immediate recruitment campaign and ensure sufficient casual, temporary and agency staff to ensure that all lines are filled.</b>
	<b>PRIORITY RATING – Immediate</b>

#### iii. *Issue: Contractor Management and Site Safety*

In this phase of the incident, one of the most significant factors was the availability of weapons on the site.

## DETAILED REPORT

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There was uncompleted work behind the Southbank Unit that was not cleaned up. The clients had access to materials such as lumps of concrete and bricks that should never have been available in a detention centre and had the capacity to seriously injure or kill someone.

There are two failings here.

The first is contractor escorting which I believe is managed by G4S. This would *prima facie* constitute a serious breach of procedures.

The second is the failure of internal checks which failed to report or act on this danger.

### ***Recommendation***

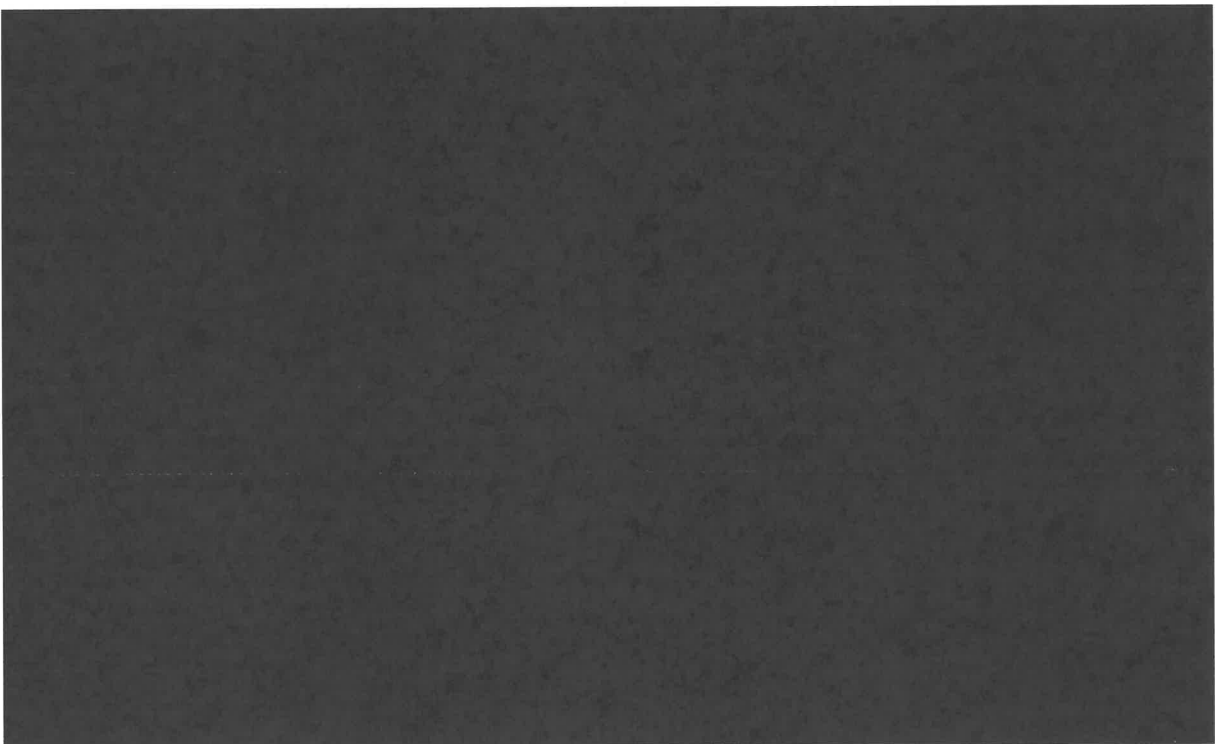
3.3	<b>RECOMMENDATION – Review the contractor management and internal checks at the rear of the Southbank Unit and institute corrective action. This review should occur as a WHS investigation to determine how the systems of work failed and to recommend corrective action.</b>
	<b>PRIORITY RATING – Immediate</b>



Operation Pearl is the Master Contingency Plan for responding to non-routine incidents. It is an agreement that was entered into by the Department and Victoria Police.

During this debrief, it was universally agreed that the existence of Operation Pearl assisted in the management of the incident and provided clarity regarding roles and responsibilities. All response agencies believe that the response during this stage of the incident was robust.

A number of opportunities for improvement were identified should it need to be enacted again.



## DETAILED REPORT

Issues agreed at the end of the de-brief included in addition to the above:

- How to improve communication between PYJP & G4S during an incident
- Why PYJP sprinklers are so easily set off
- An increase in scenario training between PYJP & Victoria Police to be investigated

### ***Recommendation***

3.4	<b>RECOMMENDATION – See Recommendation 6.1 of the previous Review. Drills and exercises should incorporate G4S.</b>
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3.5	<b>RECOMMENDATION – Review Operation Pearl in the light of issues raised in the de-briefing process.</b>
	<b>PRIORITY RATING – Medium Term</b>

3.6	<b>RECOMMENDATION – Follow up all actions raised in the Operational De-brief with Emergency Services</b>
	<b>PRIORITY RATING – Immediate</b>

### ***v. Issue: Evacuation from the Woodwork area***

One issue of concern raised by two interviewees was the evacuation of the Woodwork area.

Two staff members were quite clear that when the Parkville College staff members were evacuated, they left with the roller door open this area gave direct access from the area where the clients were from the rear of Southbank.

Had they had entered this area they would have had access to an array of weapons that would have made apprehension dangerous.

On entering the area, the Duty Manager found that she did not have the keys to close the door. (This issue will be covered in the next section).

When I inspected this area, I witnessed an area that presents an extreme level of risk in my opinion.

The security of this area is unacceptable and needs to be immediately reviewed.

### ***Recommendation***

3.7	<b>RECOMMENDATION – The WHS staff should conduct an immediate risk assessment of the Programs area.</b>
	<b>PRIORITY RATING – Immediate</b>

## DETAILED REPORT

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vi. ***Issue: Emergency Capability of non-SERT Staff***

Over the course of the last two reviews, I have observed that there is a significant capability gap between SERT and general staff members.

This was evident in the initial incident in Eastern Hill and in the response of staff asked to form a perimeter outside of the unit.

This was similar to comments made in focus groups and interviews in my first review.



Whilst I strongly support the SERT model, I believe a longer term aim is to raise the competency of general staff in a range of skills.

This should begin by enacting recommendation 1.24 of my previous review. Unit Managers should undertake a risk assessment process of each unit. Key risk points of each unit should be identified and scenarios planned. All staff should undertake drills at least twice per year against these plans.

At the same time, the exceptional communication and engagement skills of SERT need to be replicated.

POV Training should drive this.

The last part of this puzzle should be a performance framework to which Unit Managers should be accountable.

***Recommendation***

3.8	<b>RECOMMENDATION – See Recommendations 1.22; 1.24 and 5.1 of the previous review</b>
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4. OPPORTUNITIES FOR IMPROVEMENT ARISING FROM THE REVIEW

*Operational Procedures*

There are no recommended changes to procedures

*Environment*

i. *Issue: The Built Environment at Parkville*

I have already asserted in this report my belief that the buildings are no longer fit-for-purpose.

The fabric of the buildings cannot contain the clients within the building.



There are stairs in units that should not be a part of a detention centre environment. Stairs present a significant WHS risk.

The kitchens present a significant and in my view unmitigated risk. There is one door between clients and an array of weapons. On the day of my visit to Eastern Hill there were unsecured boxes of metal cutlery on the bench and one flimsy door between the clients and the cutlery. Staff are all carrying keys to the door and it was used three times in my short visit to the unit. It could be easily breached.



