



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

*Security Review of critical incidents at Parkville
Youth Justice Precinct on 6 & 7 March 2016.*

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COMMERCIAL IN CONFIDENCE

CONFIDENTIAL CLIENT INFORMATION

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EXECUTIVE SUMMARY

Ostensibly, the two incidents on the 6th & 7th of March 2016 occurred with the same starting point.

Clients in custody ran off whilst being escorted by staff within the Precinct, they then climbed onto buildings and armed themselves with various implements torn from rooves or gathered from the buildings that they entered.

Clients running off from a group whilst in custody should not be seen as a failing of the system nor should it be seen as a reflection of the health or otherwise of the system and the competence of the staff employed in that system.

In fact, this behaviour is to be expected in custodial environments. Young people in custody (as will most people) at various times assume “fight, flight or freeze” responses to various situations of stress or duress. There is a raft of “institutional” behaviours that should be considered a predictable response in what is a very abnormal environment.

We know a great deal about the population of detained young people in Australia.

Firstly as adolescents; they lack the impulse control and cognitive functions that we possess as adults. We have learned a lot about adolescent brain development. We know that the brains of young men in particular are not fully formed until sometime in their early 20’s.

This research tells us that adolescents are more likely to:

- act on impulse
- misread or misinterpret social cues and emotions
- get into accidents of all kinds
- get involved in fights
- engage in dangerous or risky behaviour

They are less likely to:

- think before they act
- pause to consider the potential consequences of their actions
- modify their dangerous or inappropriate behaviours

Secondly, Victoria has for a number of decades led the nation in the diversion of young offenders from custody. What this means is that the custodial population in Victoria represents the most serious of all offenders.

Lastly, we know that in this group there are high levels of mental health disorders, alcohol and other drug use and cognitive disorders. A further exacerbating factor has been the dramatic increase in the remand population within the Parkville Youth Justice Precinct. Within the last few years the ratio of 80:20 sentenced to remand has flipped to 20:80, with the overwhelming majority of clients now being on remand. Remand clients are known for their increased complexity and challenging behaviours, many of whom are still under the influence of drugs and alcohol when admitted or in the withdrawal stages. Their uncertain futures also tend to heighten behaviours.

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The histories of the young people involved in these incidents reveal all of these factors.

Based on the fact that this behaviour is entirely predictable in a custodial environment, my assessment of the major issues contributing to both of these incidents was:

- 1. The failing of the infrastructure to contain the young people exhibiting behaviour that was likely to have occurred and will almost certainly occur again**
- 2. The fact that they were able to get access to so many weapons from both the built environment and from program areas.**
- 3. Staffing and recruitment issues that has resulted in a higher than normal number of lock-downs.**
- 4. The high number of remand clients in the Precinct.**

Within these three issues there are a number of themes and issues that will be explored in the report.

The first is that access to rooves facilitated their access to weapons on both days.

This was due in a large part to the fact that the anti-climbing barriers were not complete at the time of both incidents as per my recommendation following the roof climbing incidents late last year.

I am not critical of the Department for this. Given my final report on the incident of 31 October 2015 was not delivered until late November, the need to design and procure a solution and the shutdown of industry over the Christmas period; this made construction impossible for a protracted period of time; the progress as at 6 March 2016 was commendable.

The second roof issue was access to the Horticulture Shed.

A risk assessment was carried out on this program. This assessment was as a direct response to my report on the 31 October incident. This program was assessed as a medium risk. Given the possible consequences of the program, it is hard to understand this assessment as I would have thought it to be high.

The assessment was undertaken by competent and qualified staff and the final analysis of risk was based on the assessed frequency and the priority in rectifying the woodwork and metalwork rooms.

I agree that these were of a greater priority than the horticulture shed.

The access that young people had to weapons was a bi-product of two factors.

The first was their access to rooves and the ability of young people to access the ceiling spaces. The rooves and internal spaces yielded an array of weapons.

The second was their ability to access a large amount of dangerous items from Parkville College program spaces. Significant concerns are held on this issue and they are still to some extent unresolved. This is despite a significant amount of work having commenced to assess and manage risk in programs.

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It is my assessment that the incident on 6 March was largely spontaneous and had little or no pre-planning. There is some evidence that the event was conceived on the morning of the event but none beyond that time.

In relation to the incident on 7 March, it is my assessment that it was planned in the music room sometime between 1.30 and 1.50 pm on the day of the incident. I do not believe that there was any plan prior to the music class. I believe that there was a rising degree of tension in the Precinct over the issue of lockdowns as the result of staffing shortages that was a contributing factor to this incident.

There were many positive elements in the management of these incidents. These will be covered in detail in the report.

First amongst these are that young people and staff have identified that the rapport that has been built between staff and clients was a significant protective factor at key points of both incidents.

The second is the emergency response by the staff at the Precinct. Emergency plans and clear command/control structures were effectively implemented from a departmental perspective. The decision-making of managers and the response of the staff resulted in no injuries to staff arising from these events.

This was not an accident. It was the result of some good planning and management. It is positive to note that a considerable amount of work and planning has been undertaken between the October incident and the current incidents. This work has significantly mitigated the potential impacts of the two events.

There are 19 recommendations contained in this review.

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 Incidents that occurred at the Parkville Youth Justice Precinct (PYJP) on 6 and 7 March 2016.

The incident on Sunday 6 March 2016 occurred while five remand clients were being escorted back to their unit from recreational activities. All five ran from staff, scaled a management fence and made their way to the horticultural training area at the rear of the site. They scaled another management fence, climbed up onto a gardening shed and kicked their way into the shed where they accessed some basic gardening tools. While threatening staff, they moved to a nearby accommodation unit using tools to smash windows and doors resulting in another five clients leaving their accommodation unit.

Staff continued to negotiate with the clients who, after some time, put down the tools and surrendered to staff. Victoria Police attended the centre but was not required to assist. The incident lasted under an hour.

On Monday 7 March 2016, four remand clients were being returned from educational programs when they ran from staff, scaled a management fence and gained access to the roof of the Southbank accommodation unit. The clients then damaged the roof and gained access to the ceiling space, smashing their way through the ceiling of two bedrooms allowing two sentenced clients to join them. All six clients then engaged in property damage and riotous behaviour. None of these clients were involved in the incident on the preceding day nor were any of the weapons from the preceding day involved (in contrast to the media reports).

Victoria Police were called and the remainder of the site was placed into lock-down. Victoria Police subsequently took control of the incident per the agreed operational protocols and engaged in negotiations with the clients. No clients or staff were injured in the incident. Considerable property damage was caused and Victoria Police will consider laying charges.

The incident resulted in a temporary closure of the Southbank Unit due to the damage sustained in the incident. Several clients were transferred to the Monash and Deakin Units at Malmsbury to assist in managing the client demographics and house clients while repairs were underway.

In response to these incidents, an independent review and analysis of the circumstances surrounding the incidents was requested by the Minister.

Purpose (as per the Department's request for services):

The purpose of the review is to thoroughly examine the incident in the context of existing operating procedures, risk assessment practices and infrastructure and make recommendations for improvement.

Specifically, the review will:

Focus on the circumstances leading up to the incidents, including any contributing factors and intelligence that might have been available;

- *Examine the immediate response by staff to the behaviours of clients that then escalated;*

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- Consider the subsequent response of staff and management of the incidents;
- Examine post-incident recovery and security practices that took place;
- Provide comment of the implementation of recommendations relating to the 31 October 2015 incident at Parkville Youth Justice Precinct.

Conduct of Review:

An independent consultant will be appointed by the Deputy Secretary, Department of Health and Human Services, North Division.

The review will:

- Be undertaken within the principles of transparency, due diligence and fairness
- Identify key learnings to strengthen policies, procedures and practices.
- Be an opportunity to work in a solution-focussed manner and to engender quality improvement initiatives.

The review will commence with an Operational Debrief of staff and Victoria Police involved in the incident supported by a review of CCTV.

The consultant will require access to material held by the Department of Health and Human Services and may request to undertake focus groups or interviews with relevant staff, clients and Victoria Police members.

Under the secrecy provisions of the Children Youth and Families Act 2005 (S 429A), material that may jeopardise the safety and security of youth justice precincts must not be provided to external bodies. The consultant is required to comply with confidentiality and privacy requirements.

Governance of the Review:

The Review will be overseen by a Steering Group consisting of:

- Deputy Secretary, North Division (Chair)
- Director, Secure Services, North Division
- Director, Operations and/or Community Services Programs and Design Division - to be determined.

The Review Steering Group will meet in accordance with the relevant milestones agreed between the consultant and the Steering Group members.

Deliverables

The consultant will provide a report from the operational debrief (22 March); an interim draft report (5 April); and a final report that identifies any required improvements to:

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

The final report, including findings and recommendations, will be presented to the Steering Group by mid-April 2016.

An implementation plan will be developed to guide the required changes recommended in the final report.

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The chronology of this event is well documented in the incident report. Copies of the Incident Reports for both days are found at *Attachment A*.

METHODOLOGY

Operational Debriefing Sessions were held at PYJP on 15 March 2016 with:

- Staff from the Oakview Unit
- [REDACTED] Unit Manager, Safety Emergency Response Team (SERT) regarding the Incident on 7 March
- Staff from Southbank and Oakview Units as well as staff from SERT who were on duty on 6 March.

A preliminary walk-around was conducted on this day to familiarise myself with how events unfolded.

A further Operational Debriefing Session was held with Eastern Hill and SERT staff on 22 March 2016 at PYJP.

All debriefing sessions were minuted. I maintained some contemporaneous notes from the meetings.

Prior to the commencement of the review, the Director, Secure Services provided me with a copy of a letter from the Community and Public Sector Union (CPSU) requesting that staff have direct access to me in the course of the review. In order to facilitate this, following each meeting, I left business cards on the table with the invitation that anyone wishing to discuss any further matters privately with me were free to directly contact me.

Two staff members took up this invitation. I met with these staff members on 30 March 2013. Some contemporaneous notes were kept of these meetings.

CCTV footage of the Incident on 7 March was reviewed. I was informed that there was little useful footage from the incident on 6 March.

Radio communications were made available and were reviewed where relevant.

The Executive Principal of Parkville College was interviewed on 22 March.

A comprehensive physical inspection of the Precinct with the exception of the Remand North and South Units was conducted on 30 March. I maintained notes during this inspection.

On 30 March, I undertook a review of client records on the *CRIS* System.

Six clients were interviewed at both Malmsbury and Parkville Precincts on 31 March. All clients who remained in custody were offered an interview and were informed that it was voluntary for them to do so. I informed them that they did not have to say anything that may incriminate them in any offence and that they could terminate the interview at any time. The following clients agreed to be interviewed:

- [REDACTED] (6 March)

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- [REDACTED] (6 March)
- [REDACTED] (6 March)
- [REDACTED] (7 March)
- [REDACTED] 7 March)
- [REDACTED] (7 March)

Two clients [REDACTED] attended interviews but declined to participate once they were in the room.

Two Victoria Police Officers (VicPol), [REDACTED] were interviewed but not debriefed on 1 April. This meeting concerned the events of 7 March. VicPol have carried out an internal debriefing of the incident.

General Manager [REDACTED] and Operations Manager [REDACTED] were interviewed on 1 April. [REDACTED] was interviewed again on 22 April.

Following direct contact from Union Organiser [REDACTED] from the CPSU, a meeting was conducted with him on 1 April at PYJP.

I have interviewed [REDACTED] from Infrastructure Projects and Security Unit on 1 April.

A final walk-through of Remand North and South and the attached Programs Centre was conducted on 1 April.

[REDACTED] Operations Manager from G4S was interviewed on 1 April.

Two staff members [REDACTED] and Unit Manager [REDACTED] who were present in the Control Room on 7 March were interviewed on 1 April.

The Daily Safety Advices (DSA's) were for Eastern Hill and Oakview Units were reviewed.

A final day of interviews was conducted at the PYJP on 22 April 2016. This included:

- Clinical Supervisor, [REDACTED]
- Principal Practice Leader, [REDACTED]
- Manager of OHS, [REDACTED]

Project Officer [REDACTED] provided advice throughout the course of the review.

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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

6 March 2016

It was suggested by staff in the Operational Debrief that prior intelligence existed as to a disturbance that was planned on Sunday 6 March. This was also raised in my meeting with the CPSU.

This was discussed with both the SERT members at the debriefing and the General Manager. The Minutes of the Classification Meeting at which this issue was raised were reviewed.

There was previous intelligence about a possible incident, however it was thought it may be in the Westgate Unit. SERT reported the intelligence to management and assessed it. They spent additional time in Westgate on Sunday 6 March and did not have any reasons to think Oakview was a risk.

Oakview staff report little of material relevance on the morning in question. One staff member reports overhearing a conversation in the kitchen where a client states something to the effect that they would "do it later." She did not report this conversation to anyone.

This conversation could have referred to almost anything. No one reported hearing or seeing anything else of relevance.

Whilst the unit staff believed that this was a pre-planned event, they could offer nothing of substance to support this.

Perhaps the most concrete evidence of any degree of pre-planning for this event came from young person [REDACTED]

He was unclear as to the timing of this.

The other two young people [REDACTED] involved in this incident were interviewed on 31 March at PYJP. Both young people indicated in their interviews that the event was not pre-planned. [REDACTED] cites boredom as his reason for being involved.

Of the five young people who commenced this incident and ran from the unit, the only that had any relevant alerts on CRIS was [REDACTED]

[REDACTED]

The following day, he spat at a SERT staff member.

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The Classification Committee minutes indicate that [REDACTED]

Of the others, [REDACTED] He was admitted to custody on [REDACTED] He had prior alerts for suicide. There was a Significant Event Case Note (SECN) on 19 January 2016 for "Inciting others." It did not provide much detail on what this involved.

[REDACTED] had no alerts at the time of the incident. [REDACTED]

[REDACTED] was re-admitted on [REDACTED] He had no relevant prior alerts. [REDACTED] Case notes do not record any other substantial level of misconduct. [REDACTED]

[REDACTED] had no alerts at all. He was admitted on [REDACTED] There were no apparent precipitating factors recorded in his notes.

The DSA's in the lead up to this event do not contain any additional or conflicting information.

The most significant contributing factors to this incident were;

- The access to the Horticulture Program tool shed
- The lack of security for a range of extremely dangerous tools in the shed
- The lack of an accurate tool count for items in the shed
- Weaknesses in the Unit doors that allowed them to be penetrated

7 March 2016

There was no apparent or specific intelligence in relation to the incident on 7 March 2016. In the Operational Debrief, staff from Eastern Hill has identified [REDACTED] as the main instigator of this incident. There seems little discrepancy that this is correct.

My interview with this young person would support this assumption.



¹ It also seems a curious statement given that they administer the Promoting Positive Behaviour Scheme

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court on [REDACTED] and was anxious about his sentence. He had two recorded threats to self-harm in February.

[REDACTED]

Having stated this, it is also clear that [REDACTED] is a very difficult young man. He was involved in the incident of 31 October last year. In the lead up to this incident, his behaviour was mixed. There were some reports of good behaviour in his *CRIS* record but overall the picture on the record is one of a young man who presents as a risk both to himself and other people. Relevant events on *CRIS* include:

[REDACTED]

A number of other clients in the unit program that day also present significant risks. What is not consistent is a clear pattern of behaviour leading up to this event.

Specifically, [REDACTED] behaviour was described as “good” or “settled” in the week leading up to the incident. [REDACTED] had no case notes, incidents or alerts that would give rise to any concerns. Whilst appearing to present a number of risk factors,

[REDACTED] had no relevant alerts. The DSA’s however present a picture of a young man who presents a considerable degree of risk.

The DSA’s in the lead up to this event do not contain any additional or conflicting information.

This incident had its genesis in a music class being held in Classroom 6 of the Programs Centre. Seven clients and two staff members enter the room at approximately 1.11 pm. The classroom teacher is not in the room when they enter.

My investigations lead me to believe that:

- The teacher had left a number of MP3 music players in the room from the previous class
- Students are not supposed to enter the room until the teacher is in there
- The count of the players was inaccurate by the teacher and that there was never a missing player.

The procedure for equipment in classrooms is that the teacher and a PYJP staff member jointly verify what is in the room and sign a sheet to agree what is there. This serves as a check at the end of the lesson to determine that all equipment is accounted for.

A review of CCTV footage of Classrooms 7 and 8 for the same times indicate that this clearly took place. Staff can be seen verifying the equipment and signing the sheet.

At best it is inconclusive that this happened at the beginning of the class in Room 6. The Youth Officer in the room indicates that it did.

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At some point in the lesson, it is ascertained that there is a missing piece of equipment and the staff radio for a metal detection wand to be bought to the classroom and a decision is made to terminate the lesson.

The wand did not arrive at the room until 1.48 pm when wandering of the clients commences. (This is some 37 minutes after the commencement of the class)

During this time, some clients in the room become increasingly agitated. They can be seen pacing the room and at times hitting windows.

Despite equipment being deemed to be missing, a client exits the room at approximately 1.13 pm and re-enters at approximately 1.29 pm.

Young people are seen moving in and out of a recording room to the side of the classroom. My opinion is that the activity looks suspicious yet staff in the classroom did not move or investigate what was occurring.

My assessment is that there was very little active engagement by the staff in the situation over the course of the class.

Once the class is ceased and the clients subjected to a search by metal detector, they were moved to the Western Passageway exit from the Programs Centre which faces onto a roadway next to the Southbank Unit. It is from here that the run away from staff. They circle the Southbank Unit and use a cyclone fence abutting the building to access the roof.

Only one young person involved in this phase of the incident agreed to be interviewed. This is

indicated that the incident was precipitated by the belief that they were going to be locked down. There is no evidence that this was the intent of staff or even that this was communicated to the clients.

He indicated that he was also upset by the assault on the previous day

does not believe that the MP3's were counted at the beginning of the class.

What has been established is that the teacher's count of what he bought into the classroom was incorrect. (Which means it was incorrect for the previous lesson as well)

It is clear that the decision to terminate the lesson was a factor in this incident. The decision to do so was the right one in the circumstances however, the decision was based on incorrect information and it is my view that it was unlikely that an accurate count was taken at the beginning of the lesson where the confusion could have been avoided.

² Staff who witnessed this assault were quite distressed at what they saw.

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Despite all of this, staff indicate that they did not suspect in any way what was about to unfold and that they were comfortable in moving the clients back to the unit.

When the four clients ran away on exiting the Western Passage Doorway, a *Code Green* was called³.

i. *Causal Factor: Building Infrastructure*

The sequence of events in the 7 March incident are well documented and the review process has not revealed facts with either this or the 6 March event that are inconsistent with the version of events contained in the indecent reports.

On 7 March, clients were able to access the roof via a fence and gate abutting the Southbank Unit. From there they armed themselves with poles from cameras and a TV antenna.

They commenced to kick at and demolish cladding that leads into the internal roof cavity. Once in that cavity they were able to access the rooms of two clients and extract them from their rooms. This was achieved by breaking off the air handling vents into the rooms and extracting them through those holes. The roof sheeting was otherwise protected over client rooms and was not penetrated.