4.1	<b>RECOMMENDATION – Undertake a full security assessment of the Precinct buildings. This should be completed with a view to assess their suitability to house clients relative to the risk levels that they present. This assessment should be carried out against the standards against which the units at Malmsbury were constructed. If found unacceptable, a new master planning process for the site should commence.</b>
	<b>PRIORITY RATING – Medium to Long Term</b>



*Attackguard* is listed on the manufacturer’s website as a low to medium grade product. The product a level above is called *Prisonguard*. This is a medium to high security product.

There are a range of possible solutions to the window security issues. An immediate assessment of possible solutions and a rectification program should commence to ensure that the windows cannot be breached.

## DETAILED REPORT

4.2	<b>RECOMMENDATION – Conduct an assessment of window security to ensure that they meet appropriate security standards. A rectification program should commence to ensure that they meet those standards.</b> [REDACTED]
	<b>PRIORITY RATING – Immediate</b>

There has now been a series of roof climbing incidents at the Precinct over recent months.

There has already been some work to eliminate climbing points at key parts of the centre. It is evident that despite the work already undertaken, roof lines still enable access to rooves. It is my assessment that unless anti-climb barriers are installed, clients climbing on rooves will continue to be a significant risk.

4.3	<b>RECOMMENDATION – Initiate a program to erect anti-climb barriers on all necessary points following an independent assessment.</b>
	<b>PRIORITY RATING – Immediate</b>

### ii. *Issue: The Configuration of the System*

The Youth Custodial System in Victoria has been changing in shape for some years. It is clear that there has been an increasing difficult cohort of clients. This has been exacerbated by changes to bail legislation.

I have already stated my belief that a number of the clients in this and the previous review should be classified as maximum security.

There are few vacancies and little space to house the multitude of separation concerns that managers are facing each day. Overcrowding in my experience significantly increases the risk of violence to both staff and clients.

Even if a new master plan for Parkville was commenced today, it would be years before new building stock is constructed and commissioned.

This has led me to the question what will be the best way to manage the next few years?

My view is therefore that there should be reconsideration of service logic of the entire Youth Justice Custodial Service.

All units should be assessed to ascertain the classification of clients that can be housed in each unit across both Precincts.

Maximum security clients should be housed in the new units at Malmsbury. This Precinct should cater for all high-security clients aged 16 and over.

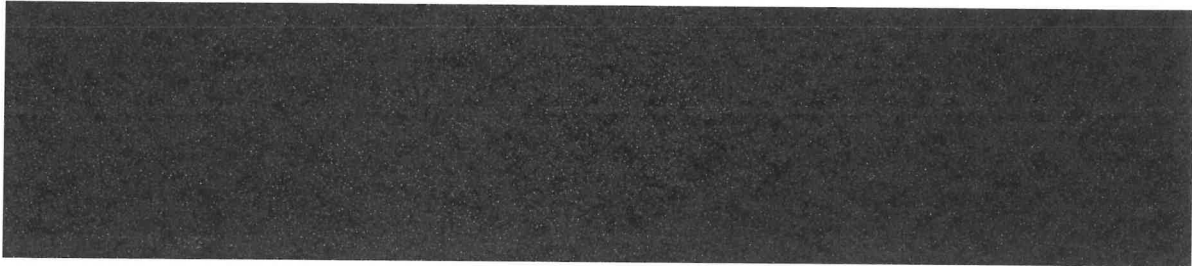
A *Complex* or *Special Needs* Unit at Parkville should be pursued as recommended in the previous review.

Movement up and down classification levels should be closely linked to the behavioural management and therapeutic systems.

**DETAILED REPORT**

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<b>4.4</b>	<b>RECOMMENDATION – High-security clients should only be accommodated in the new facilities at Malmsbury until a high-needs unit can be established at Parkville.</b>
	<b>PRIORITY RATING – Immediate</b>



<b>4.5</b>	<b>RECOMMENDATION – Review emergency key access.</b>
	<b>PRIORITY RATING – Immediate</b>

**iv. Issue: Protective Equipment**

On the day of the incident, it is my opinion that there was not a sufficient supply of shields and other protective equipment. This includes handcuffs.

My interviews indicate that there are only three ‘room entry’ shields on the precinct.

Given that staff were on the grounds and a client ran at them, there should be a re-assessment of the requirements of equipment and the training to staff that is needed to deploy them in an emergency.

Tactically, these may have assisted.

This equipment must be used by trained staff and this section should be read in conjunction with the recommendations on lifting staff capability.

<b>4.6</b>	<b>RECOMMENDATION – The General Manager and SERT Unit Manager should review the need for further equipment including body protection, handcuffs, flexi-cuffs and full clear shields. This assessment should include the training requirements of deployment.</b>
	<b>PRIORITY RATING – Immediate</b>

**v. Issue: Integration of the Safety Management System**

At the time of the review, the workplace health and safety staff had no visibility of the incident. At day five, DINMA’s had not been received.

There has been no safety investigation.

## DETAILED REPORT

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4.7	<b>RECOMMENDATION –</b> WHS officers should be given access to review this incident against the Department’s Safety Management System.
	<b>PRIORITY RATING –</b> Immediate

***Communication***

No further issues.

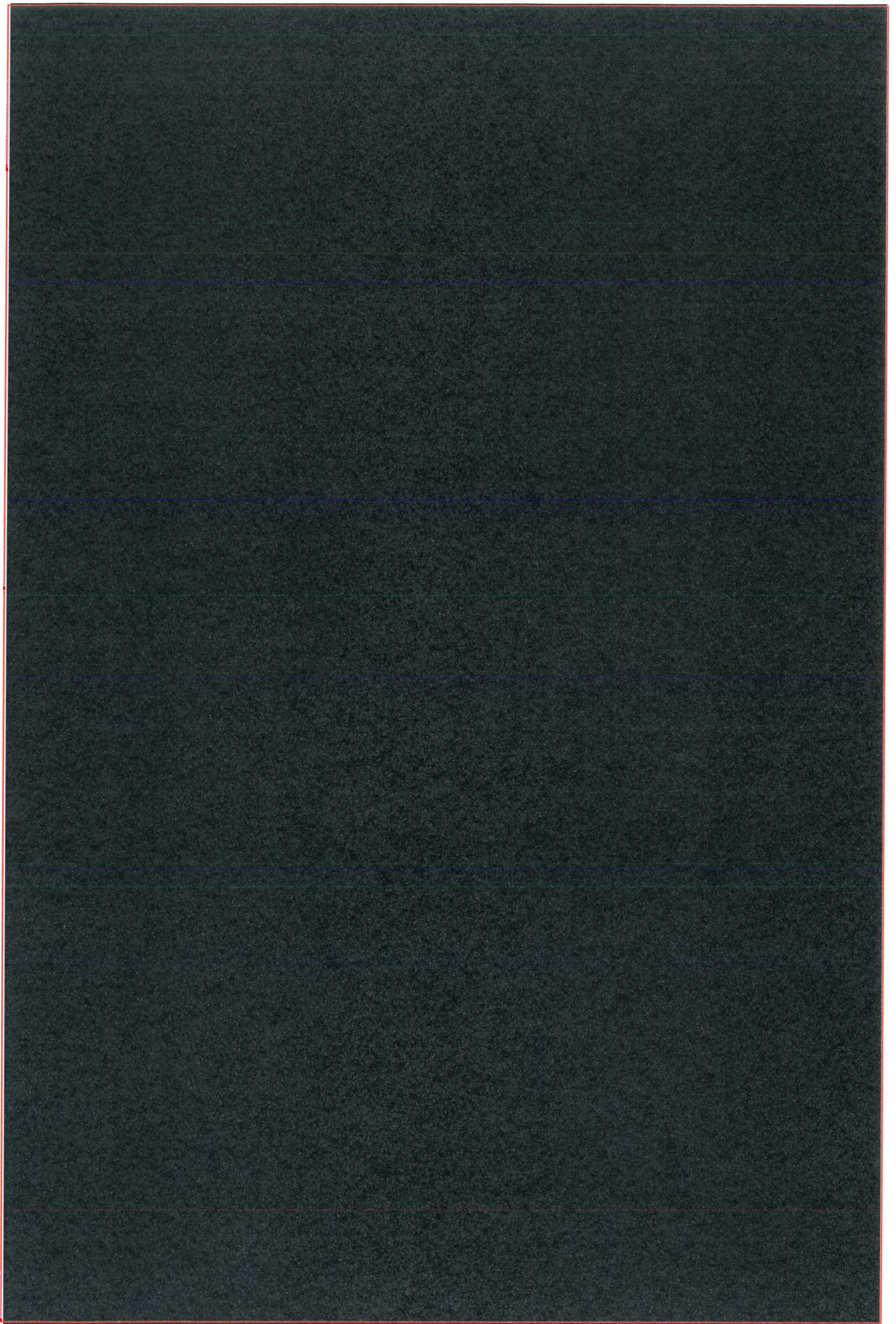
***Client Management***

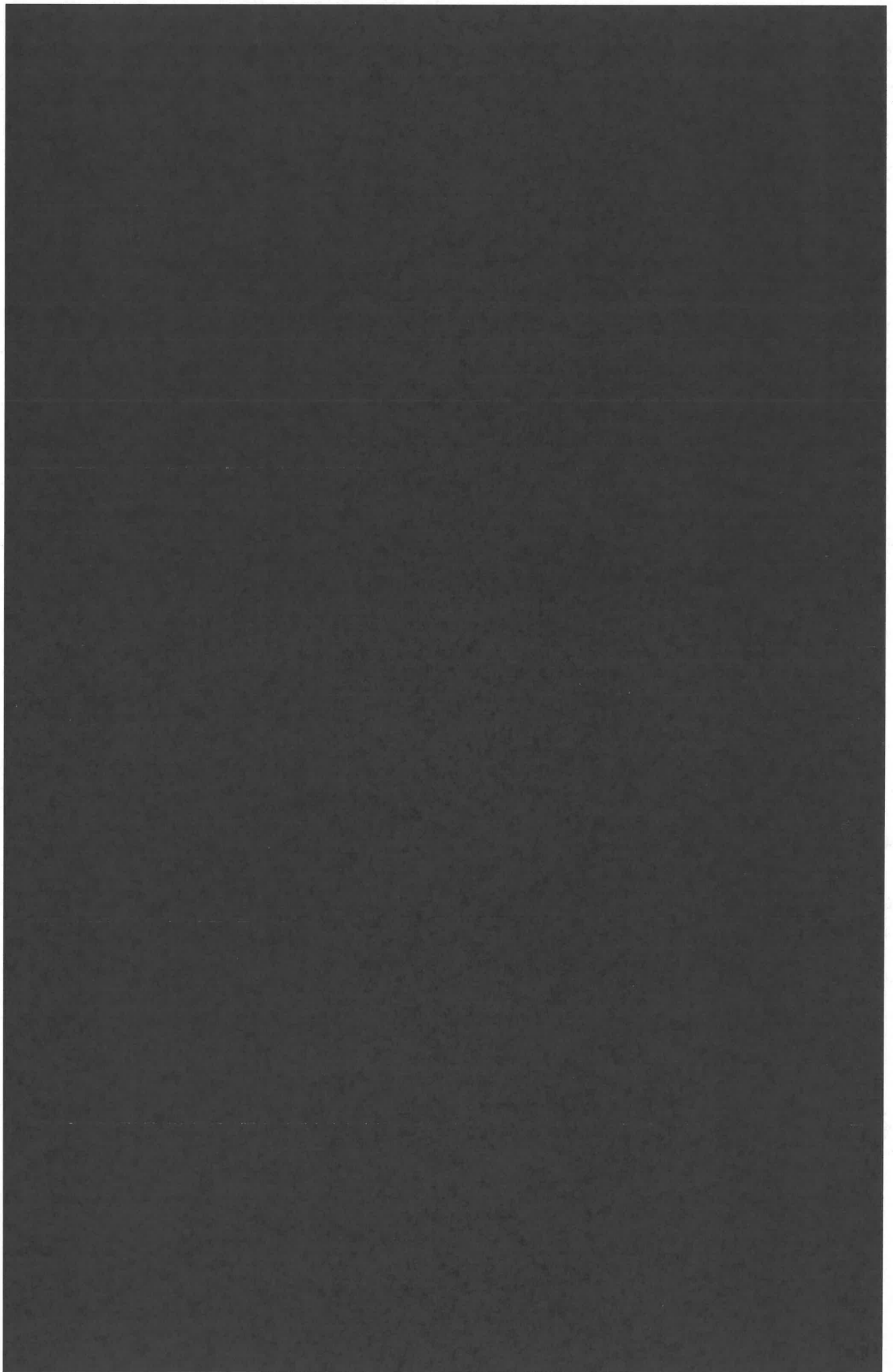
No further issues.