In the incident of 6 March, clients were able to get out of the Westgate Unit simply by kicking the door open. The outer door had already been broken down by Oakview clients. It is noted that all door and window frames are made of aluminium 'shop front' type material which in my view is not suitable for a custodial environment.

The horticulture shed has now been demolished.

I have commented on the adequacy of the buildings at the PYJP in my review of the incident on 31 October 2015. The view that I expressed then is still held; that the infrastructure at PYJP is no longer fit for purpose.

But the problem is now a bit bigger in as much as a whole cohort of clients know the building weaknesses and are able to exploit them. **This remains a significant risk.**

I observed in my time at the Precinct a wall that was kicked out. The construction is largely better block construction that is neither filled nor tied – a minimum requirement for custodial environments.

There are hollow-core, wooden doors in various parts of the Precinct which are at best domestic quality and totally unsuitable for a custodial environment.

³ A Code Green indicates that clients were attempting to escape

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In the 6 March incident, Southbank staff talk of their fear as armed clients attacked the windows and they felt that they had no means of egress. They additionally felt that there were no safe zones in the unit. They retreated to the office and locked themselves in.

A program of rectification has commenced. From the time of the commencement of the review until the conclusion of the fieldwork, substantial progress has been made on the anti-climb barriers. These are now complete.

I have inspected the works on three occasions and have made further recommendations on points where I believe rooves may have been accessible. All of these recommendations have been accepted and acted upon.

All work on anti-climb barriers including the points highlighted in my inspections have now been completed.

Substantial work has been completed at the rear of the Programs Centre which has included the re-alignment of the anti-climb barriers as well as substantial strengthening of the protection to the rear of the metal and woodwork areas. These areas represented a point of significant weakness. I am satisfied that the controls implemented address the risks at the rear of the Programs Centre.

I have observed rectification works arising from the incident on 31 October 2015. These works include window and door strengthening. Some of the windows attacked in the incident on 6 March were not penetrated because of the *Crimsafe* that had since been fitted.

The works inside the woodwork and metalwork areas prevented the incident on 7 March from being much worse. Staff overheard clients talking about attacking them. Interviews with clients support that they had intent to harm staff at some points of the incident. They were prevented from accessing some of the most dangerous weapons in the Precinct as a direct result of these works.

Clients attempted to break into the cages containing tools with significant effort and force. It was a credit to the construction of these cages that they were unable to do so.

One issue that arose from the incident on 7 March was the security of the basketball courts adjoining Oakview and Westgate Units.

The CCTV footage showed clients attempting to join in as the others rounded Southbank and climbed on to the roof.

The fencing that existed on those courts provided no impediment to clients. They were over the top of the fence before the staff member could reach the gate.

A solution has been engineered and installed. I was able to view this on my final inspection. I am satisfied that the solution provides a much more robust level of security. These works were completed over the course of the review.

Having said all of this, the buildings remain highly problematic for the types of clients that are being housed at the Precinct and in my opinion present a continued and ongoing threat to the safety of the staff and clients.

Apart from the planned rectification works, a master planning exercise needs to be undertaken at PYJP as a matter of utmost priority.

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My assessment, based on my experience in NSW is that a substantial amount of money could be spent on this Precinct and it would still present significant risks and vulnerabilities.

No one can guarantee that with all that has been completed to date and all that is planned for this site, that young people will not be able to access the rooves again.

Assessments of the rooves and ceiling spaces have occurred. Work is scheduled in the ceiling spaces and this is due for completion by the end of the financial year.

One outstanding concern that I hold is that of safe zones for staff should they be required to retreat. It is clear that the buildings have multiple points of egress through which staff can evacuate. However, if they are stuck in Units as they were on these days, there does not appear to be safe zones that can be relied upon until they are safely extracted.

I am satisfied that every reasonable effort is being undertaken within the resources allocated to Secure Services. However, it is my opinion that the site is in need of total re-development either at Parkville or another greenfield site. In the interim, fortification works need to continue including the creation of a 'safe zone' for staff within each of the units.

ii. *Causal Factor: Tools and Equipment in Parkville College*

Second to the weaknesses in the built environment, the access that clients had to tools and other items from programs that became weapons was the next most significant causal factor in both of these incidents.

This issue was highlighted in the review of the Incident on 31 October last year.

Following that report, a risk assessment process was undertaken in the Programs Centre. A new procedure on tools and equipment on the Precinct has been introduced. A governance process has been established. The governance meetings have been documented and I have been supplied with minutes of the meetings.

In the risk assessment following the 31 October incident, the areas deemed to present the highest risk were the metalwork and woodwork areas.

This assessment resulted in substantial changes to the storage of tools in the wood and metalwork areas and the manner in which classes are conducted.

After the wood and metalwork programs, jewellery was the program assessed as the next highest risk. Modifications were made to the operation of this program.

I have outlined in the introduction to this report, that the timeliness and scope of these works averted a much more serious incident than what unfolded on March 7.

I agree with the priority placed on works to this area over others.

On 6 March an array of tools that became very dangerous weapons were easily and quickly available to clients from the Horticulture shed.

The inventory that was in the shed was dated 2012 and was inaccurate. This made the resolution of the incident difficult as DHHS staff could not be certain that they had recovered all of the items taken from the shed.

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My initial inspection of this area revealed pavers that were loose and concrete chunks left over from past programs. Either could be used as dangerous weapons had they been used on 6 March. The area is only protected by a cyclone mesh fence.


On March 7, clients were able to access steel-capped boots, a radio, spray cans and other items obtained from the Programs Centre. On the dates of my inspections of the three programs centres, all of these items and more were still lying about and were not secured.

A comprehensive tool register has been prepared but it is not in a form that I believe represents good practice. The list that I have reviewed:

- Does not detail the location of the items on the list
- Does not in my assessment contain all of the tools, equipment and consumables in areas controlled by Parkville College.

By this, I mean that **all** store rooms and class rooms should have an accurate list of what is in that area. It should be checked and verified **every** time the area is used.

Store rooms still contain a significant amount of material that if accessed can again become weapons.

 Equipment should be moved to secure store rooms and be incorporated into the methodology recommended above.

Items that should be considered dangerous weapons such as welding rods, metal scissors and metal poles were all observed stored in a manner that makes them a potential risk.

Since my review in 2015, a process has begun at Parkville in relation to tool accountability.

There have been regular and documented meetings. The issue is now firmly on the agenda and progress has begun on what I consider to be a critical safety and security issue.

There is a daily process to monitor tools and equipment in classrooms and this is being monitored and reported on for compliance.

My concern is that the system is yet to be considered a mature and reliable system of work. Some of my interviews indicate that staff do not always sign these off. The compliance figures confirm this. On 7 March, I am not convinced that the program equipment reconciliation was carried out at the commencement of the class as it should have been.

Whilst a system is in place and in the light of events that occurred after it was in place, there is a need to ensure that these efforts are effectively implemented by **all** parties on site in a manner that reflects a mature and reliable system of work.

In two areas of Parkville College radios are still stored in areas that can be penetrated or accessed by clients.

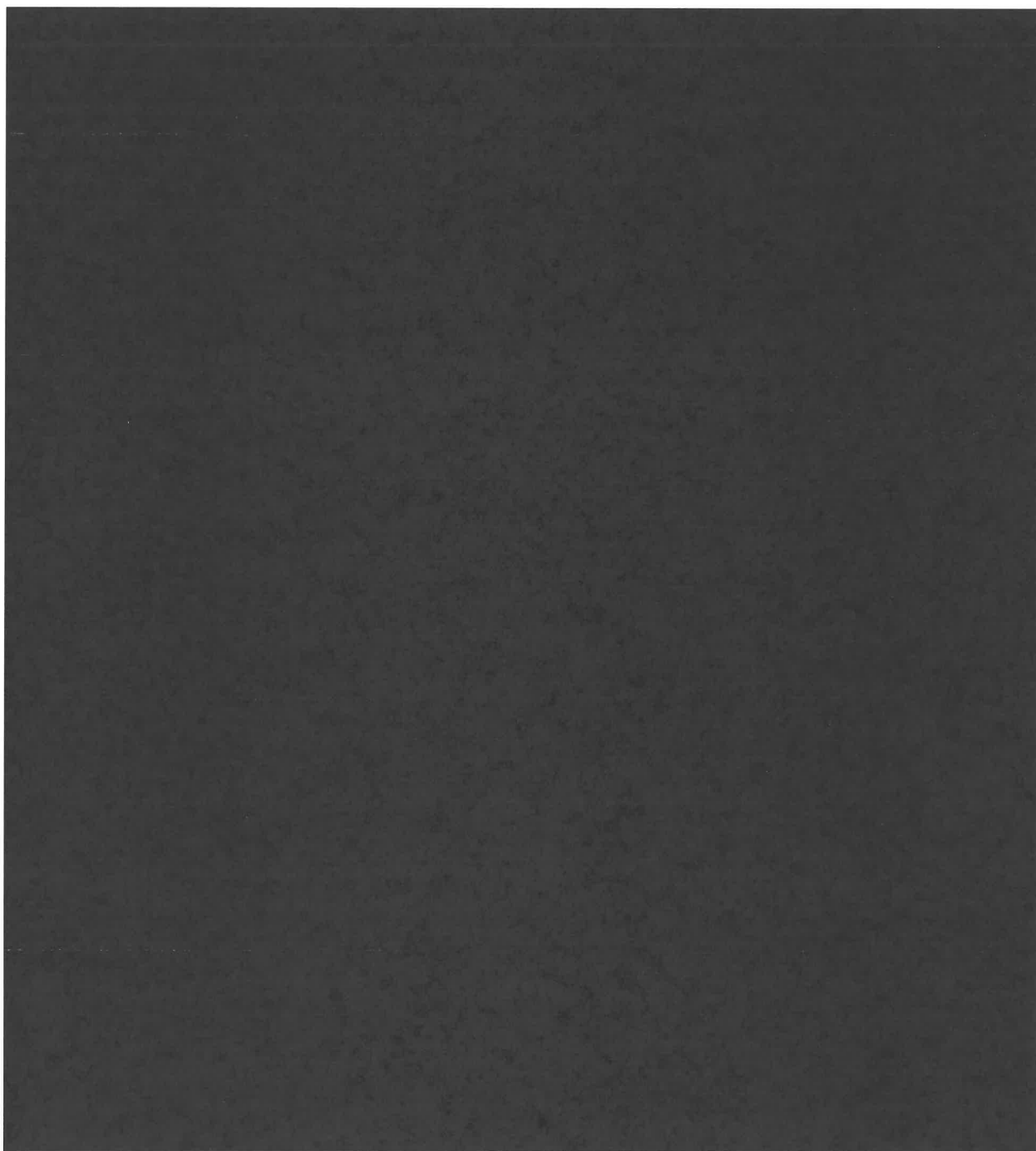
It is my conclusion that there has been significant progress in this area, but there are still some concerns that I hold as to the reliability of systems of work and a full understanding by all parties on site as to what constitutes a safe system of work and a shared commitment to safety.

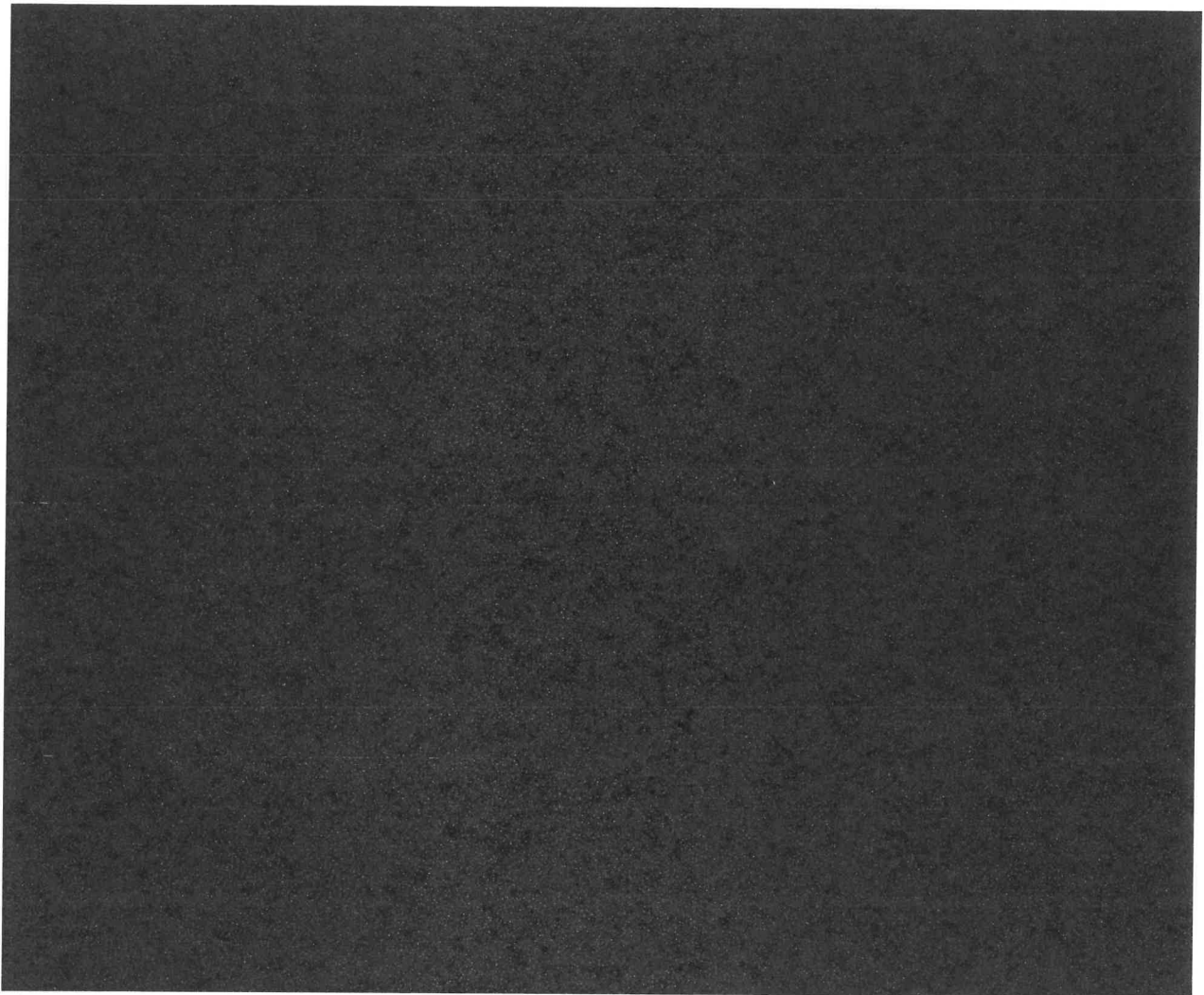
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Despite the changes to the metalwork and woodwork areas, I do not believe that they are operating in a safe manner.

On the day of my inspection I observed the operation of a woodwork class. Whilst the improvements are substantial in terms of the cages and shadow boards, the cages are left open during class. Clients from outside the room could easily gain access to them if the door is open for any reason. There is access to a number of very dangerous implements within one metre of the door.

iii. ***Concern: OHS and Parkville College***





iv. *Concern: Control of Movements*

I have observed a number of client movements in the Precinct over the course of three assignments with Secure Services. Some are done well, others not so.

In the ones that have not been well managed, clients are left to run around and break ranks with little control or discipline exerted by staff.

Staff from Oakview Unit were able to describe the methods that they employed on 6 March. There do not seem to be any concerns as to how they moved clients from the unit to the court on 6 March.

In the short to medium term, movements should be considered an activity with some degree of risk.

My recommendation will centre on a reconsideration of movements to consider, based on the risk profile of the group:

- More consistency in movement procedures
- The assistance of SERT were necessary

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- Breaking clients into smaller groups
- The use of handcuffs for clients presenting the highest risk.

The last issue in relation to movements is egress from the Programs Centre. There is a walk through metal detector that seems to have been designed as the point of egress from the Centre.

The unit is not functional and my understanding is that the Western Passage Doorway is the usual means of egress from the Centre.

The metal detector should be repaired and this point should serve as the only exit point of the Programs Centre.

v. ***Contributing Factor. Staff Shortages and Lockdowns.***

One of the interesting revelations in the client interviews was the impact of lockdowns resulting from staff shortages.

Why this was interesting was that this was not raised in any staff interviews or debriefing sessions, yet with the young people, this was a prominent theme.

██████████ nominated this as the prime motivator for the incident on 7 March. (There was no evidence that the clients were going to be locked down but for some reason they thought that they were going to be.)

██████████ was similarly animated about the issue.

██████████ raised the issue as well.

All state that scheduled lockdown are getting longer and that lockdowns in the middle of the day are getting longer.

Subsequent investigations indicate there are very high levels of casual and agency staff and that on a significant amount of days, where shift lines cannot be filled.

On the day that I visited Remand South, it was in lockdown all day due to a lack of staff. Practice appears to be to rotate lockdown days across the centre.

Information provided to me indicates that staff do not consider it safe to unlock doors with less than five staff members. This does not appear to be a structural issue but rather one of custom and practice.

Staffing in Victoria seems generous when compared to the jurisdictions with which I am familiar.

In NSW, units of 15 clients are staffed with three Youth Officers and a Unit Coordinator for every second Unit. In a recent report, the NSW Auditor General found that NSW has 3.9 staff members for every young person.

In the ACT there is one staff member for every four to six clients with Unit Coordinators.

In both jurisdictions, additional staff is allocated on the basis of risk.

In Queensland, the figure is one staff member for every four young people.

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Staff appear to be focussed on ratios rather than the inherent risk or considering other approaches such as letting smaller groups out of their rooms. (There are some cases in which half of the clients are let out at once.)

Once I started asking questions on this issue, it would appear that there are significant concerns as to the numbers of available, permanent staff and that there is a high number of casual and agency staff being utilised.

I do not assess that casual or agency staffing was a causal factor in either of the day's events, but it is clear that lockdowns are increasing tension on the site and contributing to the level of risk on the site.

Clearly, inconsistency in practice between staff can be a trigger for escalated behaviours of clients. Inconsistency in practice can be exacerbated through the lack of permanent, experienced and competent staff such is the situation at PYJP.

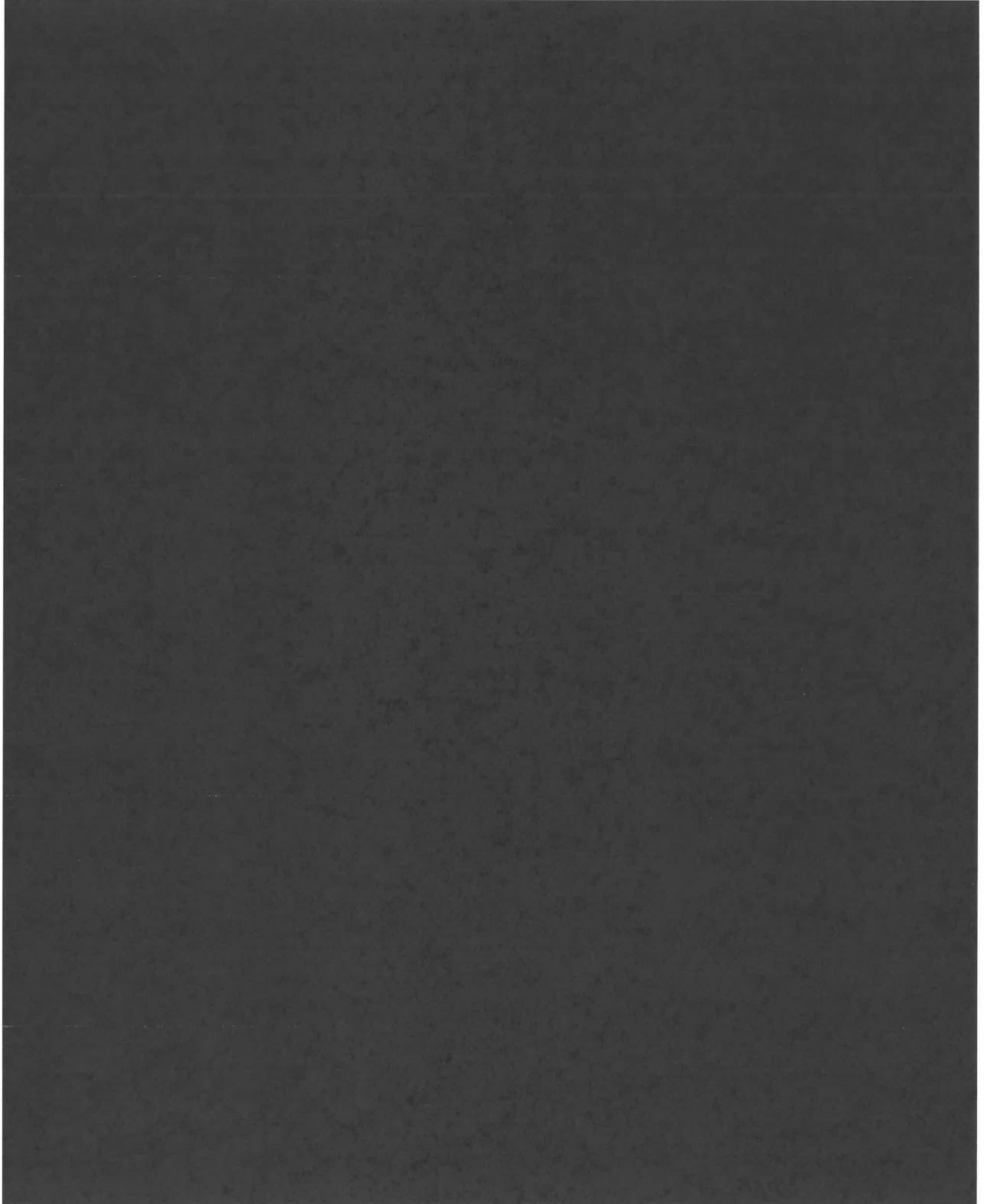
I understand that a new approach to recruitment is being implemented. I have not had the opportunity to review or discuss this approach.

Recommendations

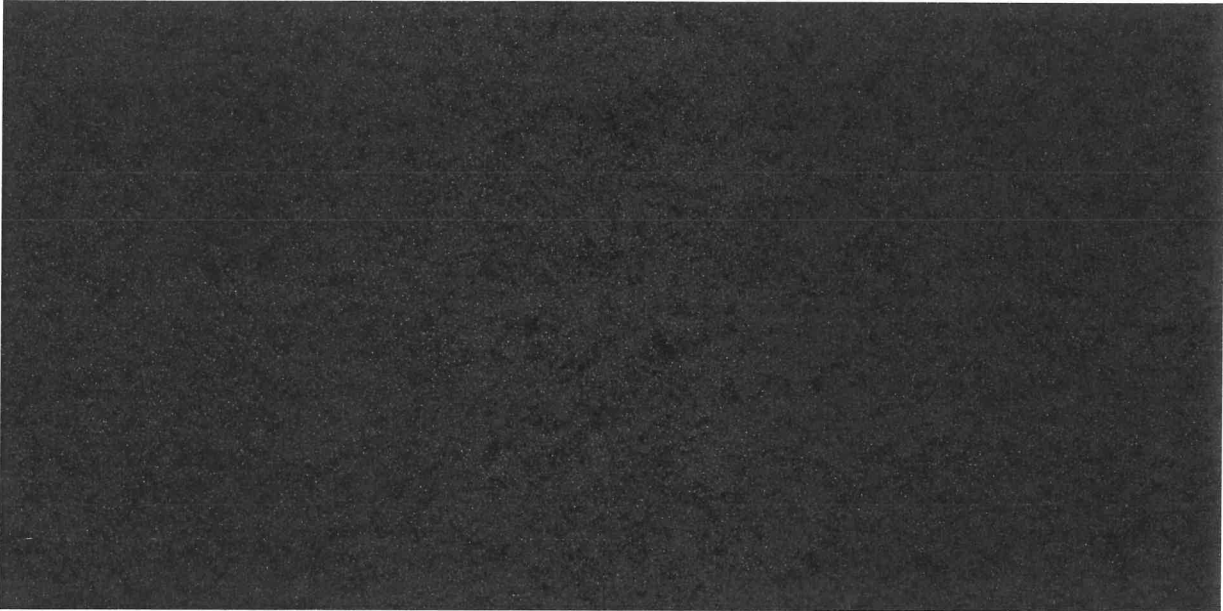
1. **Undertake a master-planning exercise for the Parkville Youth Justice Precinct. This review should assess the long term viability of the facilities and re-development options both on and off-site. This should be done as a matter of some urgency.**
2. **Ongoing fortification works should include the creation of "safe zones" to which staff can retreat in emergencies.**
3. **Undertake an immediate and comprehensive inspection of all three Programs Centres. This should include all storerooms, staff areas and cupboards. Excess, unnecessary and broken items should be immediately removed. All staff areas should be cleaned and be cleared of excess items. A comprehensive register of all tools, equipment and consumables in the Programs areas needs to be established. Each room should contain a list of equipment, tools and consumables which is checked before and after use.**
4. **Amend the operating instructions in woodwork , metalwork and other high-risk programs to ensure that tools and other items of equipment are taken out as needed, recorded and accounted for on the way out and in; and that all other items are locked away. The cages in woodwork and metalwork should be locked at all times after items are removed for use.**
5. **Strengthen procedures and practice in relation to client movements around the Precinct and the manner in which clients enter and exit the Programs Centres. This should include utilising a single entry and exit point in the Main Programs Centre and the utilisation of the walk-through metal detector. There should be a concentration on improved practice over the next six-months to ensure that client movements around the Precinct are orderly and in accordance with procedures. SERT should be utilised to assist for client groups assessed as high-risk. Individual clients considered at high-risk should be moved in handcuffs.**
6. **Establish joint Occupational Health and Safety mechanisms between PYJP and all site stakeholders specifically Parkville College and the health service.**

2. THE IMMEDIATE RESPONSE OF STAFF TO THE BEHAVIOURS THAT THEN ESCALATED

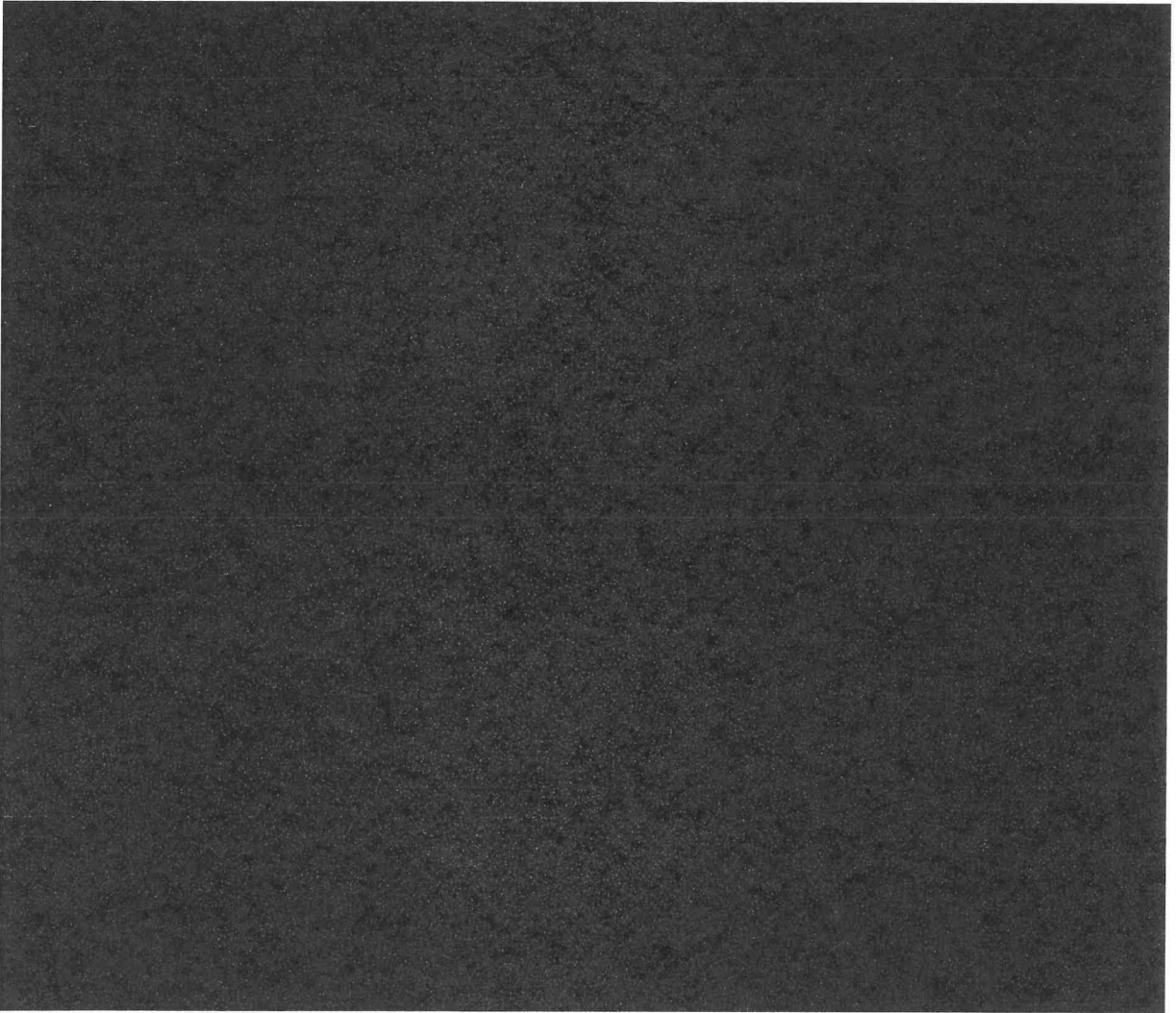
6 March 2016



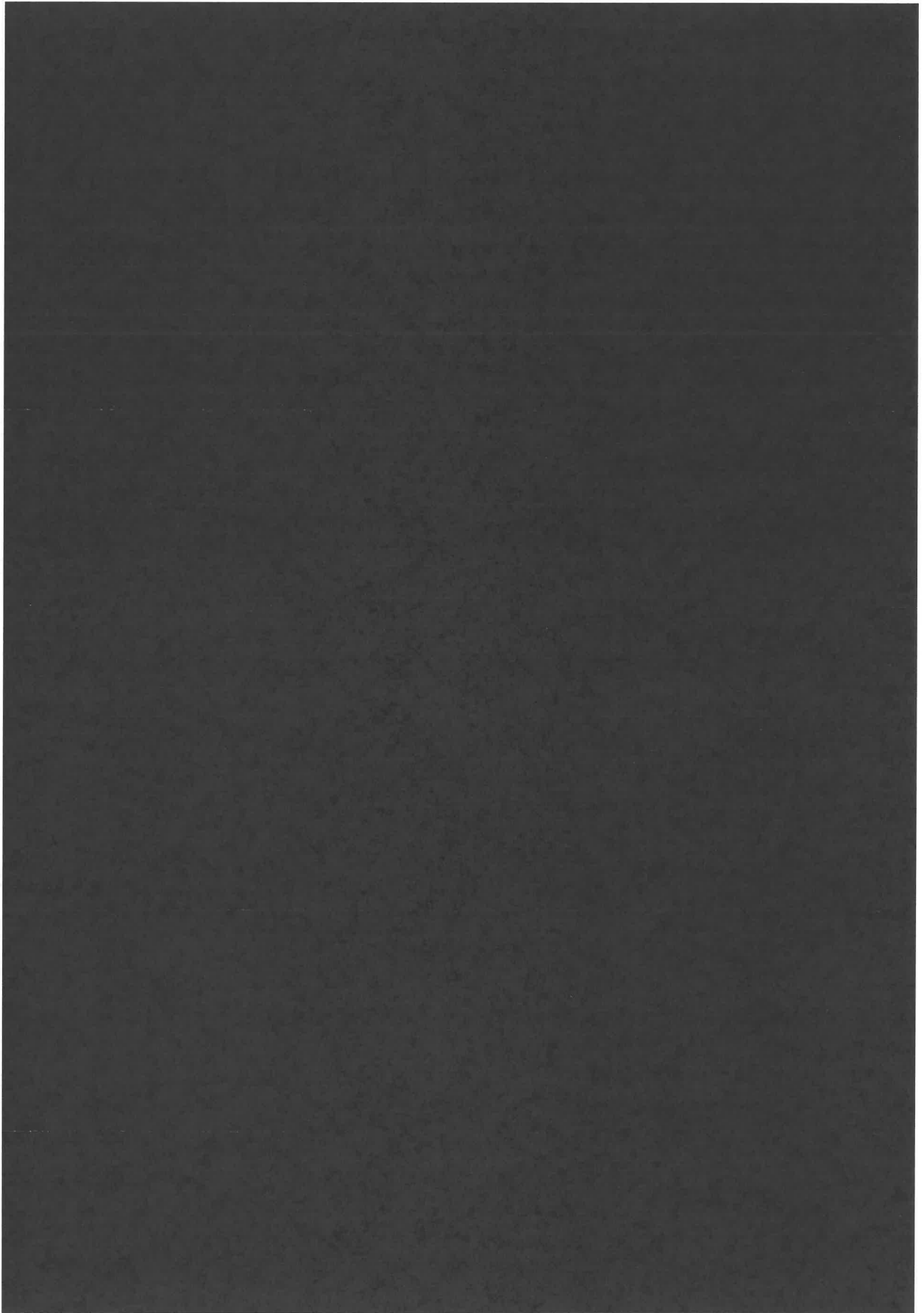
DETAILED REPORT



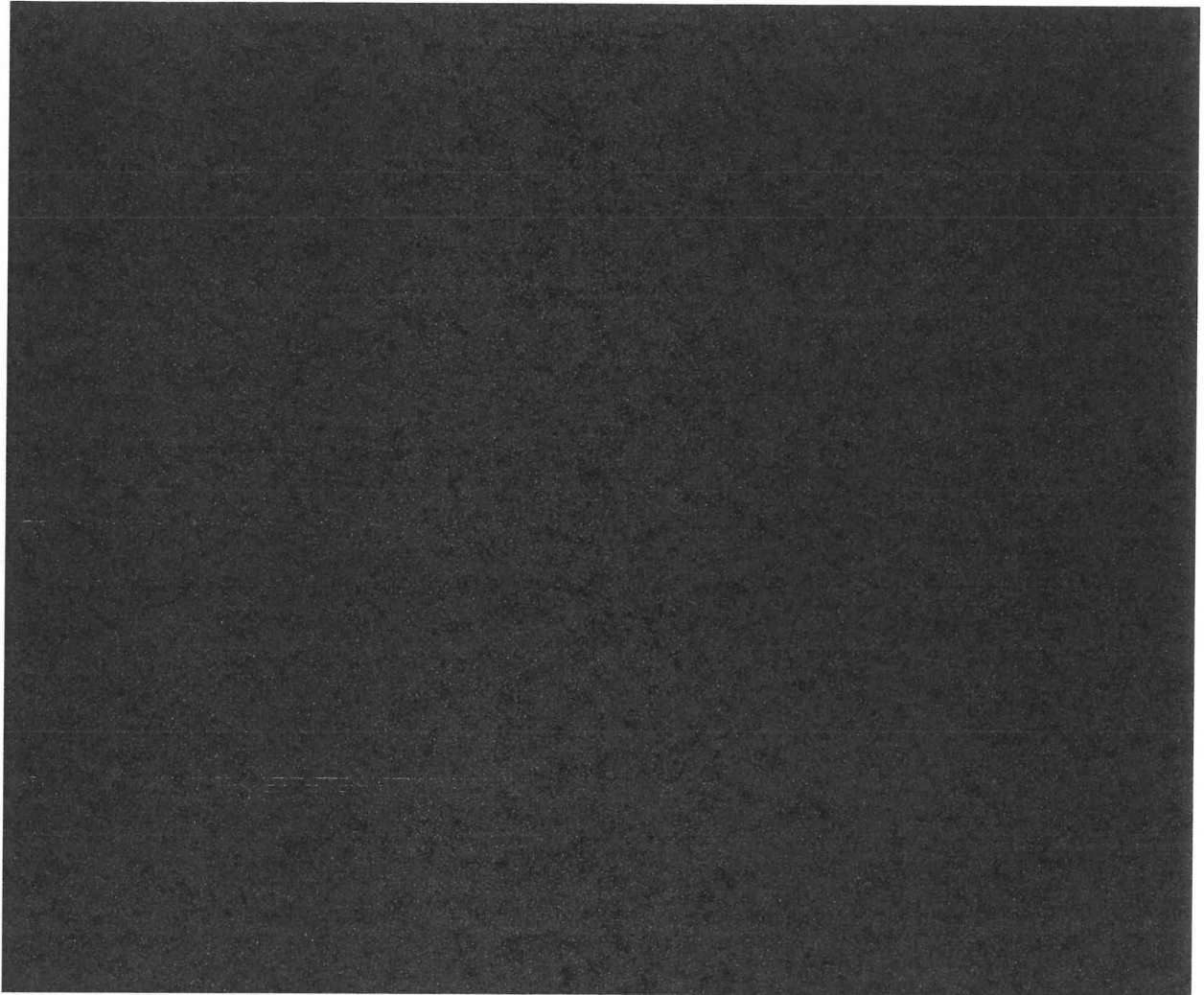
7 March 2016



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i. ***Finding: The Emergency Response by DHHS staff on both days was disciplined and well executed***

From a DHHS perspective both of these incidents were very well managed.