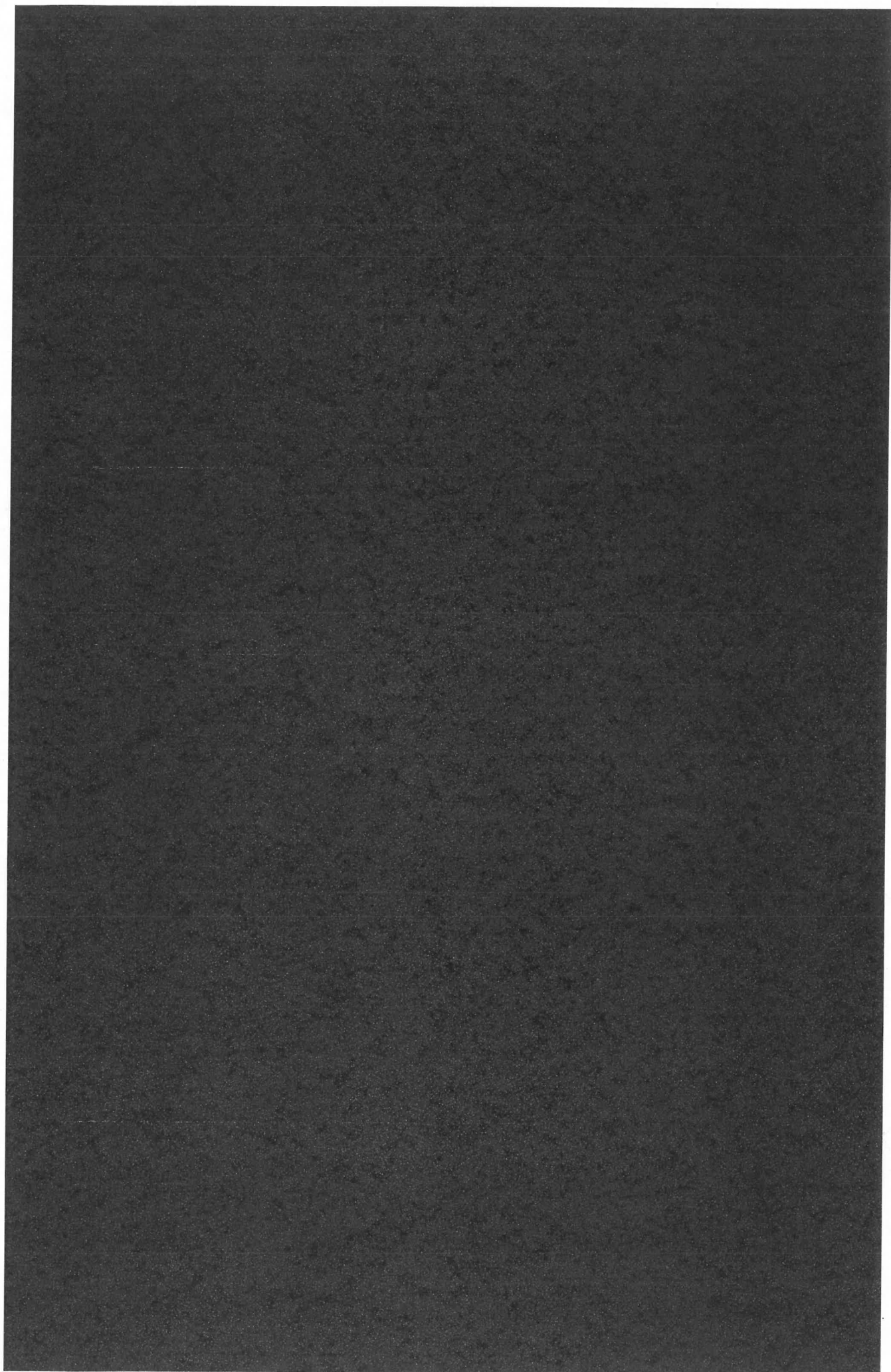
***Staff Response***

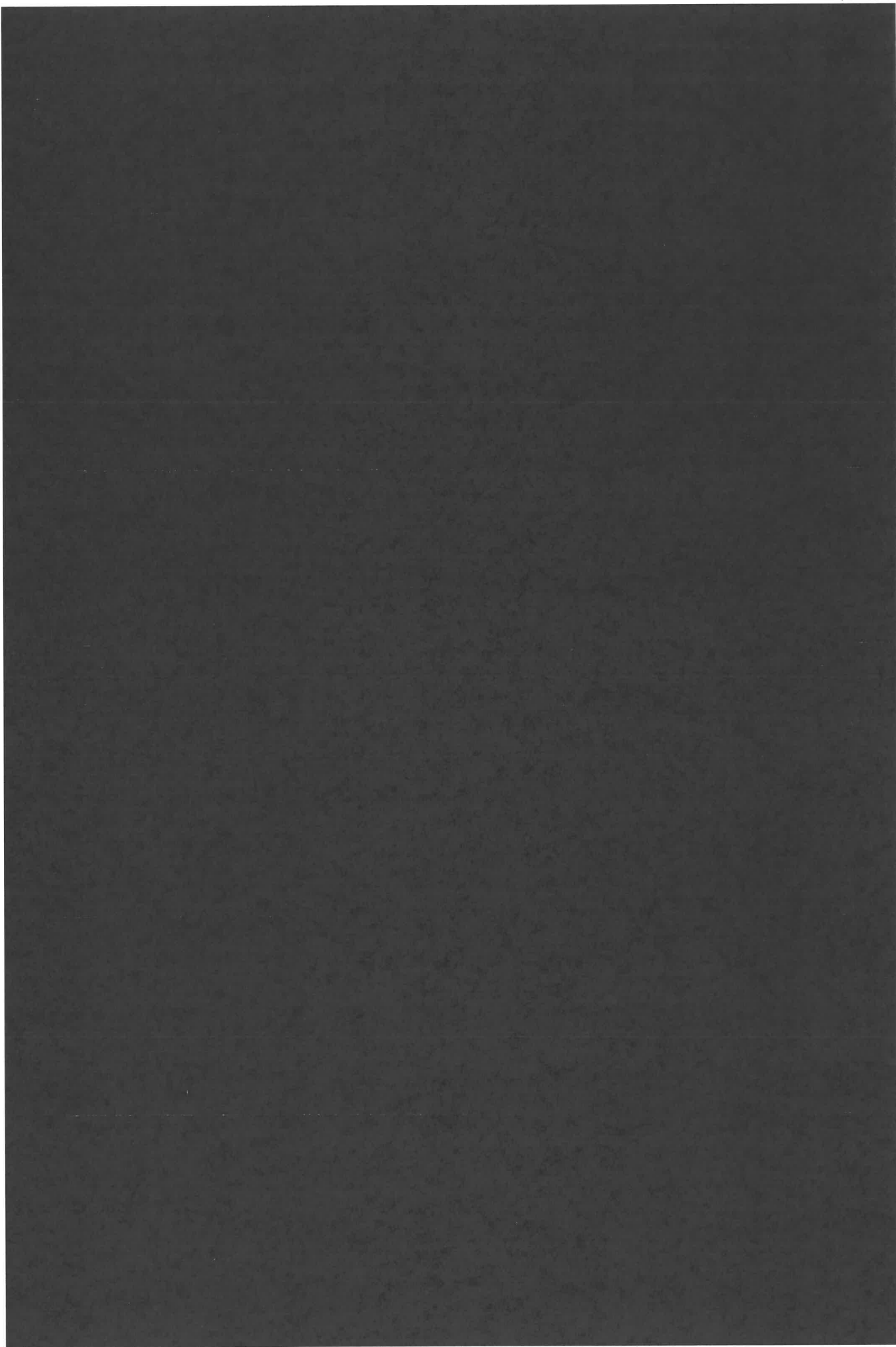
No further issues.