There is evidence of:

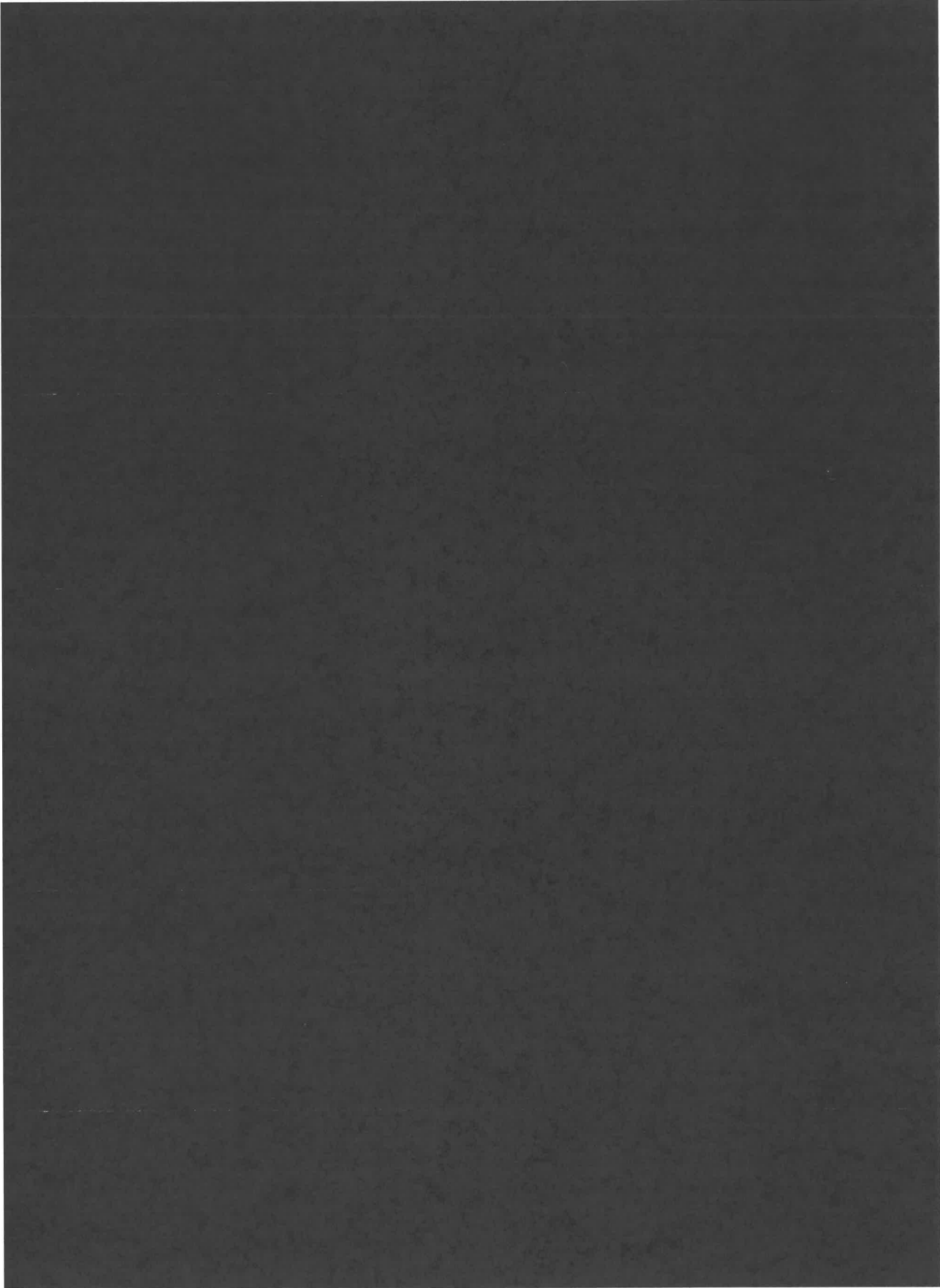
- Clear and effective command structures
- Good decision making
- Clear communication
- Good team work
- An appreciation of and appropriate response to emerging risks
- A clear focus on safety of people
- Staff followed instructions

Overall there is almost no criticism to be made of the emergency response of DHHS staff.

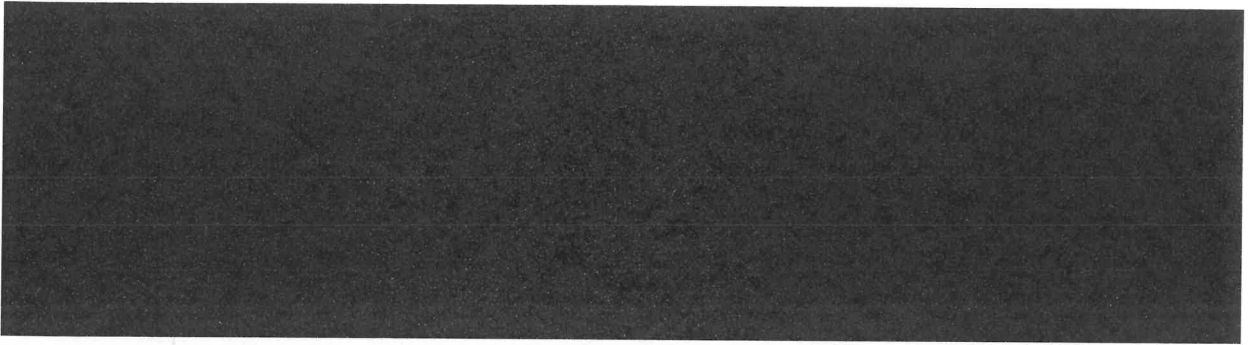
ii. ***Concern: Code Aqua calls and secondary incidents***

One trend that I have noticed in the last three incidents is that the Code calls arising from the incidents spark a round of secondary incidents that present a risk to the Precinct.

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v. ***Concern: The Operation of the Control Room***

During the Operation of the ECC, the Control Room was a busy place.

All telephone calls from outside the centre come to the Control Room after hours. Staff were fielding calls from a range of people including family members of staff, the media and emergency services.

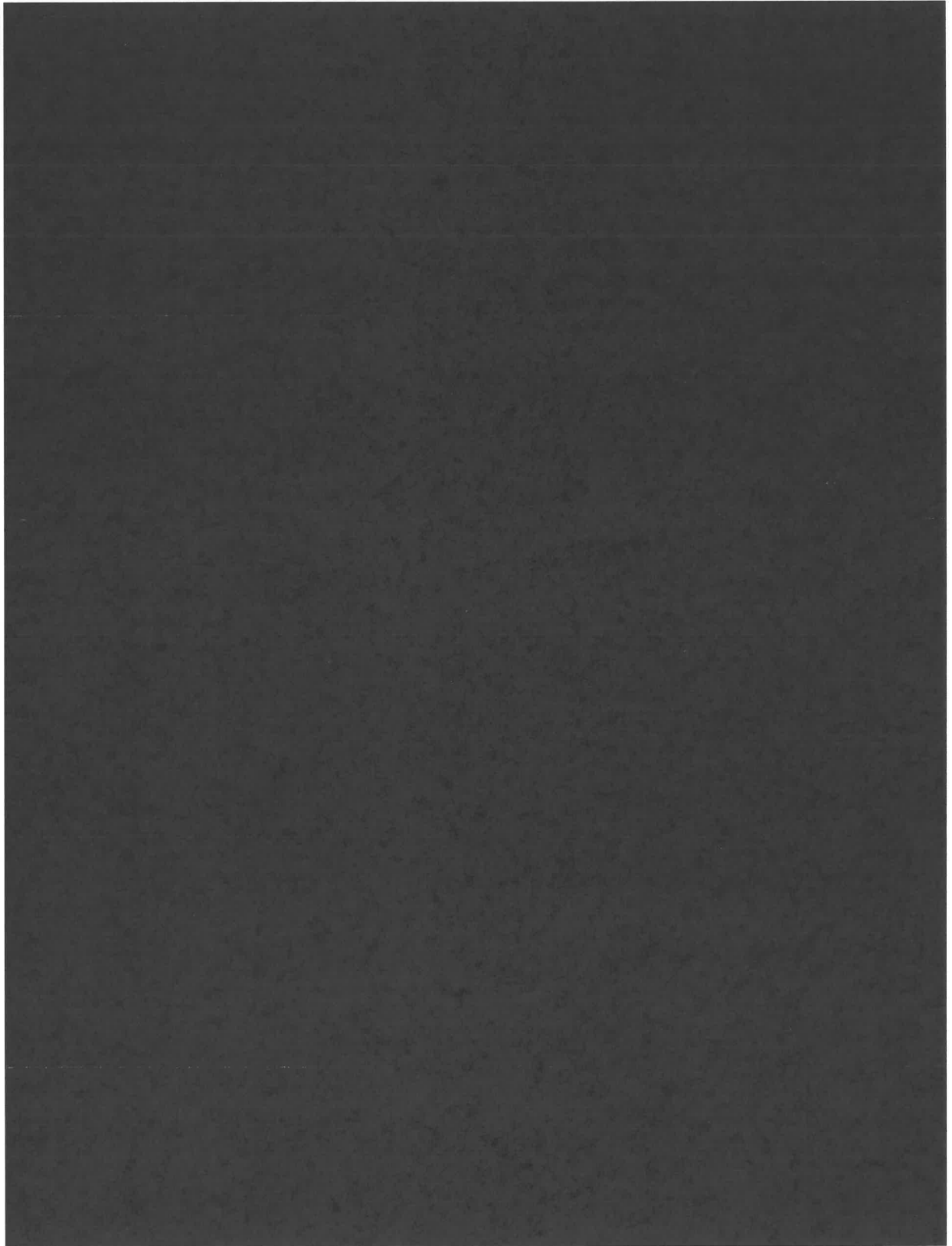
With radio communications compromised, staff were using the telephone to ask the Control Centre if they needed assistance and other extraneous calls.

These were not needed and consideration should be given to diverting all calls to another location as the first response.

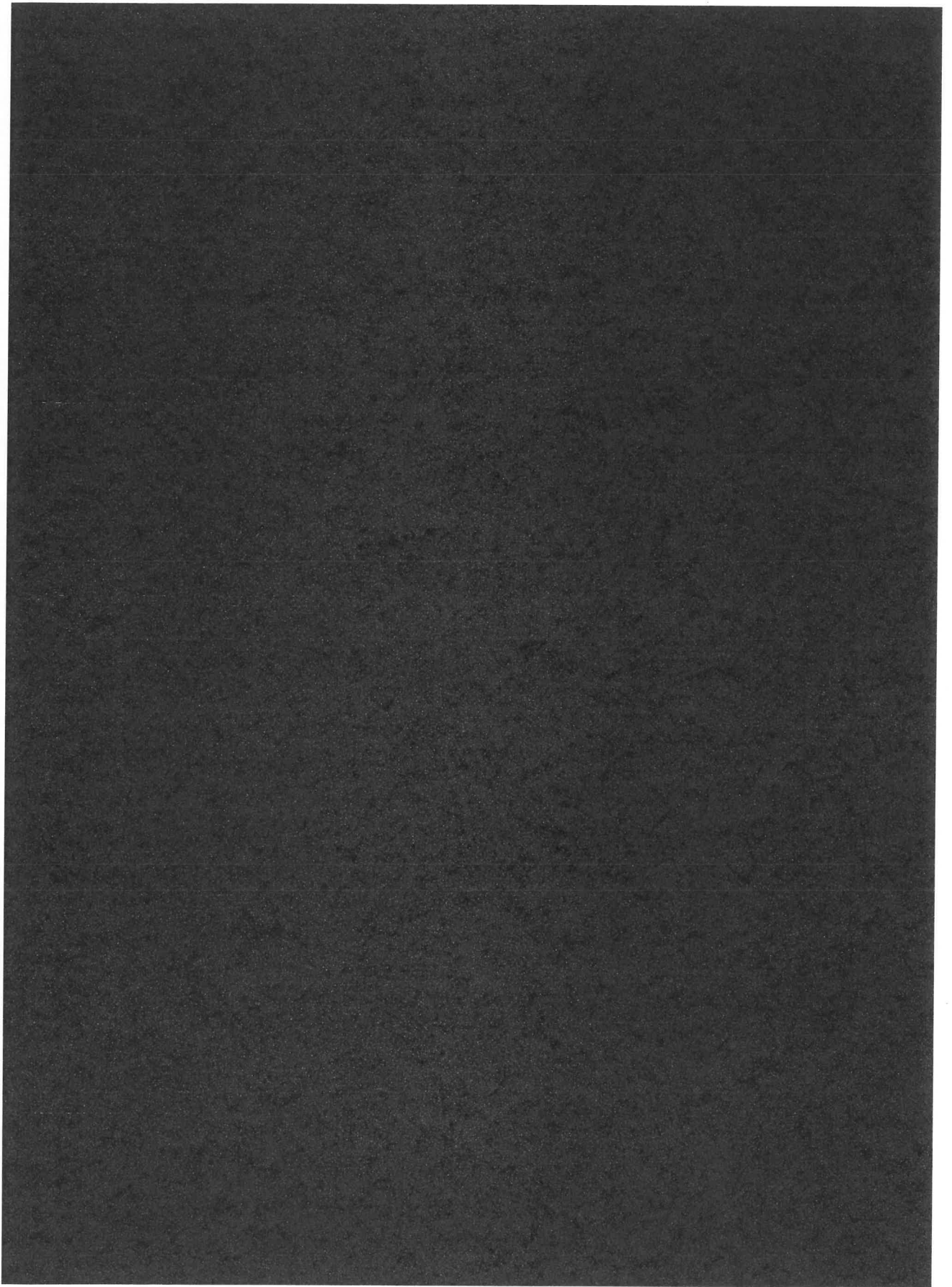
Recommendations

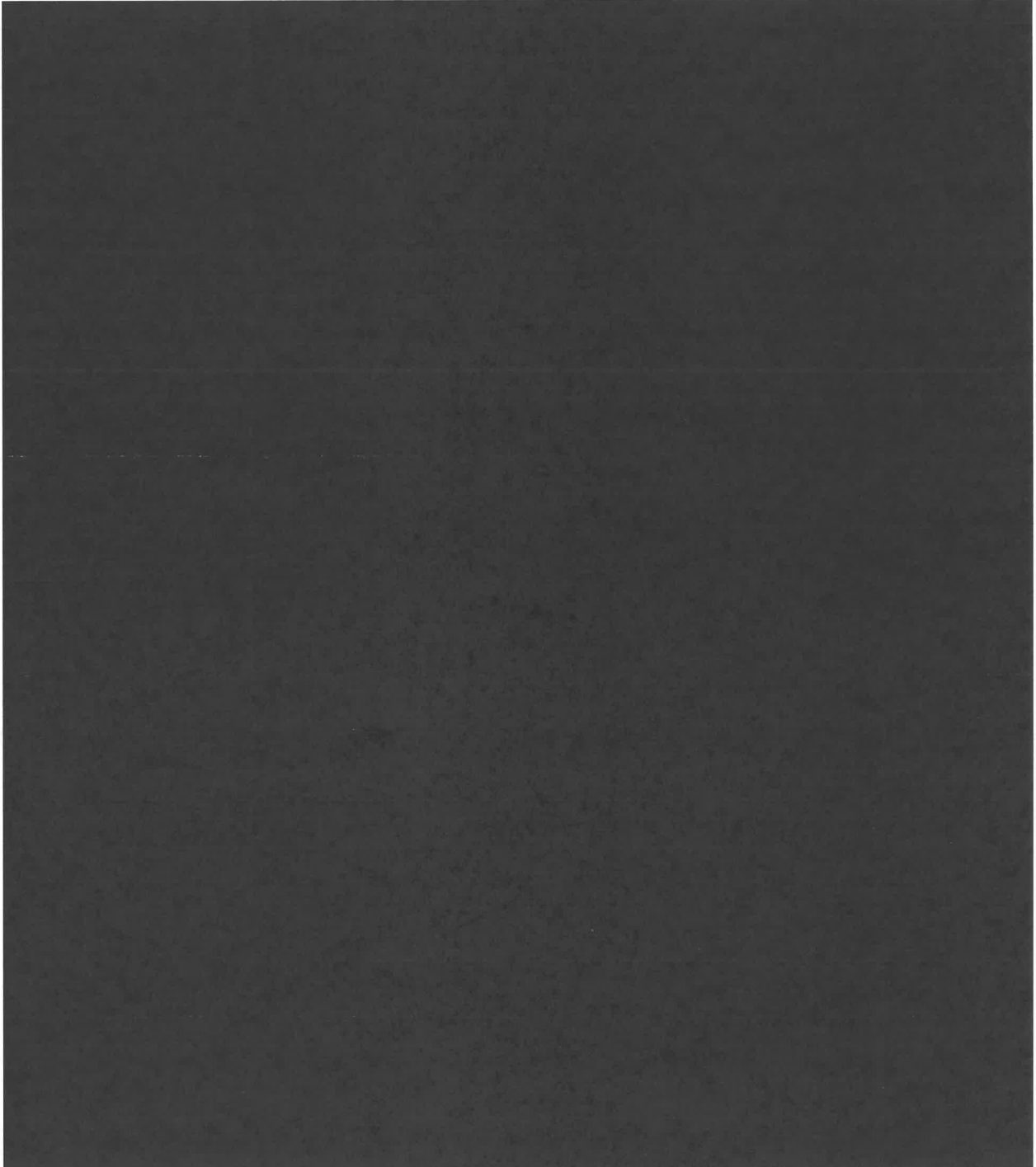
7. **DHHS staff is commended on their response to both incidents.**
8. **The practice instruction around implementation of Code Aqua calls is reviewed taking into account the issues raised above.**
9. **Formulate requirements for Non-SERT staff to respond to critical incidents that may require the use of limited protective equipment such and shields. Further training is provided selected staff to assist in emergency situations. Preference should be given to staff who are already “secondary responders.”**
10. **Review Control Room and Command Centre Operations during Emergencies. This should be on the work plan of the Emergency Planning Committee (EPC). This review should consider the establishment of a separate Command Post during emergencies and diverting telephones during emergencies. The design and layout of the Control Room should also be reviewed.**

3. THE SUBSEQUENT RESPONSE OF STAFF AND MANAGEMENT OF THE INCIDENT



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ii. *Issue: The role of SERT in the Management of Incidents and Negotiations*

In both days, the role of SERT in negotiations was a vital one.

SERT have assessed that their role in negotiations was a vital one. I concur with this assessment and believe that the Department should have confidence in the role and competence of this Team of people.

Most interestingly, the clients themselves have commented positively on the role that SERT played.

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On 6 March, one young person stated that he surrendered to a SERT member that he trusted.

On 7 March all three that were interviewed indicated that it was SERT who ultimately played the key role in their surrender.

In analysing the views of two participants, the Police and the clients, it is clear that SERT played a strong role and could have been bought back into the negotiation process at an earlier time.

The views of the clients in negotiations were interesting. It is hardly surprising that they were antagonistic to Police. What they did reveal was a different quality of negotiations with SERT.

They felt that they had rapport with SERT members. They felt respected and even commented that SERT had tried different techniques including the use of humour. They stated that they trusted SERT.

The Police also commented on the quality and professionalism of SERT negotiators. [REDACTED]

iii. *Issue: The value of trusted staff and rapport building*

I have commented above on staff views on behaviour management. Whilst I believe that order and stability are important factors in Youth Justice Centre operations, I also strongly believe that the quality of relationships between staff and residents is one of the most important protective factors.

My interviews lead me to conclude that there are significant numbers of staff who do not understand this.

On the positive side, clients have remarked on this in a number of interviews.

In relation to the incident on 7 March, [REDACTED] stated that he gave up when asked to do so by a worker ([REDACTED] from Remand North) requested him to. He also talked of his respect for a number of SERT members.

[REDACTED] said of SERT that “we knew them”, “they talk to us differently”, “they tried to joke with us so that it was not so intense.”

Those interviewed in the Sunday incident stated that they did not want to hurt staff.

My own observations in my three assignments with Secure Services is that one of the strengths of SERT in particular is the rapport that they build with clients on good days for when it is needed on bad days.

iv. *Issue: SERT Equipment*

This issue was raised in my review on the incident of 31 October.

The first point to make is that there was sufficient equipment to be issued to all staff members.

I noted in the CCTV that the shields are short and concave in shape. These shields are primarily designed to place clients against walls in order to control their movements.

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A review has been conducted of the equipment issue to SERT. An order has been placed for the requested equipment arising from that review.

Given that a number of incidents have involved rooves, there was concern that SERT had access to only one ladder.

Police talked of the bravery of SERT staff as the incident progressed to the Eastern Hill roof. They indicated that their actions clearly prevented the clients from returning to the Programs Centre roof which would have prolonged the incident.

They also talked of the significant pieces of building materials that were thrown at them. There are real questions as to the adequacy of their equipment in this phase of the incident.

Recommendations

- 11. Convene a meeting with Victoria Police to further discuss the joint response to 7 March and issues that have arisen from the incident from both perspectives with a view to reviewing and more broadly disseminating Operation PEARL.**
- 12. The role of SERT is included in the review of Operation PEARL.**

4. POST-INCIDENT RECOVERY AND SECURITY PRACTICES THAT TOOK PLACE

There are a number of aspects to be discussed in this section of the report. There are:

- The securing of the site following both events
- Staff welfare following both events
- Briefing of staff on the morning of 7 March
- Action taken in relation to the client management
- Rectification works on the Precinct
- De-briefing with Police

6 March 2016

Some issues have been identified with the post-incident response on this day in relation to securing the site.

It is possible that a full perimeter sweep was not carried out and the site was not fully secured on the night in question. This was compounded by the fact that an inaccurate tool inventory in the Horticulture shed made verification of what was missing impossible.

Some clients may also have been secured in their rooms without being properly searched.

Infrastructure, Projects and Security (IPS) identified the scope of works to be completed from the damage on 6 March. This totalled \$21,100.00.

Works were promptly completed.

Following the event, SERT conducted its own "hot debrief."

The Clinical Manager conducted three "Defusing" sessions. Two with general staff and one with SERT at the request of that team.

The aim of these sessions is to provide psychological first aid and to assess staff for signs of distress and trauma.

There was no follow-up from these sessions.

In my debriefing with staff, it is my assessment that there were some Southbank staff showing signs of trauma. They were fearful that had the unit been accessed, they had no safe place in which to retreat.

Young people were assessed and placed on behaviour management plans.

7 March 2016

A briefing of the events of the previous day was provided at the morning meeting.

In the debriefing session that I convened, it was suggested by some staff that there was not a briefing on 7 March outlining what occurred on 6 March.

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These staff were corrected and it was indicated that a full briefing was provided on the morning of 7 March and that their unit was not represented.

Infrastructure Projects and Security Unit completed \$120,000.00 worth of repairs following the incident.

Their role is worthy of commendation. The fact that the units (Southbank in particular) were operational so soon is a credit to the pre-planning of contractors, the building of strategic partnerships and the expertise of staff.

I cannot speak highly enough of what was achieved.

In relation to staff welfare, there are some significant gaps in the response of 7 March.

On this day all teams of staff claim that they have not had the opportunity of an emotional debrief.

SERT has conducted its own "hot debrief" 7 March.

I have interviewed the Clinical Supervisor who confirmed that staff were not seen or followed up.

Her account is that she was not granted access to the site on the night of 7 March and that in the following days she was not able to access a list of who was involved in the incidents or find people who were.

The Incident advice was completed on 9 March and this contains a detailed list of staff involved in the incident.

This represents a breakdown in processes. Staff were still emotional at the time of my debrief and were expressing frustration that they had not been followed up.

Staff raised their concern that there had been no follow up with either casuals or agency staff.

Some staff were exhibiting signs of distress. This was particularly the Southbank staff who felt under attack on 6 March.

I have recommended a revised incident review and response process in the review on Occupational Violence. This process is near completion and I am satisfied that it will address the concerns that are identified.

Staff were critical of some aspects of the handling of staff welfare on 7 March.

Other staff welfare issues were identified.

The first concern is that water was not provided to SERT even though it was very hot and they were dressed in their full kit.

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The second is the manner in which staff left the Precinct on 7 March. Police provided catering for their personnel. DHHS staff feel that they were let go with little support or care for their wellbeing. Their view is that at the conclusion of the night, they were simply sent home.

Police offered food to some staff on their way out. This in my view only exacerbated their feelings to their own department.

There has been a series "Town Hall" meetings held with the Director, Secure Services following the events of 6 and 7 March. One was held immediately after the events, others have been held over the course of the review period.

Given that the 7 March incident received prominent media attention, families of staff on duty were calling the centre. I have previously commented on the fact that the calls went directly to the incident control centre.

At the time of writing this report, no charges have been laid by Police over any of the last three disturbances that I have reviewed (including 31 October last year).

Staff in this and other reviews that I have conducted talk about a lack of consequences for clients involved in these incidents.

I asked them in this series of debriefs what that looked like. Many described a more punitive attitude to clients which I cannot endorse.

The consequence that they should face is to the courts and the community for their actions. It is not an ideal look that clients have not been charged by Police over these incidents or the incident of 31 October last year.

A large number of the clients involved in both incidents were moved to Malmsbury and/or placed on Safety Separation Plans.

All of the clients who remained at PYJP were on restricted movements. All were issued with a Formal General Manager's Warning.

It is clear from reviewing the DSA's that they are on restricted movements outside of the unit.

Recommendations

13. **The Infrastructure, Projects and Security Section are recognised for their achievements in the recovery from these incidents.**
14. **Commence representations to Victoria Police to request that investigations and charges proceed from the incidents of 31 October 2015 and 6 and 7 March 2016.**
15. **A systematic follow up of all permanent, casual and agency staff on duty over 6 and 7 March is conducted as a matter of priority.**

5. THE IMPLEMENTATION OF RECOMMENDATIONS RELATING TO THE 31 OCTOBER 2015 INCIDENT AT PARKVILLE YOUTH JUSTICE PRECINCT

In my review of the Incident at PYJP on 31 October 2015 I made 24 recommendations. A small number of these related to recommendations that arose from the earlier review on Occupational Violence.

My assessment is that:

- 15 of the Recommendations are met (action is still underway on some but I am satisfied with that sufficient progress has been made to meet this standard)
- 9 of the Recommendations are in progress

There are no recommendations that have not had some action undertaken.

Having now completed three reviews for Secure Services, it is my assessment that three critical issues face PYJP in particular:

- Weaknesses in the built environment
- Staff shortages
- Behaviour Management

I have discussed the built environment extensively in this and my last report. Similar observations have been made in the Ombudsman's Review in 2010.

I understand that the decision to rebuild a youth justice facility is a multi-million dollar decision. I have been involved in the construction or re-development of seven detention centres in NSW.

However, it is my opinion that Secure Services cannot be expected to house the mix (Remand/Sentenced), complexity and severity of offenders in the current set of facilities.

In short, Victoria is housing a number maximum security clients in low to medium security infrastructure at Parkville.

The remaining two present significant challenges to the Department on a number of fronts. These will be discussed in the next sections.

i. *Issue: Behaviour Management*

This issue is not a causal factor in the events of 6 and 7 March but staff and the CPSU continue to raise it in all three projects that I have completed for Secure Services.

There are at least three layers to this issue as I see it:

- The current state of behaviour management
- The implementation of the therapeutic model of practice
- The risks in transitioning to the new model of practice

When I first commenced work for Secure Services 12 months ago, there was a significant degree of good-will and expectation for the proposed therapeutic model.

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It was clear that change management had commenced and there were a not insignificant number of people wanting to adopt this way of operating.

My assessment is that over the 12 months of my involvement that this good-will has diminished.

Concurrently, there is a small group of people (largely but not exclusively aligned with the CPSU) who are quite negative about behaviour management at PYJP. They talk about the ‘lack of consequences’ for abhorrent behaviour and are negative around *Promoting Positive Behaviour*.

I have written previously about my views on these issues and won’t reiterate them here. Some of the things advocated by this group cannot be supported as they are contrary to both legislation and best-practice.

My concern is twofold.

The first is that the people who were vocal and supportive of the change agenda seem to be fewer and less supportive.

The second is that negative group have legitimate concerns that they do not feel are being effectively addressed.

A great deal has happened and continues to do so.

I know that the Director has addressed the issue squarely at “Town Hall” meetings.

The Principal Practice Leader has been in place for some time.

The appointments of a Senior Practice Leader and Practice Leaders are imminent.

There will be a Practice Leader for every two units on the Precinct. They will conduct individual and group supervision as well as attending Care Team Meetings.

The development of the model has commenced. One immediate change has been the consolidation of plans for young people. Currently, clients can have 3-4 different plans. These are being consolidated into a single format.

My concern rests not on the model or the work being done but largely on **engagement and change management**. This initiative is too important to fail and it is the loss of positive voices and the prevalence of negativity in my work that is concerning.

Talking to internal stakeholders I am hearing words such as staff “disengaging” from the process and of them developing a “victim mentality.”⁴

The CPSU continues to represent a view from its members that focusses on what is not working. The CPSU has been consistent in advocating this across my three assignments. Again, whilst I do

⁴ These are direct quotes from two people who are highly supportive of the therapeutic model.

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not agree with the solutions that they propose, I do share the concerns that some of the fundamentals of the current system need to be addressed.

Some of this is as simple as consistency.

I have still seen examples of staff failing to implement systems. Whilst Eastern Hill staff were quick to point out that [REDACTED] received more than other clients, I saw one in that unit that had 22 bottles of toiletries in their room as well as sundry items like *Tim Tams* and chips.

Similarly in that Unit, the Principal Practice Leader implemented a plan on a very difficult young person in line with the new model. His trigger behaviours were identified and a model for his safe management was proposed.

This model was not followed on a given day resulting in the young person assaulting another client.

Perhaps the most relevant behavioural factors in the two incidents are the following:

- A number of clients have developmental disabilities
- A number have obvious therapeutic needs
- Whilst some present significant risks to staff, they also are a risk to themselves
- A number are Indigenous and potentially are victims of intergenerational trauma

The sad reality of clients in detention are that they are BOTH victims and perpetrators.

That makes the plans for a therapeutic framework all the more vital.

My concerns centre on the fact that I see staff feeling increasingly disengaged around behaviour management as it currently stands.

I sense that there has been a deterioration in engagement and that now is the time to commence a dialogue with staff and the CPSU. This must be a process that is led by **both** the Principal Practice Leader and the management of the Precinct. Without this dialogue, the change process for the new model will be more difficult.

ii. *Issue: Staffing*

This issue has again been a constant issue across all three of my reviews.

Almost every level of Secure Services has expressed concern at this issue and the lack of staff and subsequent lock-downs have been a contributing factor in the events of 7 March.

Recommendation 3.2 of the Review of the 31 October incident has been implemented. This recommended an immediate recruitment campaign.

From this, 40 staff have been recruited and have commenced training. This will result in every currently vacant line being filled.

A new continuous employment model has been implemented. The first induction for this model is scheduled in June.

I am satisfied that a sustainable model of recruitment has been implemented.

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I have spoken earlier in this report on the perceptions, custom and practice of staff.

Again, across my three assignments with Secure Services, staff have constantly talked of being under-staffed. To some extent, this has referred to overall staff numbers.

It is my view that the Victorian Youth Justice System is one of the best-staffed in the nation.

It is of concern that staff will not unlock clients with less than four staff. This is in my view entirely unnecessary and contributes to the level of tension on the Precinct.

It will be a significant challenge to wind this back but it is my recommendation that these discussions commence. In any “normal” day, four staff to 15 clients is neither unreasonable nor inherently unsafe.

What is needed is a system to deal with dynamic risks as they emerge rather than relying upon fixed staffing ratios.

SUMMARY TABLE OF RECOMMENDATIONS

I have included a table that gives a status report on each of the 24 recommendations from my previous review.

No.	Recommendations	Status
Section 1		
1.1	See Recommendations 1.16 and 1.32 of the previous review. (This recommendation related to the establishment of an intelligence function and leaderships development.	On track. SERT and Intelligence Functions have been placed under the Manager IPS. Training has already commenced.
1.2	Establish a minimum level required for daily SERT operations. If that number cannot be achieved, assistance should be sought from Malmsbury.	Completed. This was confirmed in an interview with the SERT Unit Manager.
1.3	Review recruitment strategies for SERT to consider external recruitment from appropriately qualified and skilled individuals.	Review completed. Internal recruitment was the preferred model.
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.	Completed. Confirmed in an interview with the General Manager.
1.5	See Recommendations 1.2; 1.10 and 1.12 of the previous review. (These relate to Misbehaviour, Classification Meetings and the creation of an OHS Culture.)	In progress. The first two issues are being dealt with in the review of Behaviour. The latter has progressed. This was confirmed in a meeting with the OHS Coordinator. One outstanding issue is that whilst SERT reports from incidents are routinely shared with the OHS

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No.	Recommendations	Status
		Section, other incidents are not.
Section 2		
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.	This issue has been discussed above.
2.2	Ensure that all internal doors can be locked and secured.	Work as commenced on this and the following recommendation but the status quo has prevailed on the basis of legal advice.
2.3	Review the legislation and practice surrounding Isolation and locked doors within Units.	See Above
2.4	See Recommendation 5.1 of the previous review	Work has commenced but is still at the formative stages.
Section 3		
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.	Emergency Planning Committees (EPC) are being convened on each precinct. These structures were very effective on 6 and 7 March.
3.2	Conduct an immediate recruitment campaign and ensure sufficient casual, temporary and agency staff to ensure that all lines are filled.	Completed
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.	Completed
3.4	See Recommendation 6.1 of the previous Review. Drills and exercises should incorporate G4S.	On the work plan of the EPC
3.5	Review Operation Pearl in the light of issues raised in the de-briefing process.	On the work plan of the EPC
3.6	Follow up all actions raised in the Operational De-brief with Emergency Services	On the work plan of the EPC
3.7	The WHS staff should conduct an immediate risk assessment of the Programs area.	Completed
3.8	See Recommendations 1.22; 1.24 and 5.1 of the previous review. (These refer to POV training, annual unit risk assessment and drills. The Unit Performance indicators are discussed above.)	Work has commenced but the progress at a Unit level need be reviewed and unit drills expedited.
Section 4		
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 Malmsbury were constructed. If found unacceptable, a new master planning process for the site should commence.	This work has commenced and has under-pinned the work to date. The process is extensively discussed in the report.

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No.	Recommendations	Status
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. This should include the Control Room.	Completed. Subject to resourcing
4.3	Initiate a program to erect anti-climb barriers on all necessary points following an independent assessment.	Completed
4.4	High-security should only be accommodated in the new facilities at Malmsbury until a high-needs unit can be established at Parkville.	Completed
4.5	Review emergency key access.	Completed
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.	Completed
4.7	WHS officers should be given access to review this incident against the Department's Safety Management System.	Completed

6. OPPORTUNITIES FOR IMPROVEMENT ARISING FROM THE REVIEW

Secure Services has undertaken a considerable amount of work in assessing and mitigating risk following the events of 2015. Indeed, it has been the subject of a number of internal and external reviews.

I can see evidence that following each there has been a response that has resulted in substantial improvements to service delivery in Parkville YJP.

There is a significant change agenda occurring and I am loathe to include a large number of recommendations as these can only serve to distract from higher priority tasks.

Operational Procedures

There are no additional recommendations made to those already identified in this report.

Environment

i. *Issue: Ongoing Site Risks*

There has been significant effort in rectifying the risks identified in the site to date. I have stated at the outset of this report that clients entering into 'fight or flight' responses should be expected.

At some point in the future, another client or group of clients will run off. If their access to rooves and ceilings is cut off, then risk assessment and planning must ask the question what next?

There are still many points of vulnerability in the precinct.

In my inspections of the Precinct I have identified just a few.

Gardens and Retaining Walls

There are some areas of the Precinct where items from gardens could be used as weapons. Primarily these are rocks and treated pine borders.

There is loose concrete on the ground in various parts of the Precinct.

Windows into Program Spaces, Staff Rooms and the Main Kitchen

If penetrated, all of these areas could see a similar situation to the matters that are the subject of this review.

Dental Treatment Room

This space represents an extreme risk if accessed by clients or even when clients are in there. There are numerous dangerous items, knives and dental tools in unlocked draws.

I believe that the storage of equipment in this area is unsafe and should be immediately rectified.

DETAILED REPORT

Unit Kitchens

I have long been uneasy with these spaces. Loose appliances are left on benchtops that could easily be swung as weapons.

Cutlery is stored in what is basically domestic grade cabinetry with a lock on the draw.

Louvres above doors could be easily penetrated as can the doors themselves.

The Gymnasium and Pool areas

Store rooms and the cleanliness of these areas was of some concern. Again if accessed, some of these areas contain items that could again become weapons.

In general, the pool area looked like no one had responsibility for it. I found a piece of material on the ground that could easily have been concealed and used as a ligature for a self-harming client.

Clients had attempted at some point to kick in the roller door to the kitchen. The kitchen contained a number of appliances and items that could be used as weapons.

Summary

This is not an exhaustive list; my point is that preparations should start now to assess the next potential weaknesses to which clients will default if they cannot access rooves.

ii. *Issue: Cameras and the UPS System*

There was no available and useful footage of the incident on 6 March.

There is a good network of cameras in units and this was rightly the priority for initial installation.

[REDACTED] better ground coverage will become more imperative.

iii. *Issue: Media Access to the perimeter and by air*

Both Police and DHHS staff have commented on the impact of the media on the incident on 7 March.

The helicopter clearly heightened and prolonged the incident.

Photographers were able to gain direct line-of-sight from below the Precinct.

Some of this cannot be prevented.

Adult Corrections agencies in Australia have rightly been concerned with similar issues.

My inquiries in NSW indicate that Corrections Victoria currently have carriage of this issue at national level.

DETAILED REPORT

It is possible to pursue this either directly with this agency or potentially via AJJA as a national initiative.

Communication

There are no additional recommendations made to those already identified in this report.

Client Management

There are no additional recommendations made to those already identified in this report.