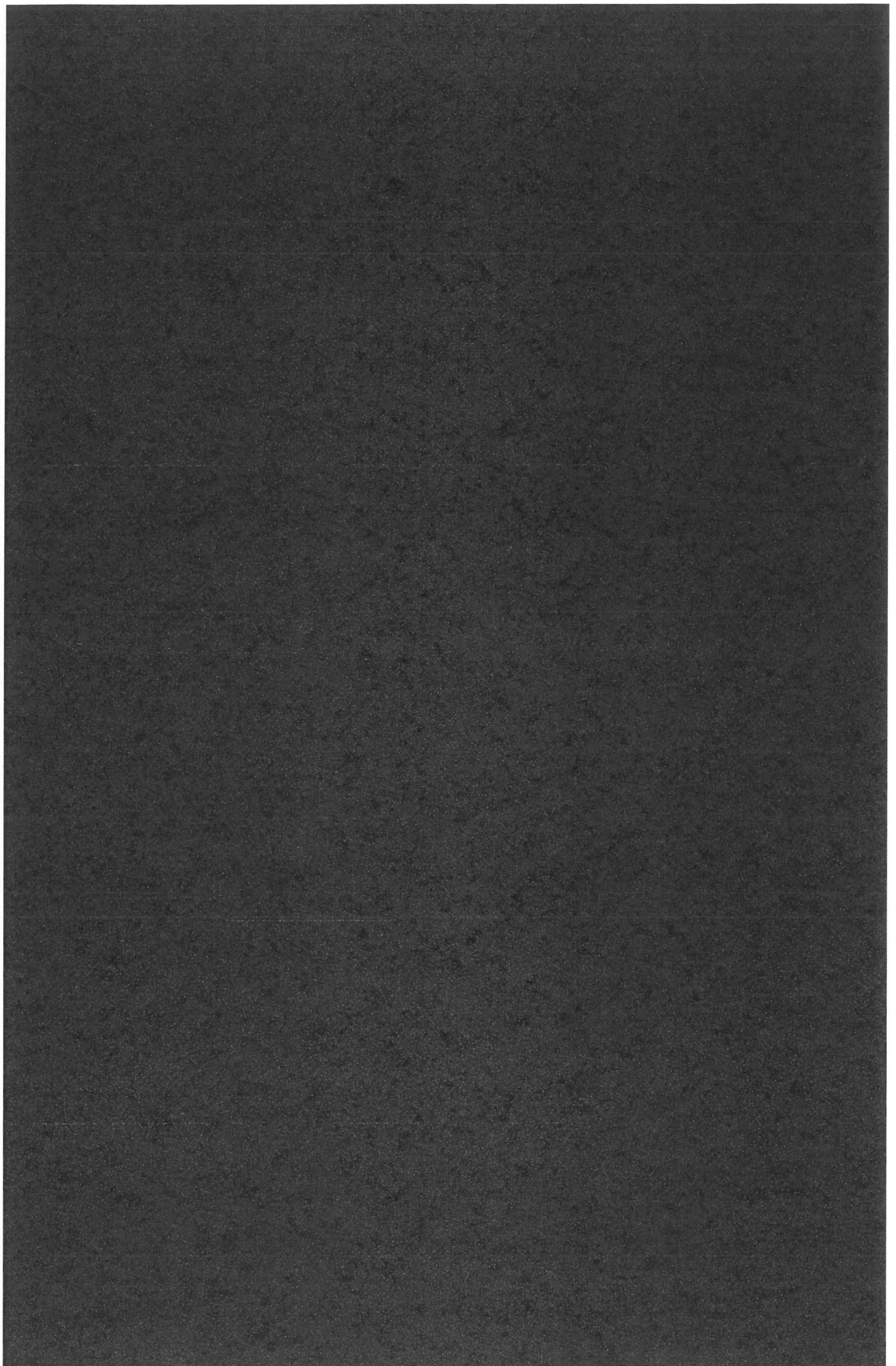
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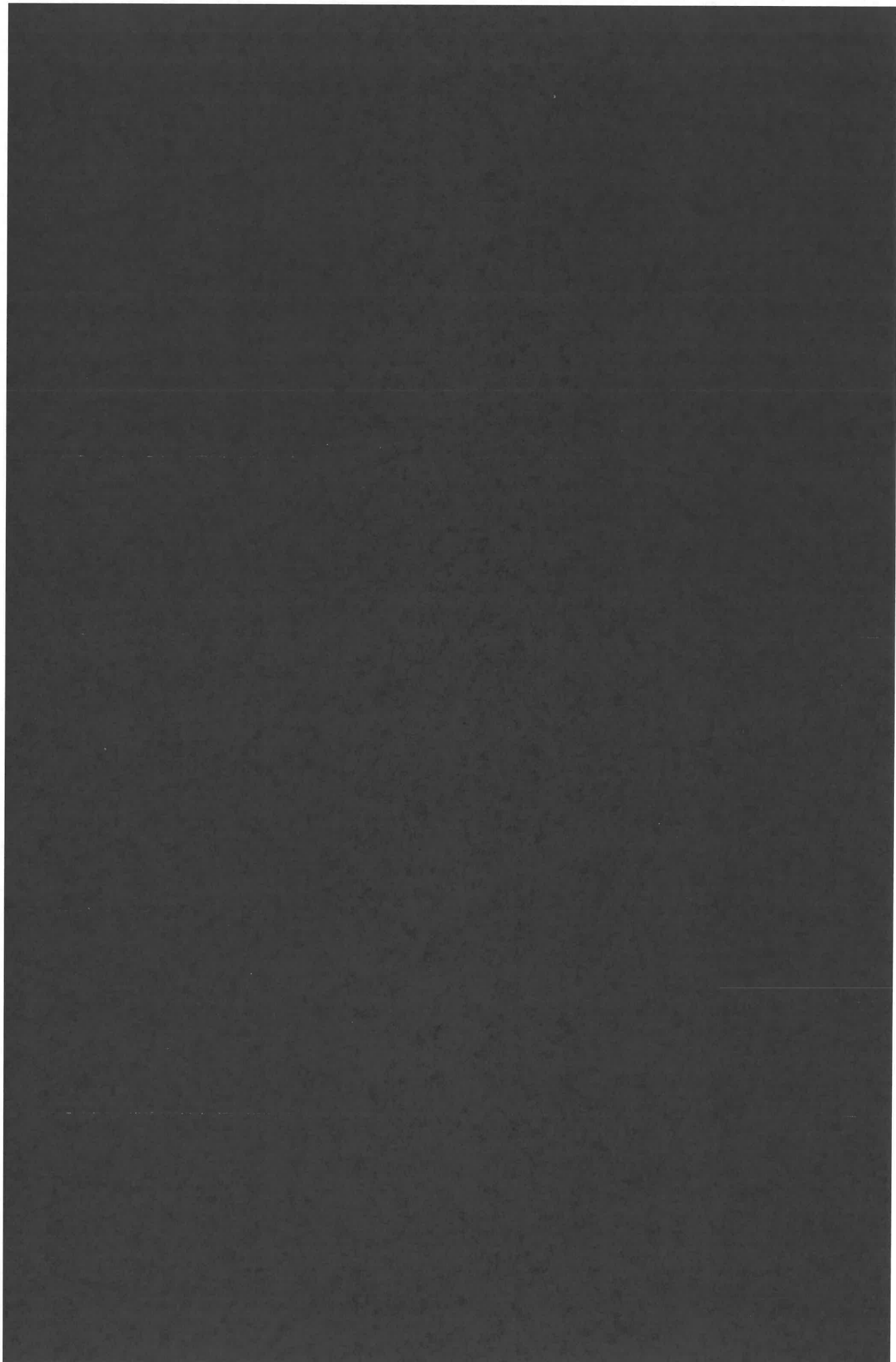


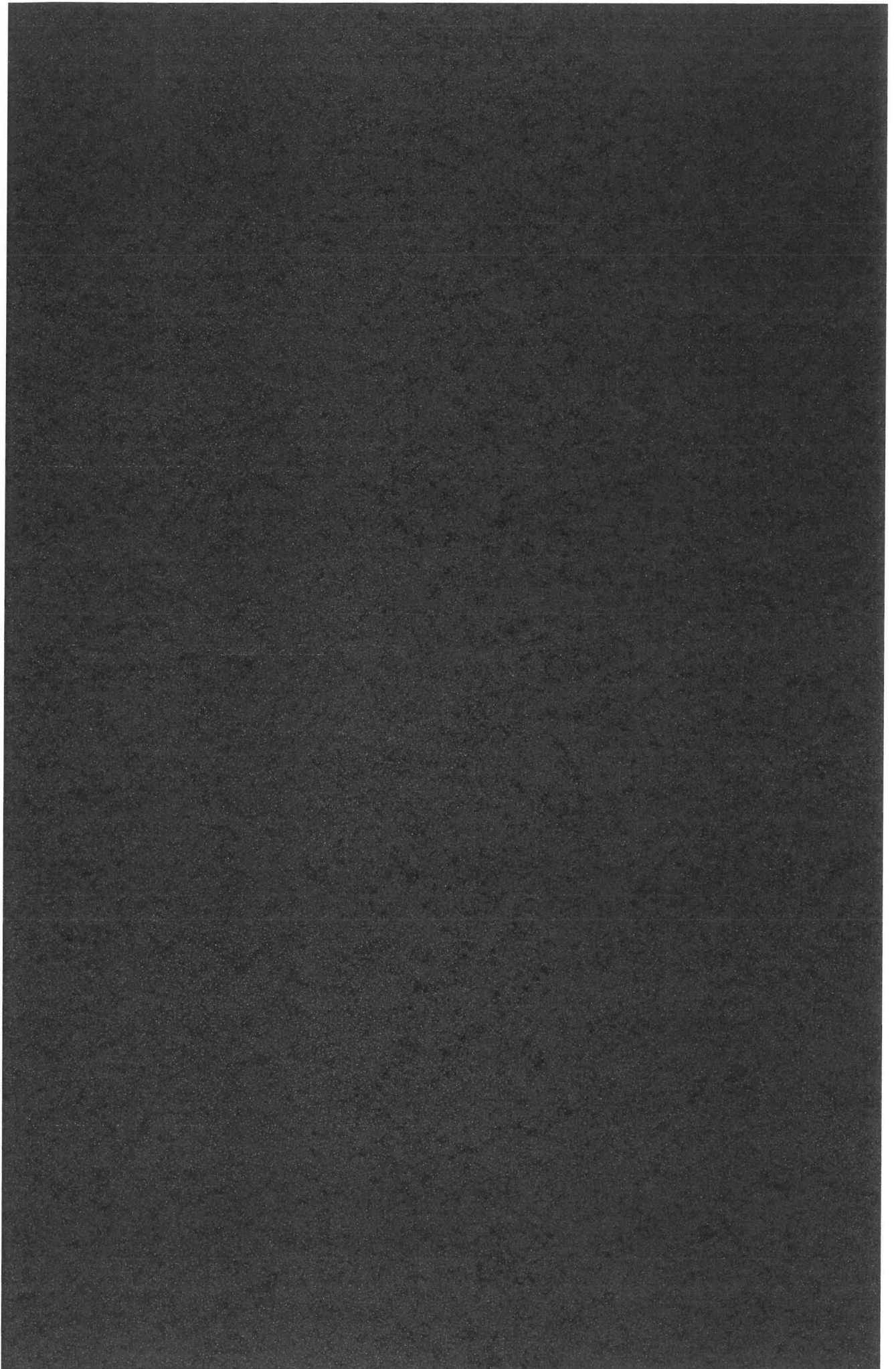


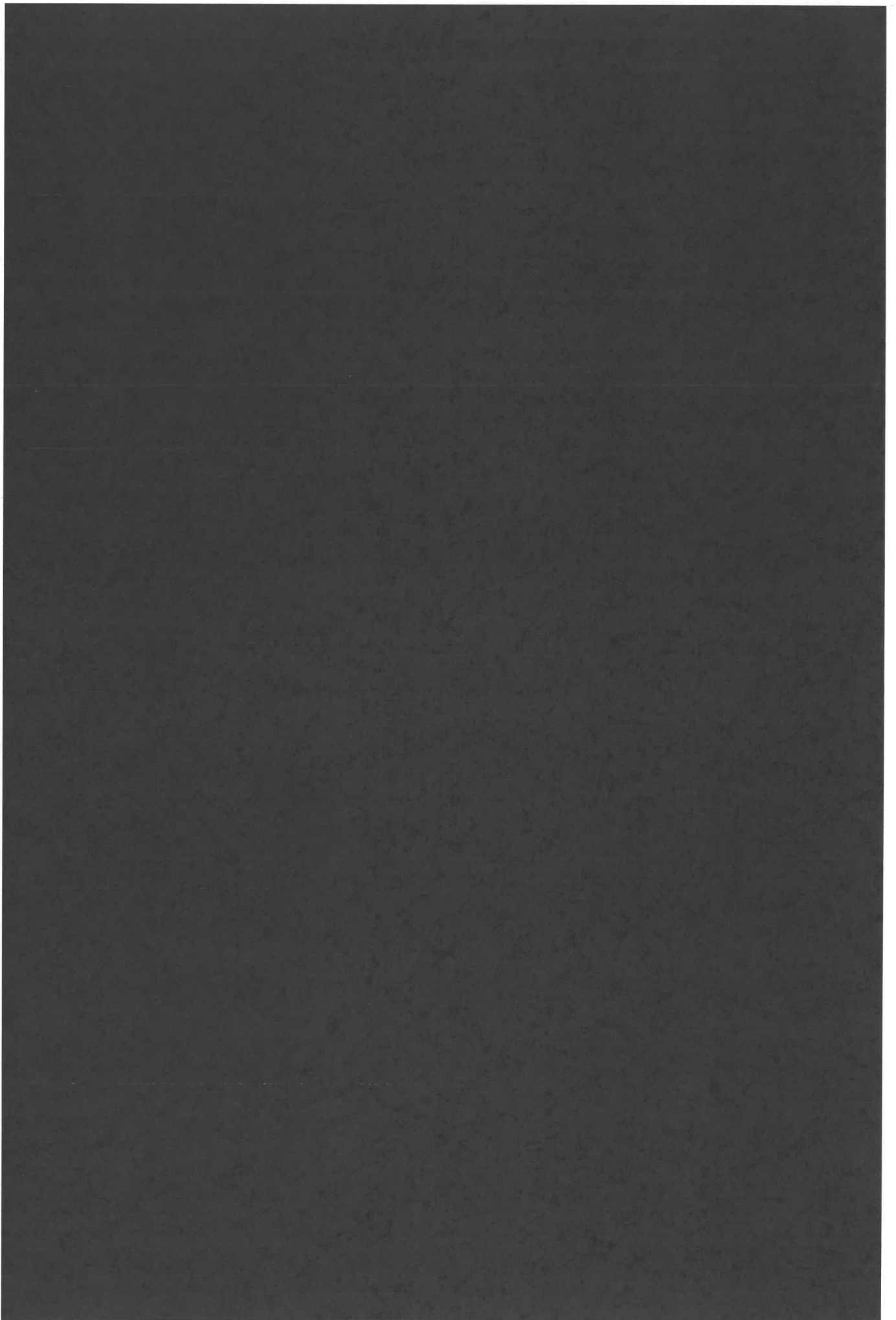


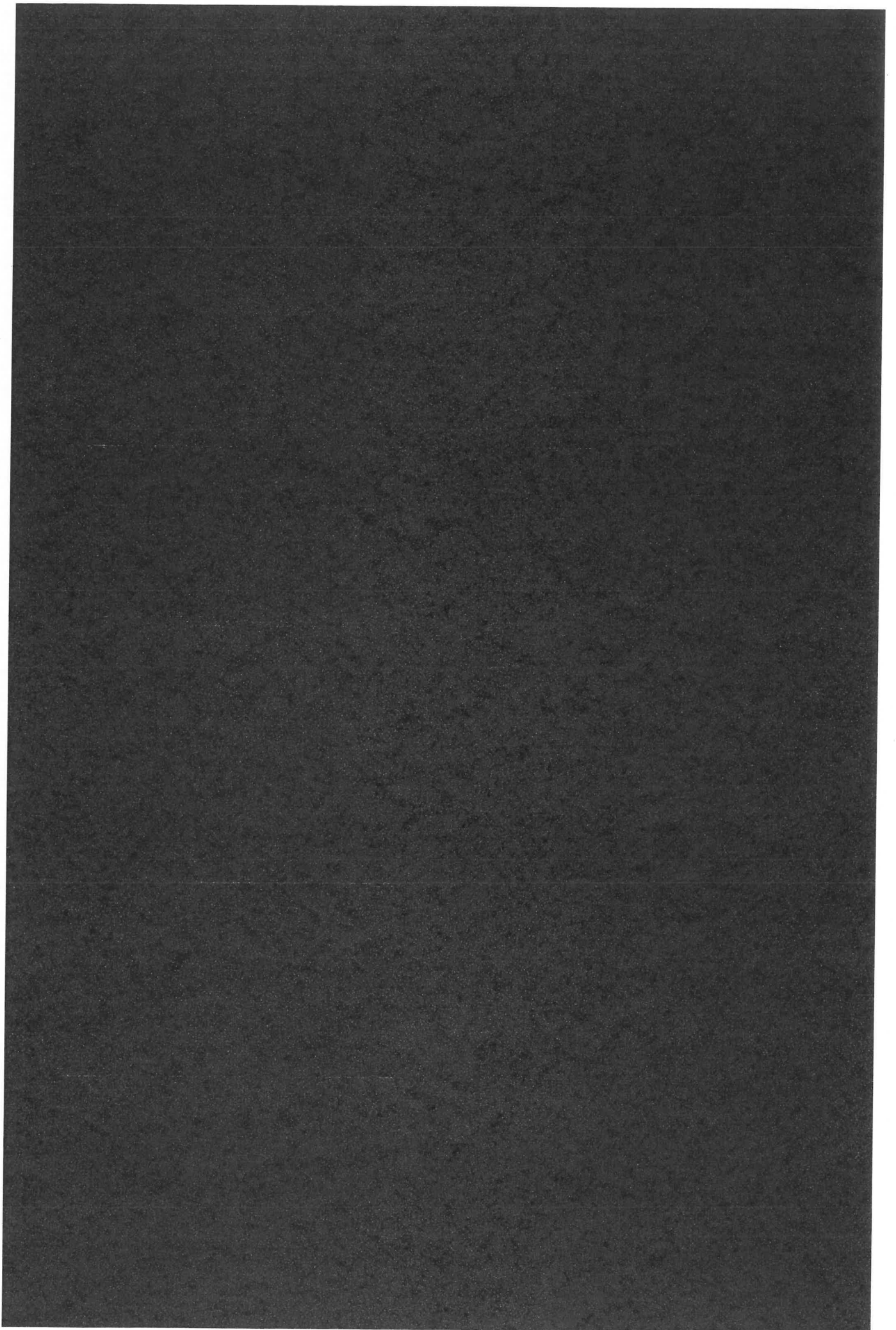


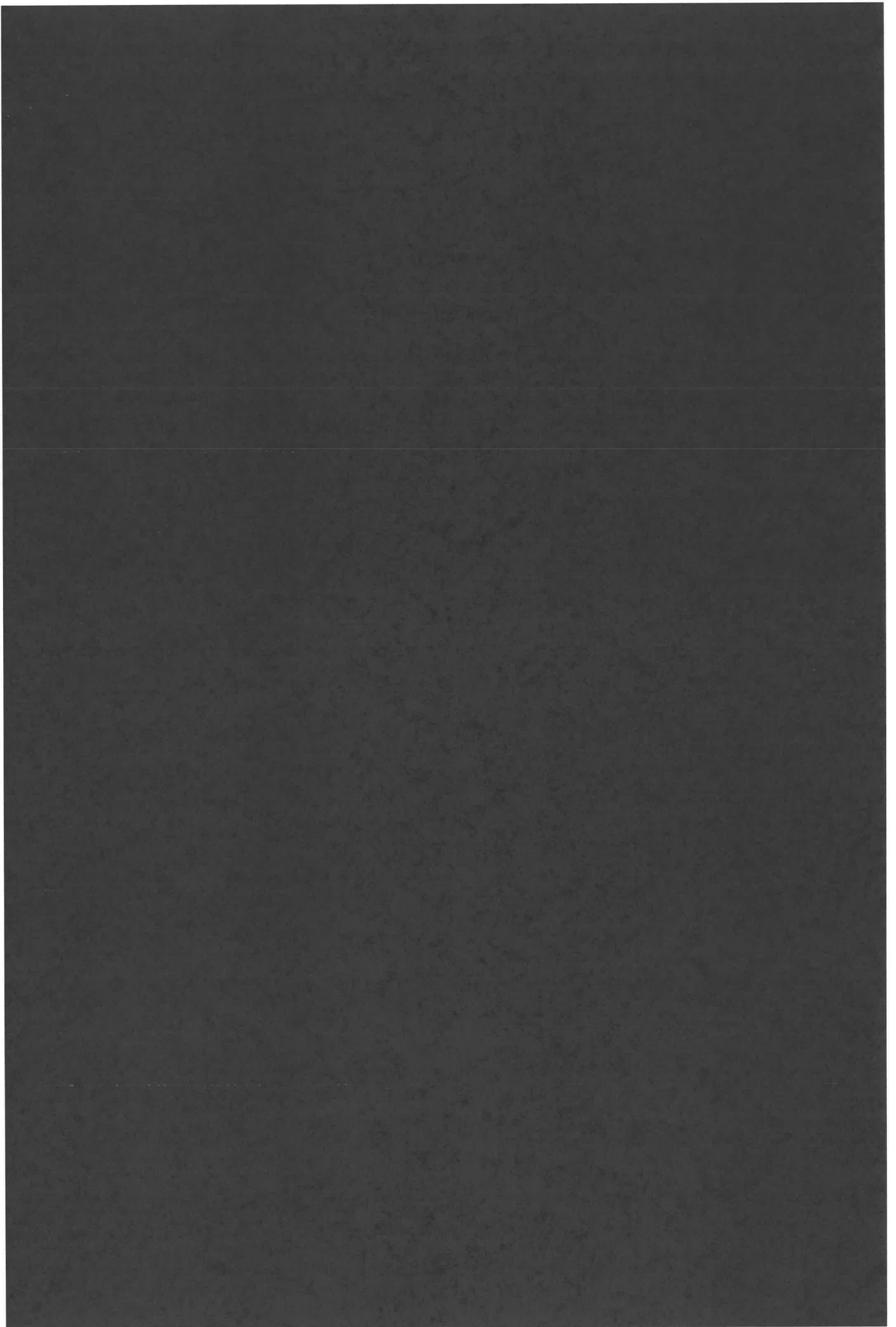


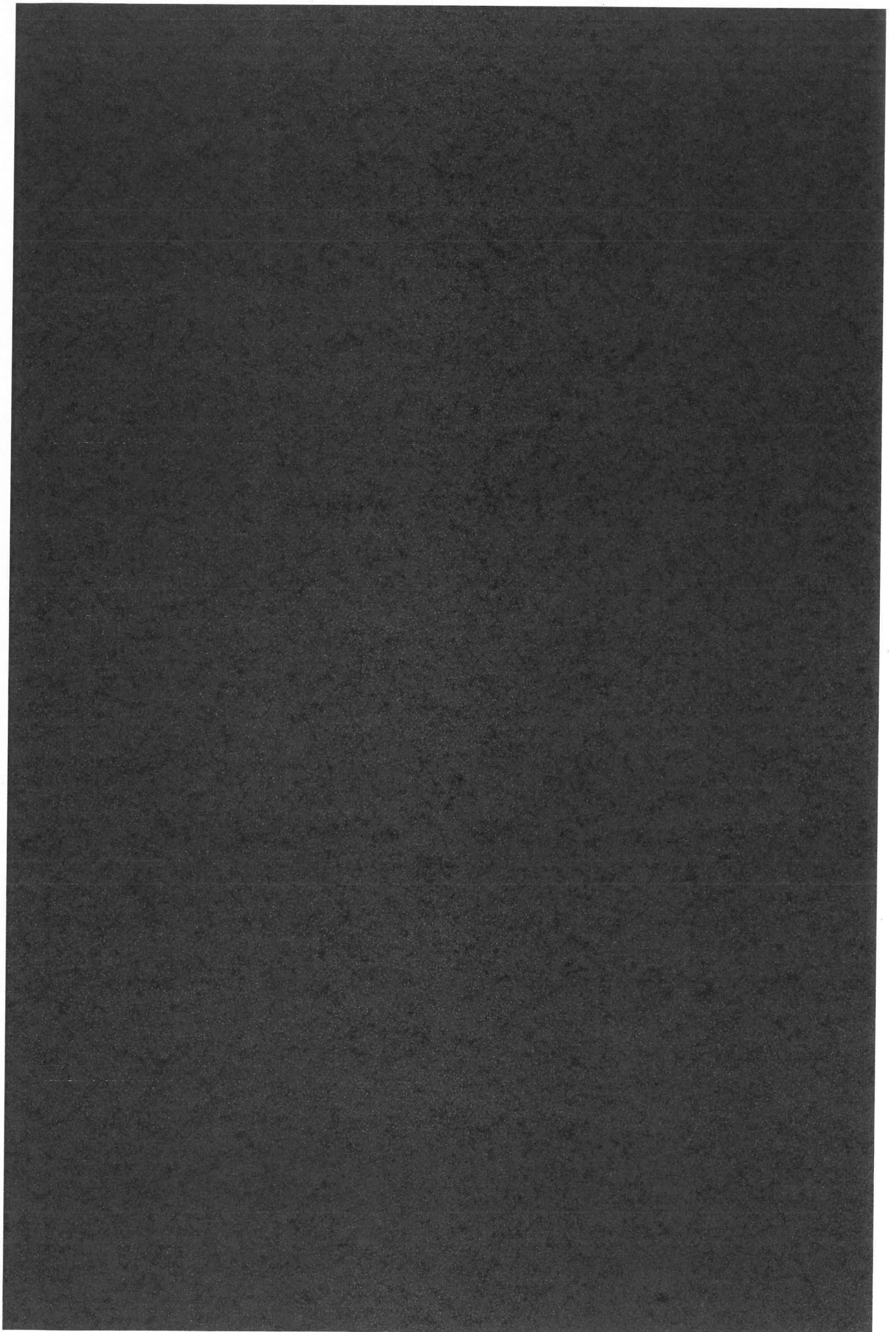


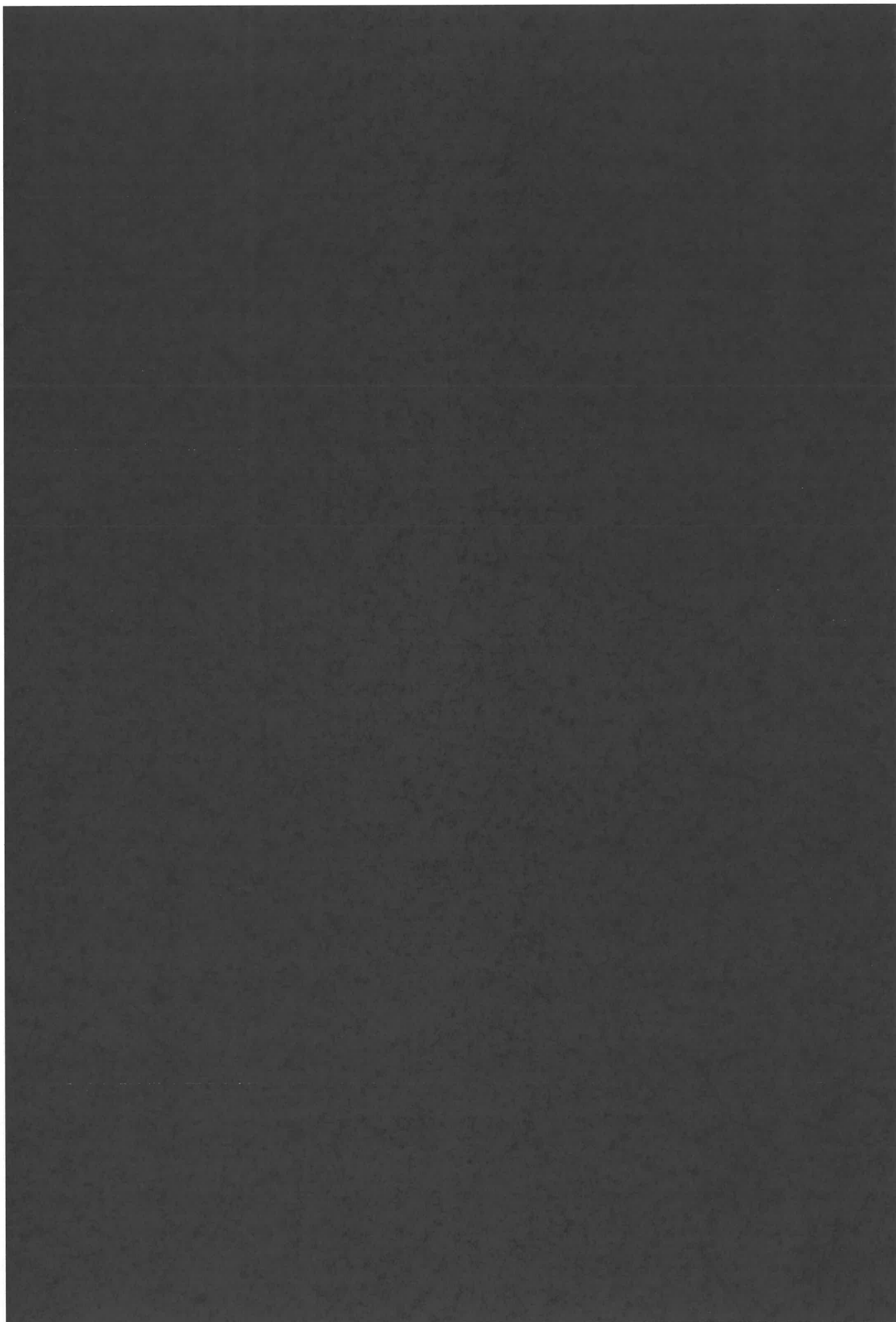












**ATTACHMENT**

**ATTACHMENT B - SUMMARY OF RECOMMENDATIONS**

No.	Recommendations	Recommendation Rating
<b>Section 1</b>		
1.1	See Recommendations 1.16 and 1.32 of the previous review	N/A
1.2	Establish a minimum level required for daily SERT operations. If that number cannot be achieved, assistance should be sought from Malmesbury.	Immediate
1.3	Review recruitment strategies for SERT to consider external recruitment from appropriately qualified and skilled individuals.	Medium Term
1.4	Review the structure and functioning of morning meetings. The meeting should consider the response capacity of the shift when planning the day's activities.	Immediate
1.5	See Recommendations 1.2; 1.10 and 1.12 of the previous review.	N/A
<b>Section 2</b>		
2.1	Commence a program of engagement with front-line staff in relation to Behaviour Management. I will not prescribe the form that this takes but it should seek to understand what is not working from a staff perspective and seek their input on improvements.	Immediate
2.2	Ensure that all internal doors can be locked and secured.	Immediate
2.3	Review the legislation and practice surrounding Isolation and locked doors within Units.	immediate
2.4	See Recommendation 5.1 of the previous review	N/A
<b>Section 3</b>		
3.1	Review Incident Command and Control Structures in the Precinct to ensure that incident management structures reflect best practice. Bi-annual drills should be carried out in incident control and management.	Immediate