Staff Response

i. *Issue: Identification of staff in incidents*

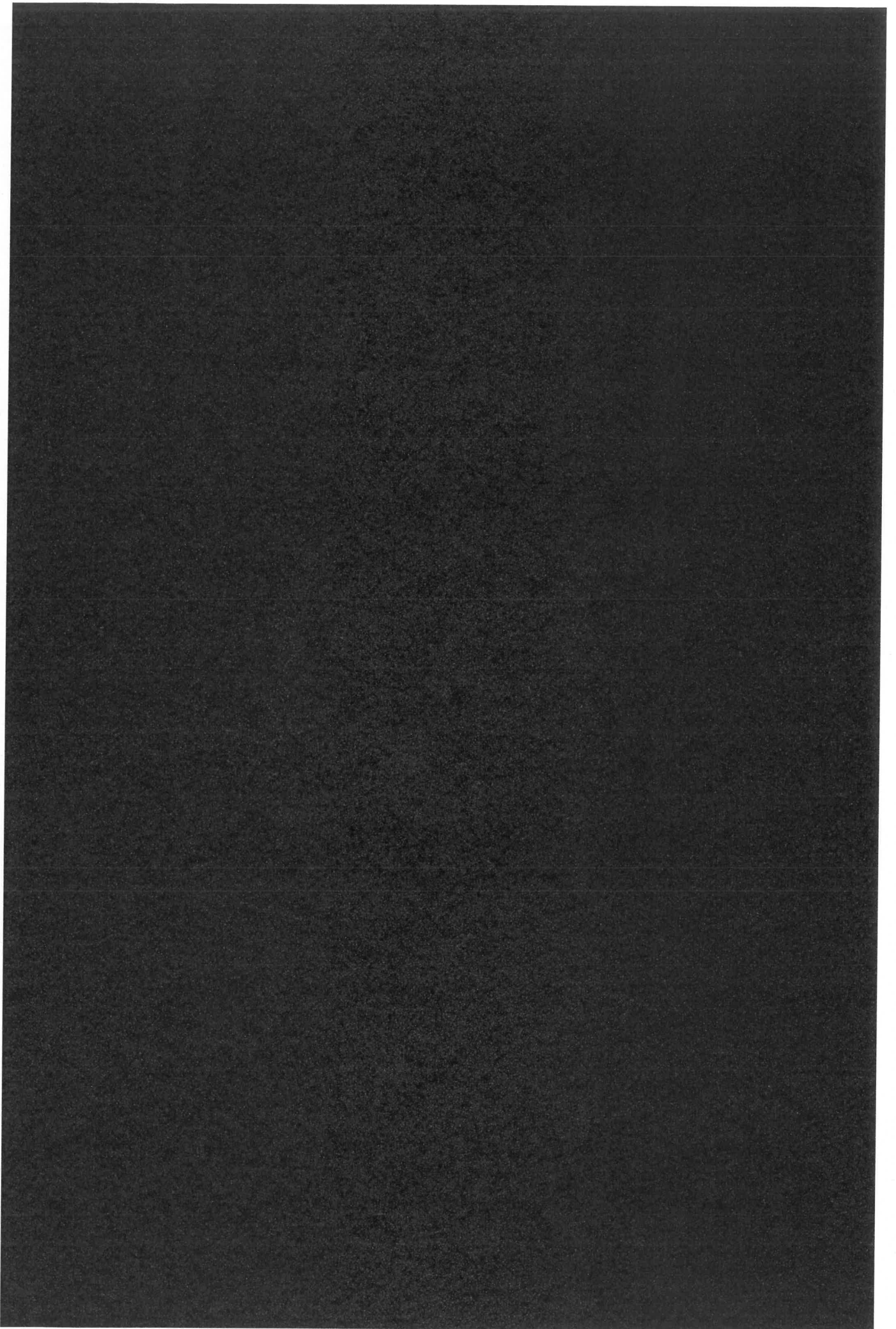
There are some concerns that some staff on the days in question were not able to be fully and properly identified by partner agencies.

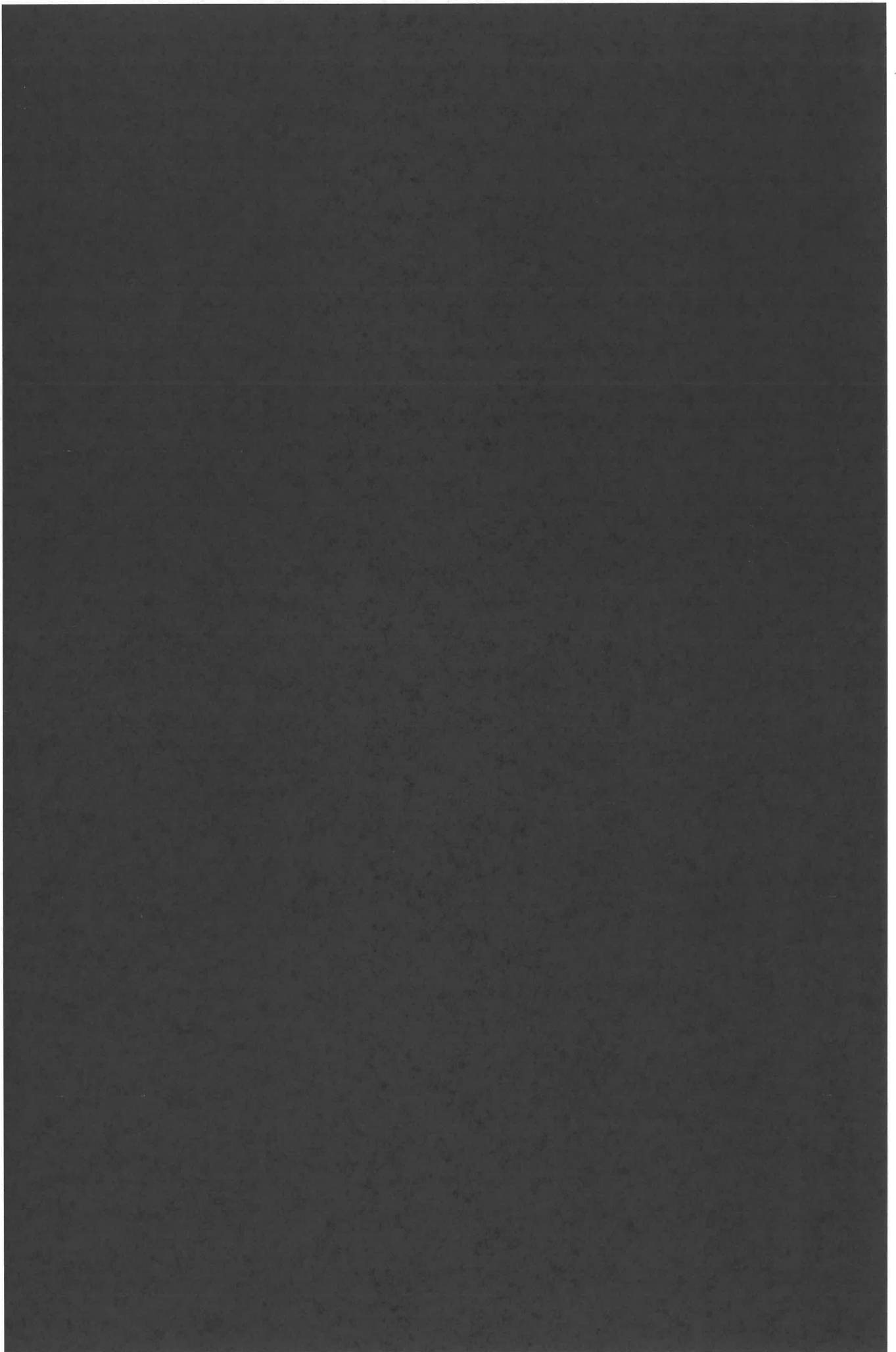
Name tags of management-level (potentially also supervisory) staff would assist for Police and other emergency services to identify key staff in similar incidents.

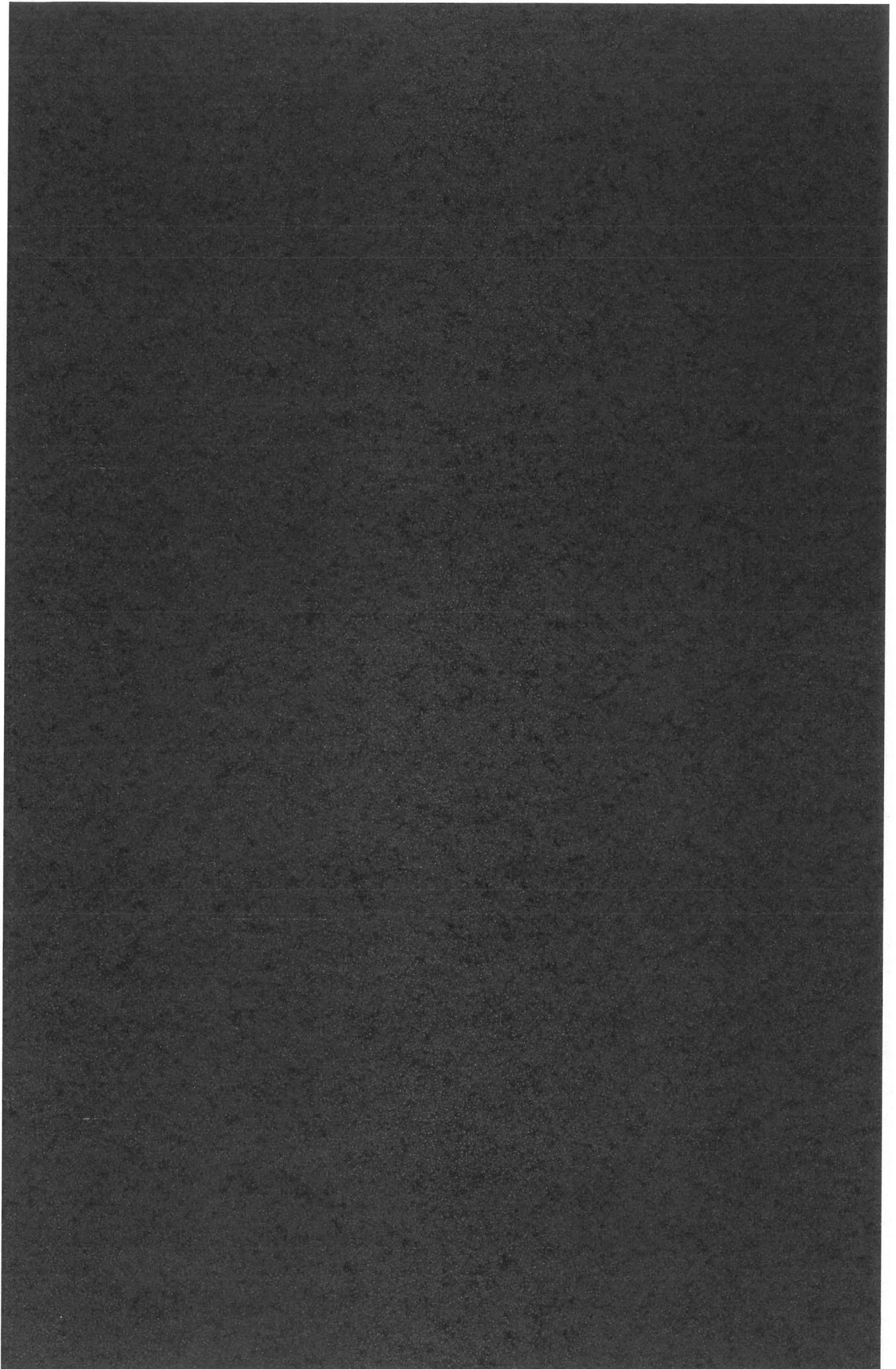
Recommendations

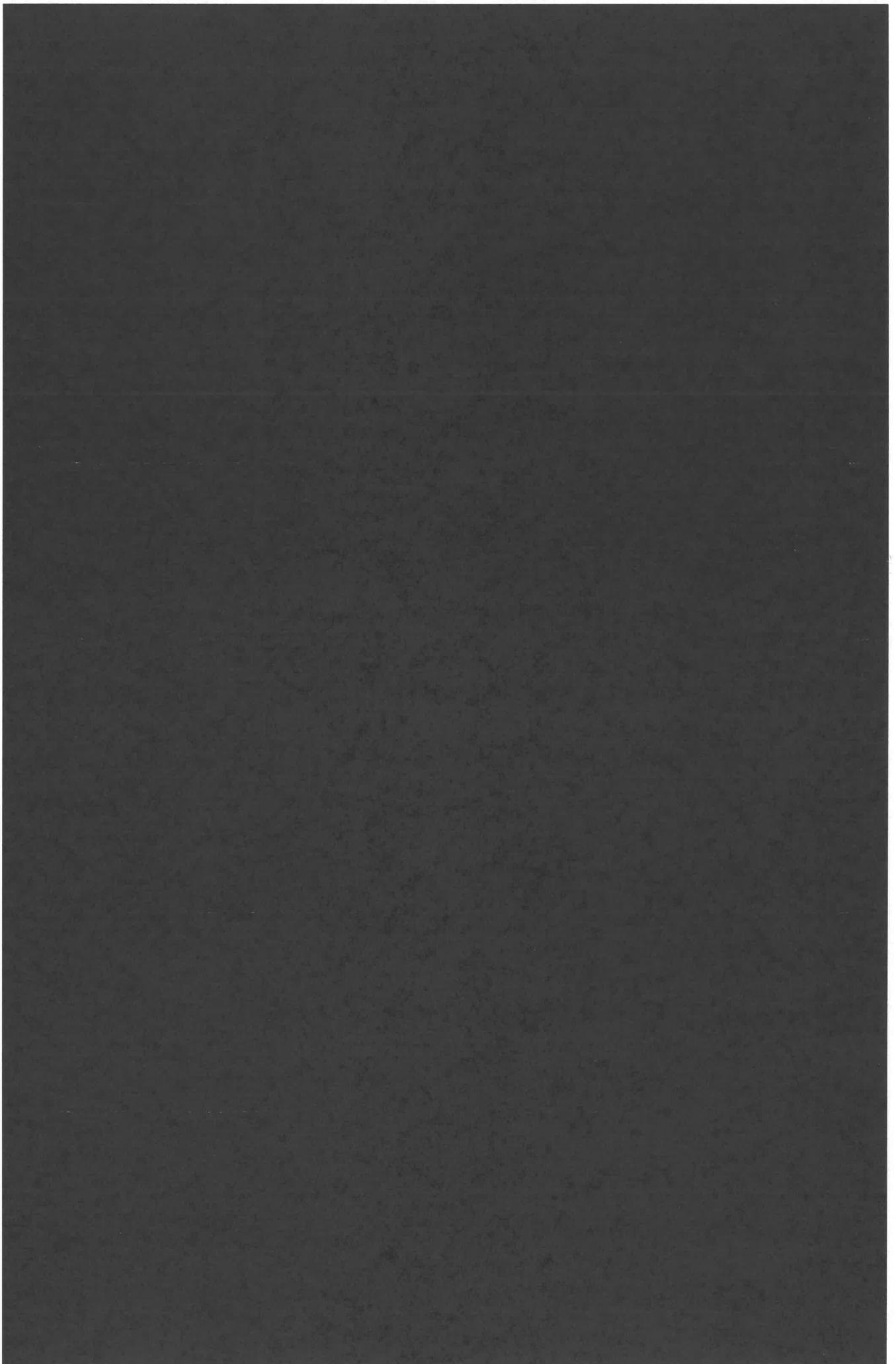
16. Complete a full site risk assessment for hazards taking into account the matters raised in this section of the report. This review should specifically include the Dental Treatment Room and Unit Kitchens.
17. Complete an audit of CCTV Camera's and establish a priority list for installation as resources become available.
18. Ascertain the status of no-fly zones over correctional centres with Corrections Victoria to see if any leverage can be obtained from the adult system.
19. Issue nametags with positions to all staff from Unit Managers and above – with consideration to be given to Unit Supervisors.

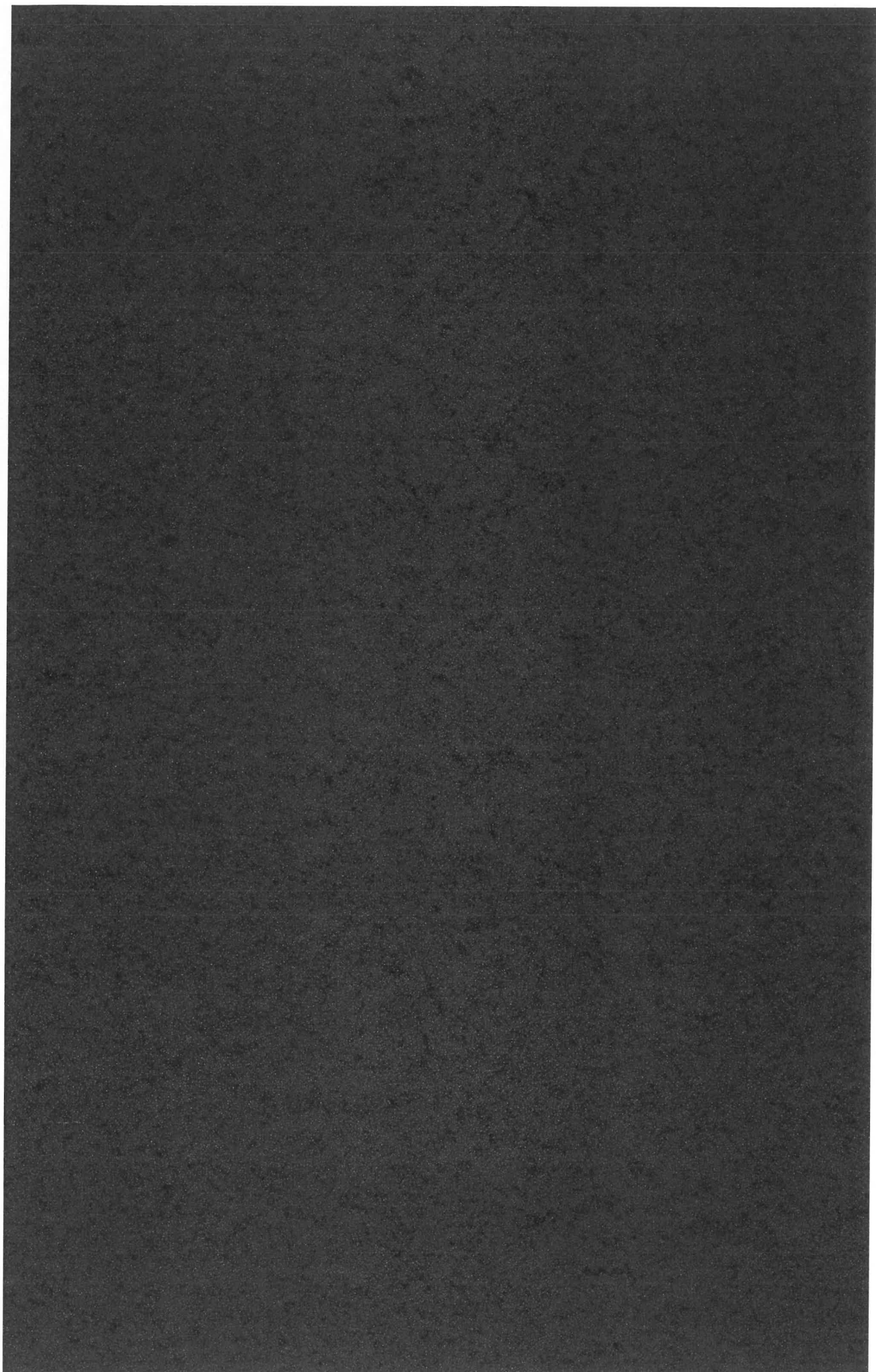

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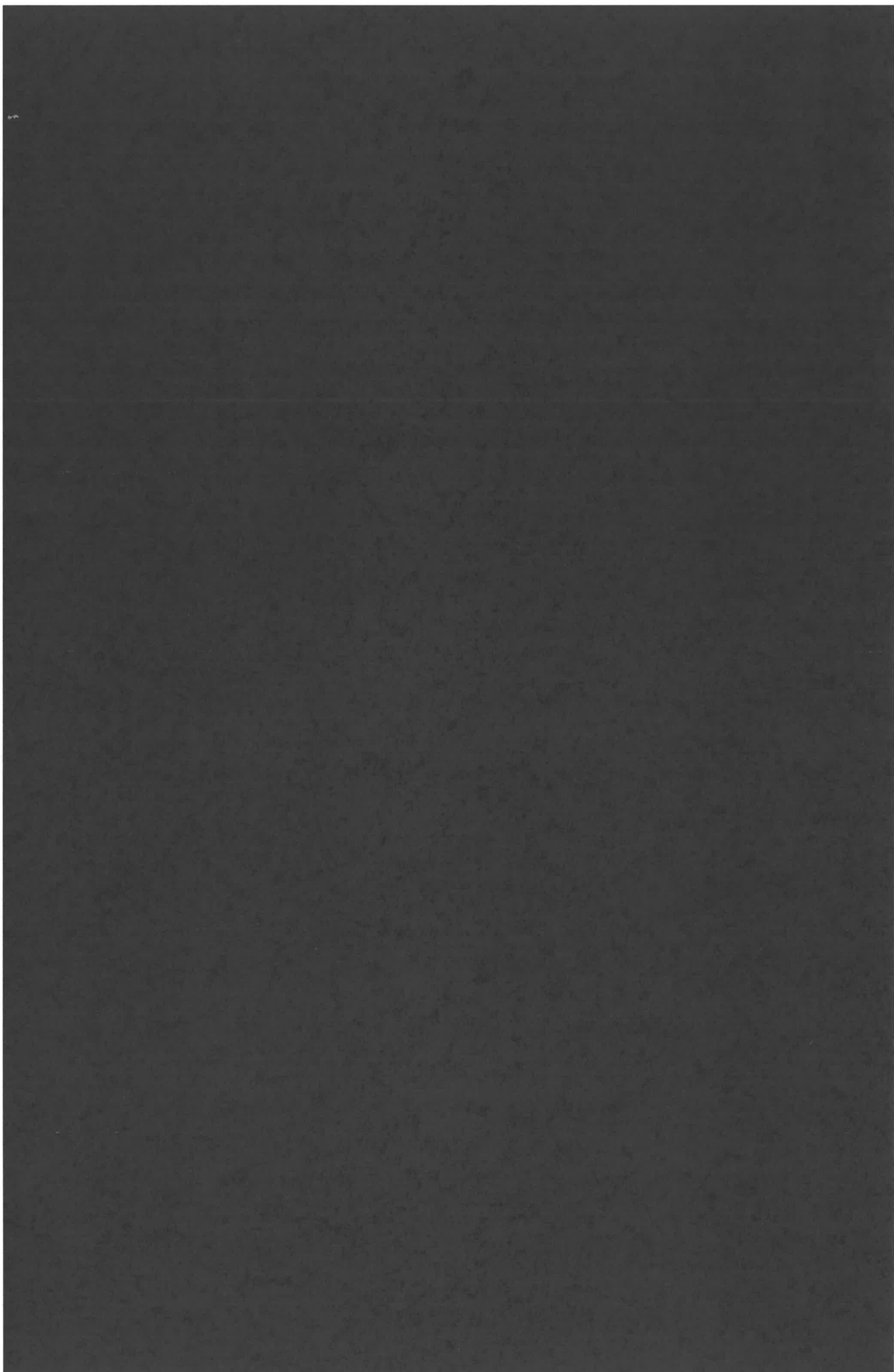