3.2	Conduct an immediate recruitment campaign and ensure sufficient casual, temporary and agency staff to ensure that all lines are filled.	Immediate
3.3	Review the contractor management and internal checks at the rear of the Southbank Unit and institute corrective action. This review should occur as a WHS investigation to determine how the systems of work failed and to recommend corrective action.	Immediate
3.4	See Recommendation 6.1 of the previous Review. Drills and exercises should incorporate G4S.	Immediate
3.5	Review Operation Pearl in the light of issues raised in the de-briefing process.	Medium Term
3.6	Follow up all actions raised in the Operational De-brief with Emergency Services	Immediate
3.7	The WHS staff should conduct an immediate risk assessment of the Programs area.	Immediate
3.8	See Recommendations 1.22; 1.24 and 5.1 of the previous review	N/A
<b>Section 4</b>		

## ATTACHMENT

No.	Recommendations	Recommendation Rating
4.1	Undertake a full security assessment of the Precinct buildings. This should be completed with a view to assess their suitability to house clients relative to the risk levels that they present. This assessment should be carried out against the standards against which the units at Malmesbury were constructed. If found unacceptable, a new master planning process for the site should commence.	Medium to Long Term
4.2	Conduct an assessment of window security to ensure that they meet appropriate security standards. A rectification program should commence to ensure that they meet those standards. [REDACTED]	Immediate
4.3	Initiate a program to erect anti-climb barriers on all necessary points following an independent assessment.	Immediate
4.4	High-security should only be accommodated in the new facilities at Malmesbury until a high-needs unit can be established at Parkville.	Immediate
4.5	Review emergency key access.	Immediate
4.6	The General Manager and SERT Unit Manager should review the need for further equipment including body protection, handcuffs, flexi-cuffs and full clear shields. This assessment should include the training requirements of deployment.	Immediate
4.7	WHS officers should be given access to review this incident against the Department's Safety Management System.	Immediate

**ATTACHMENT C - ACCOUNTABILITY AND RESPONSIBILITY STATEMENT**

Peter Muir Consulting Pty Ltd takes responsibility for this report, which is prepared on the basis of the limitations set out below.

The matters raised in this report are only those that came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made.

The Department of Health and Human Services should assess recommendations for improvements for their full commercial and operational impact before they are implemented.

This report is confidential, has been prepared solely for the use of the Secure Services, Department of Health and Human Services and ownership of the report and any attachments lies with your organisation. It is the responsibility of your organisation to determine if you wish to release this report, in whole or in part. However, this should not occur without our prior written consent.

No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose.