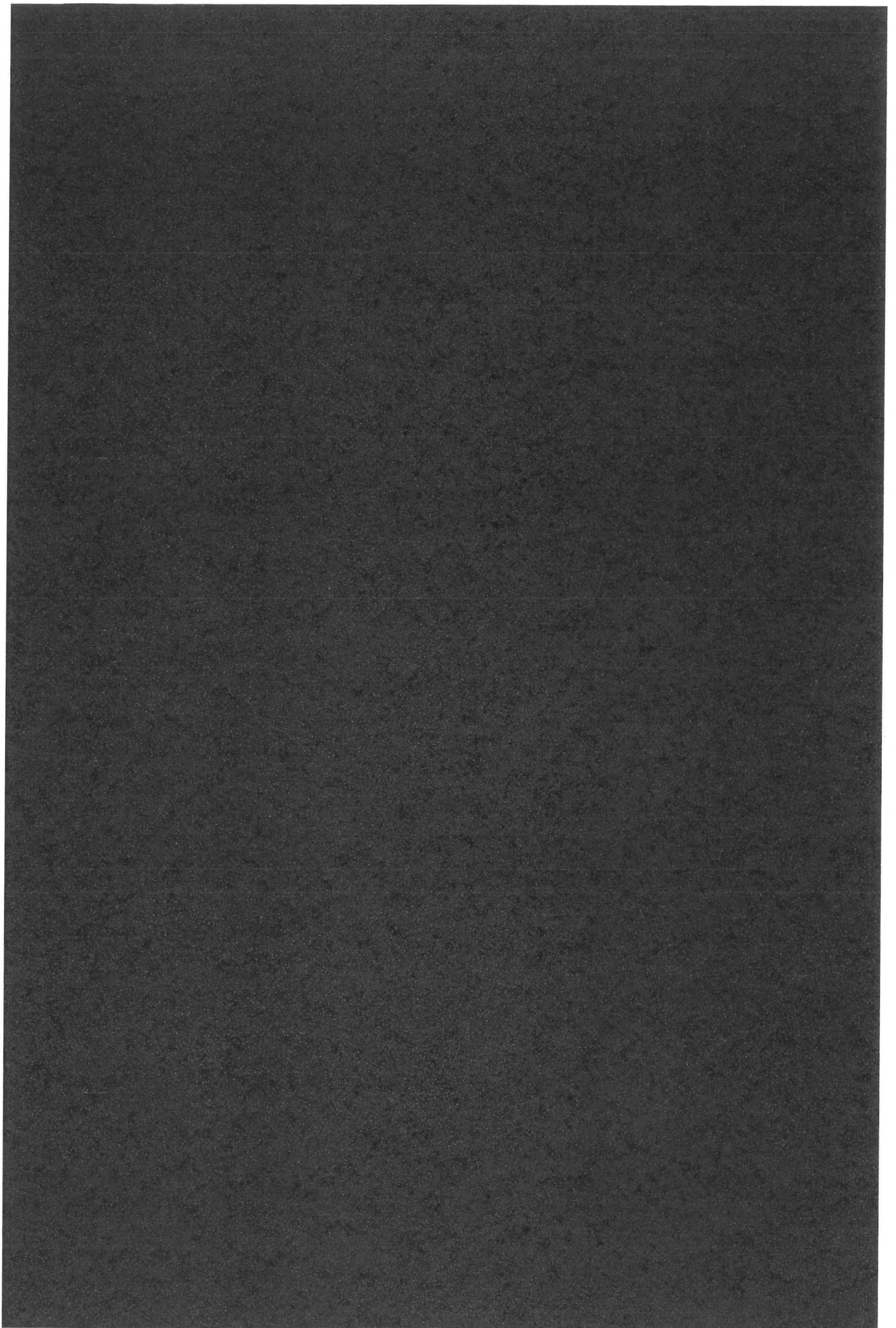


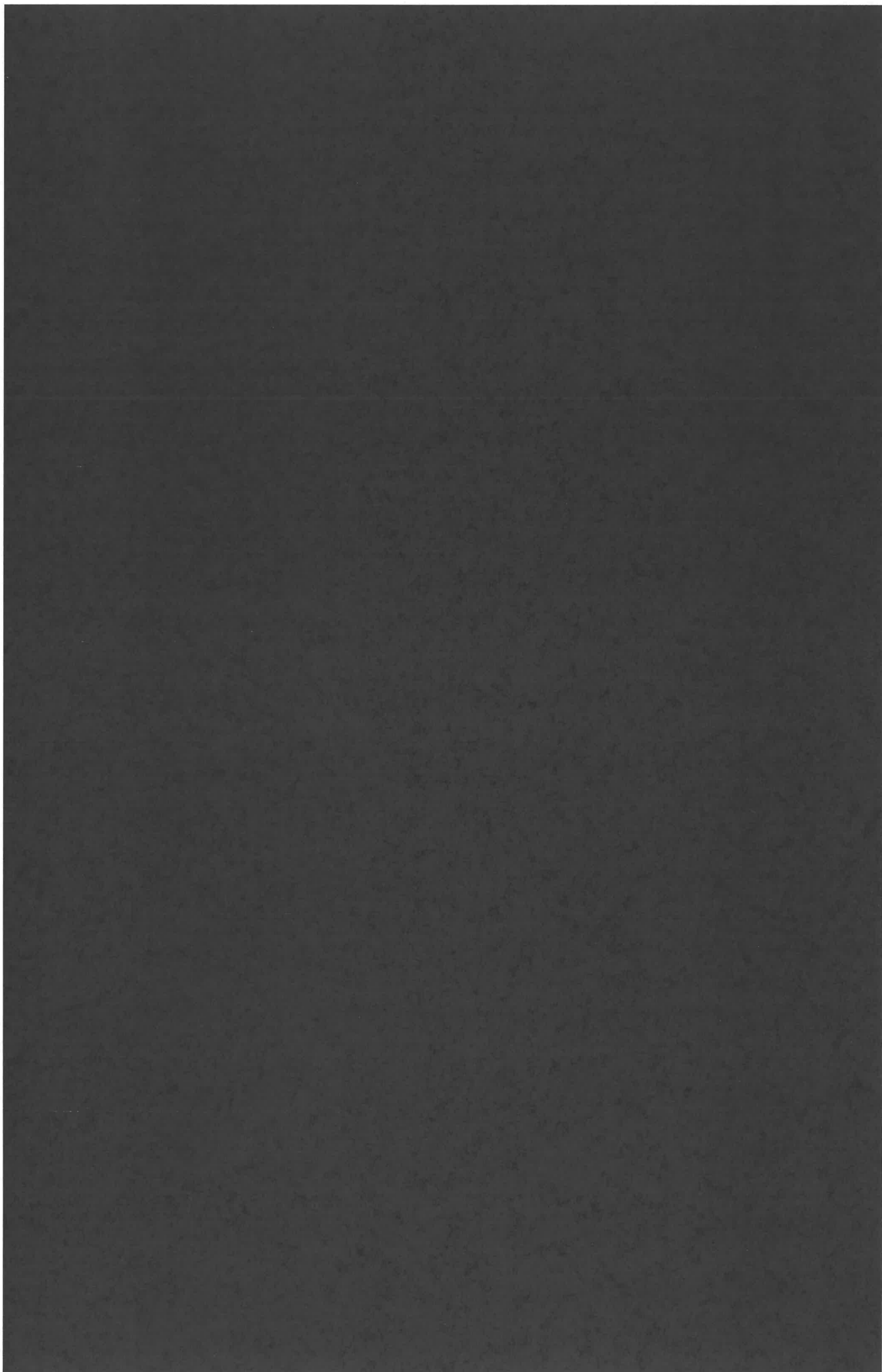


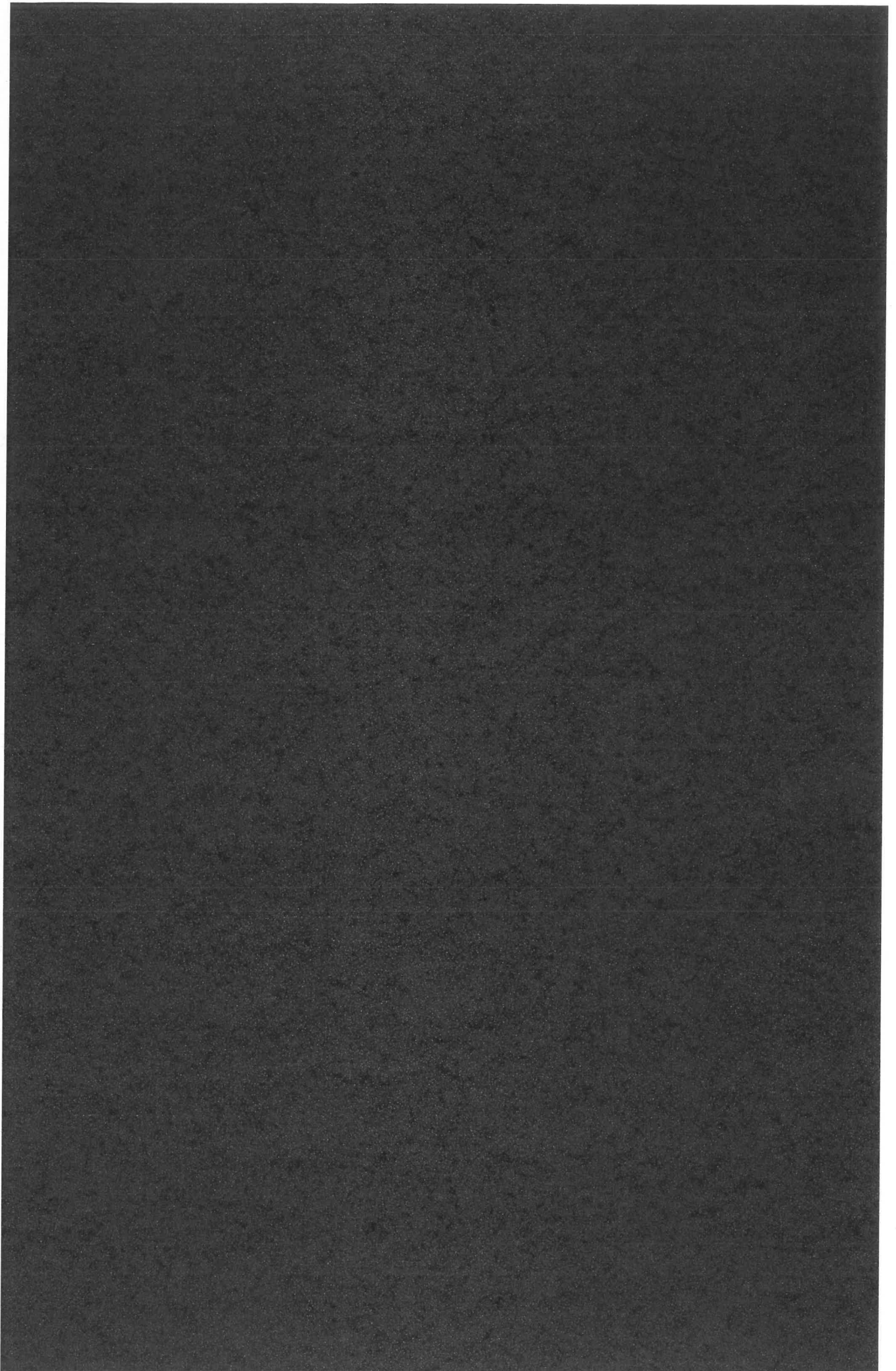


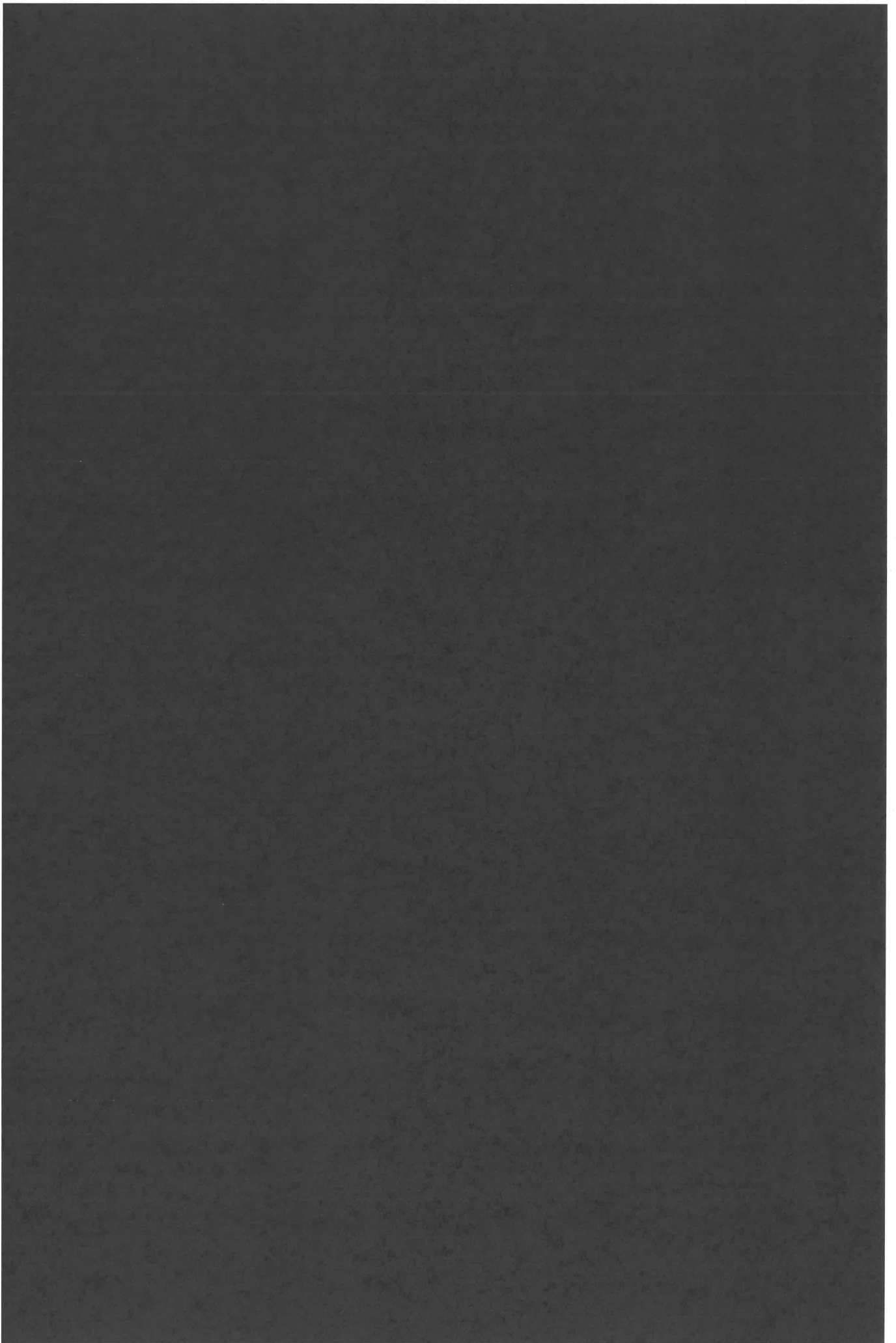


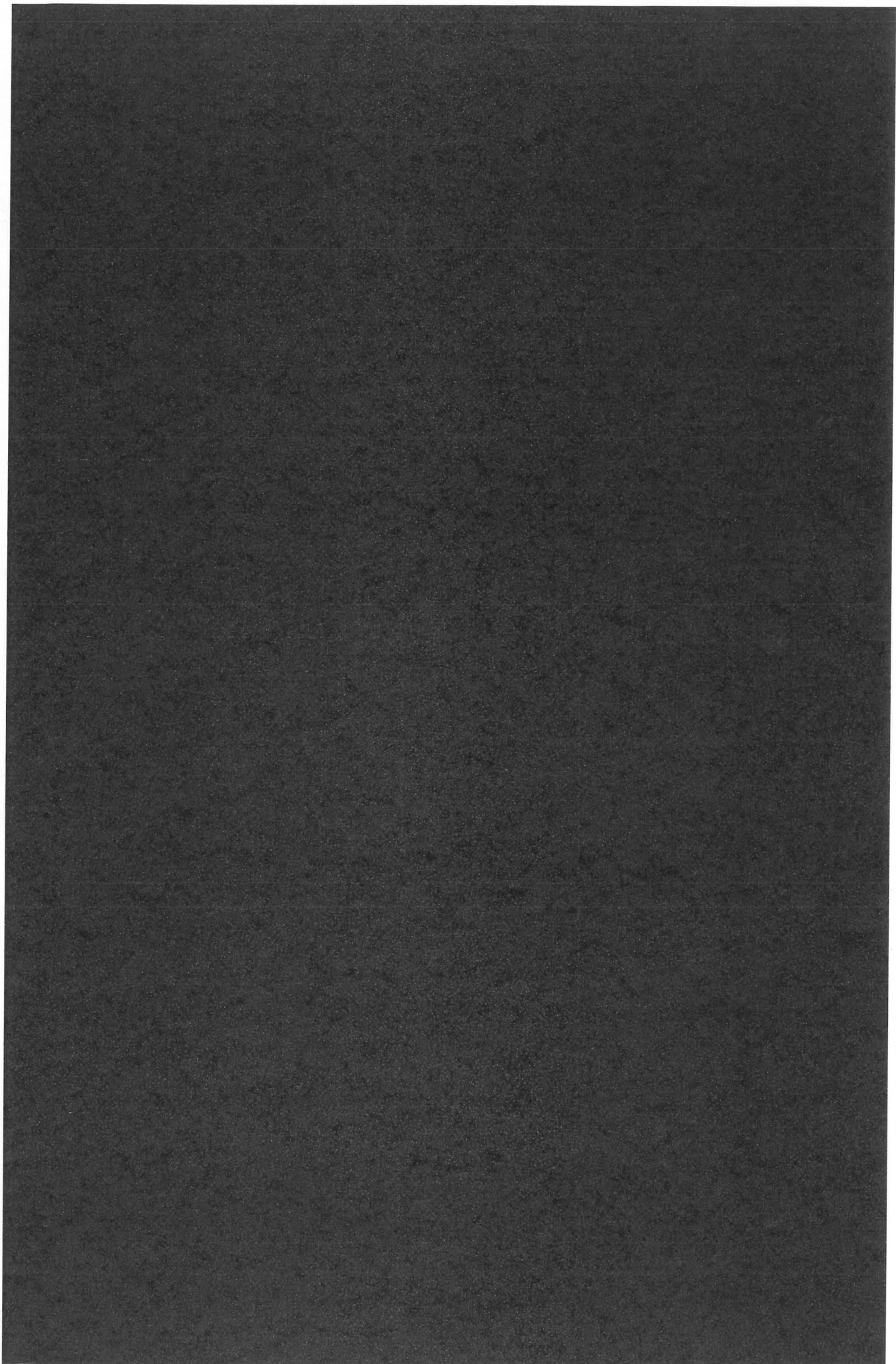


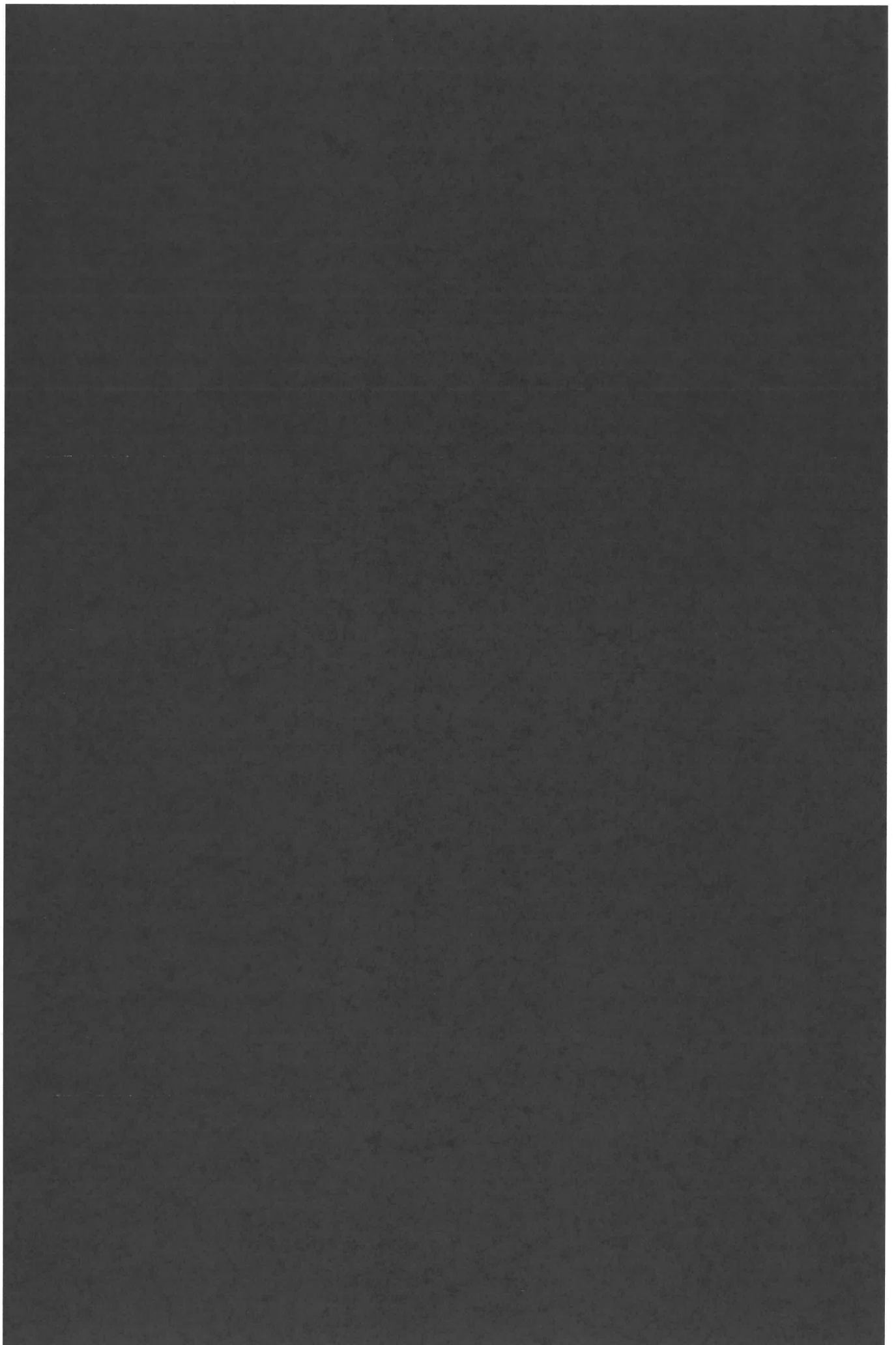


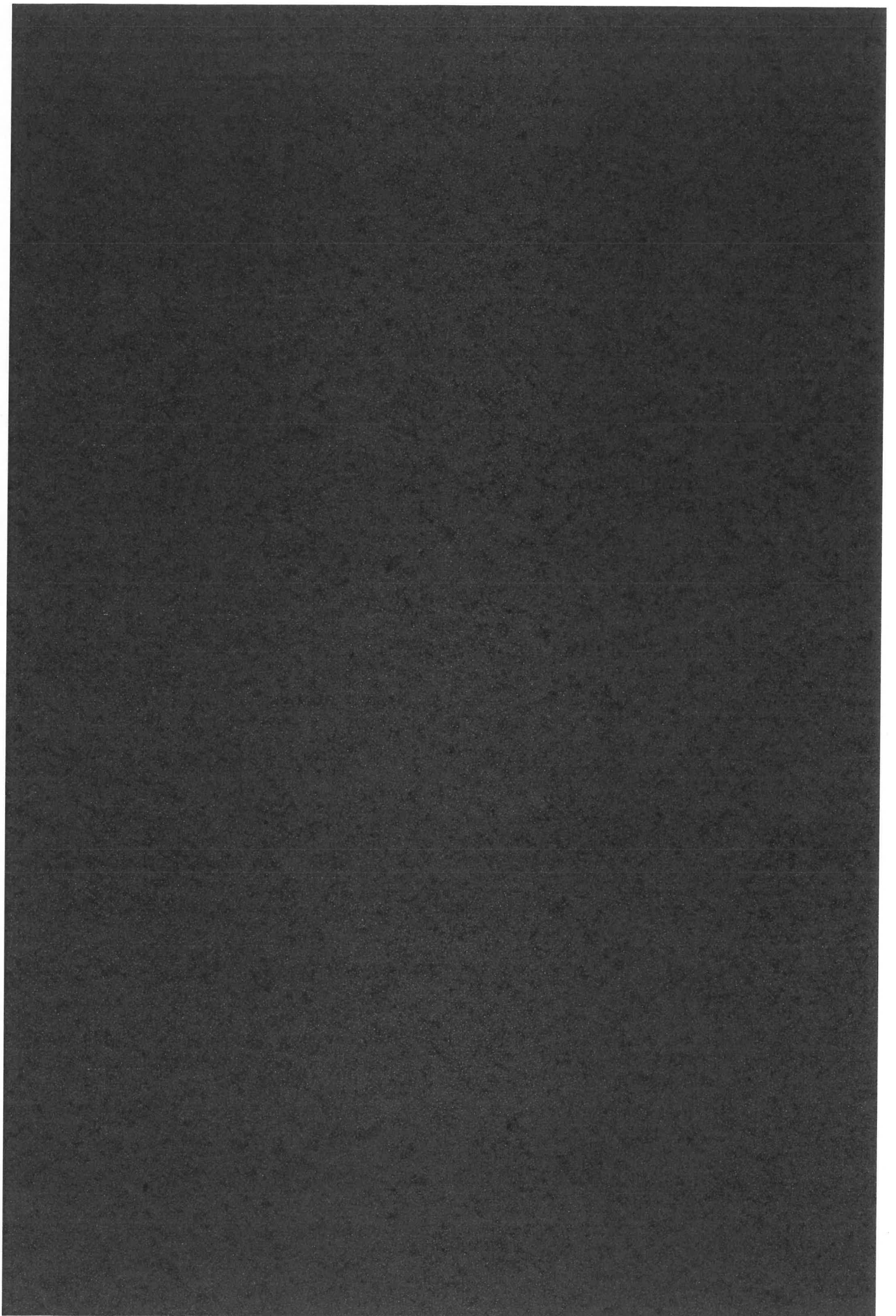


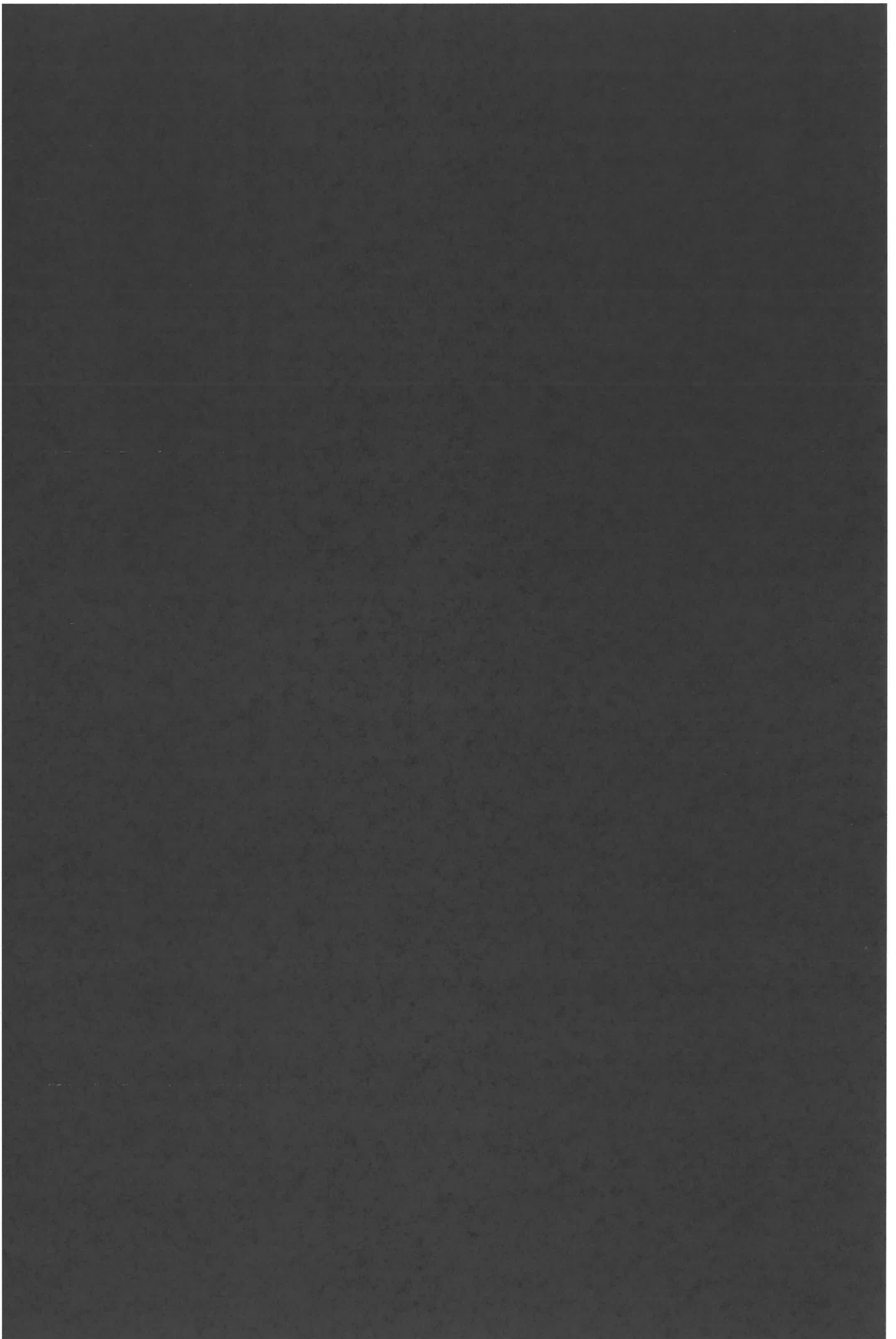












ATTACHMENT

ATTACHMENT B - SUMMARY OF RECOMMENDATIONS

No.	Recommendations	Recommendation Rating
Section 1		
1	Undertake a master-planning exercise for the Parkville Youth Justice Precinct. This review should assess the long term viability of the facilities and re-development options both on and off-site. This should be done as a matter of some urgency.	Medium-Long Term
2	Ongoing fortification works should include the creation of "safe zones" to which staff can retreat in emergencies.	Medium Term
3	Undertake an immediate and comprehensive inspection of all three Programs Centres. This should include all storerooms, staff areas and cupboards. Excess, unnecessary and broken items should be immediately removed. All staff areas should be cleaned and be cleared of excess items. A comprehensive register of all tools, equipment and consumables in the Programs areas needs to be established. Each room should contain a list of equipment, tools and consumables which is checked before and after use.	Immediate
4	Amend the operating instructions in woodwork , metalwork and other high-risk programs to ensure that tools and other items of equipment are taken out as needed, recorded and accounted for on the way out and in; and that all other items are locked away. The cages in woodwork and metalwork should be locked at all times after items are removed for use.	Immediate
5	Strengthen procedures and practice in relation to client movements around the Precinct and the manner in which clients enter and exit the Programs Centres. This should include utilising a single entry and exit point in the Main Programs Centre and the utilisation of the walk-through metal detector. There should be a concentration on improved practice over the next six-months to ensure that client movements around the Precinct are orderly and in accordance with procedures. SERT should be utilised to assist for client groups assessed as high-risk. Individual clients considered at high-risk should be moved in handcuffs.	Short Term
6	Establish joint Occupational Health and Safety mechanisms between PYJP and all site stakeholders specifically Parkville College and the health service.	Immediate
Section 2		
7	DHHS staff is commended on their response to both incidents.	Immediate
8	The practice instruction around implementation of Code Aqua calls is reviewed taking into account the issues raised above.	Short Term
9	Formulate requirements for Non-SERT staff to respond to critical incidents that may require the use of limited protective equipment such and shields. Further training is provided selected staff to assist in emergency situations. Preference should be given to staff who are already "secondary responders."	Medium Term
10	Review Control Room and Command Centre Operations during Emergencies. This should be on the work plan of the Emergency Planning Committee (EPC). This review should consider the establishment of a separate Command Post during emergencies and diverting telephones during emergencies. The design and layout of the Control Room should also be reviewed.	Medium Term
Section 3		
11	Convene a meeting with Victoria Police to further discuss the joint response to 7 March and issues that have arisen from the incident from both perspectives with a view to reviewing and more broadly	Short Term

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No.	Recommendations	Recommendation Rating
	disseminating Operation PEARL.	
12	The role of SERT is included in the review of Operation PEARL.	Medium Term
Section 4		
13	The Infrastructure, Projects and Security Section are recognised for their achievements in the recovery from these incidents.	Immediate
14	Commence representations to Victoria Police to request that investigations and charges proceed from the incidents of 31 October 2015 and 6 and 7 March 2016.	Immediate
15	A systematic follow up of all permanent, casual and agency staff on duty over 6 and 7 March is conducted as a matter of priority.	Immediate
Section 6		
16	Complete a full site risk assessment for hazards taking into account the matters raised in this section of the report. This review should specifically include the Dental Treatment Room and Unit Kitchens.	Short Term
17	Complete an audit of CCTV Camera's and establish a priority list for installation as resources become available.	Medium Term
18	Ascertain the status of no-fly zones over correctional centres with Corrections Victoria to see if any leverage can be obtained from the adult system.	Medium-Long Term
19	Issue nametags with positions to all staff from Unit Managers and above – with consideration to be given to Unit Supervisors.	Medium Term

ATTACHMENT

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.



