An investigation into the management of young people at Brisbane Youth Detention Centre between November 2016 and February 2017.

March 2019
The Brisbane Youth Detention Centre report

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The Honourable Curtis Pitt MP
Speaker
Parliament House
George Street
BRISBANE Q 4000

Dear Mr Speaker

In accordance with s.52 of the Ombudsman Act 2001, I hereby furnish to you my report, "The Brisbane Youth Detention Centre report: An investigation into the management of young people at Brisbane Youth Detention Centre between November 2016 and February 2017."

Yours faithfully

Phil Clarke
Queensland Ombudsman
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Foreword

This report presents the findings of an investigation into the management of young people at Brisbane Youth Detention Centre (BYDC) between November 2016 and February 2017. The investigation examined a number of incidents at BYDC during this timeframe, culminating in a violent and destructive riot at the centre on 30 January 2017.

I have decided to present this report to the Queensland Parliament because I consider it in the public interest to do so. It is important that the youth justice system, and youth detention centres in particular, are both transparent and accountable regarding their practices and how young people are treated.

I commenced the investigation following a number of complaints received from young people detained at BYDC regarding the alleged actions and decision-making of some BYDC staff. These complaints were followed by referrals of a number of related issues from the Crime and Corruption Commission (CCC). Further issues were included in the investigation following a visit by Ombudsman officers to BYDC, where concerns were identified regarding the suitability of some of the rooms that young people were being accommodated in.

In order to investigate the issues raised in this report, Ombudsman officers conducted numerous interviews with BYDC officers and young people detained at BYDC. The perspectives of both staff and young people are outlined in this report.

It is clear that there was significant disruption and discontent among young people at BYDC during the relevant period, which culminated in a riot on 30 January 2017. There were a number of causes for the riot, but the management of certain young people at BYDC in the preceding months was a significant factor.

This report identifies opportunities for administrative practices to be strengthened to ensure that youth detention centres are a safe and secure environment for staff and young people.

I would like to thank officers from the Department of Child Safety, Youth and Women, and particularly staff from BYDC. I would also like to thank my staff, and particularly acknowledge Principal Investigator Rhiannon Hunter and Senior Investigator David McMurtrie for their hard work and professionalism in conducting the investigation and preparing this report.

Phil Clarke
Queensland Ombudsman
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# Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>admission room</td>
<td>Holding room for young people newly admitted to Brisbane Youth Detention Centre</td>
</tr>
<tr>
<td>Assistant Director-General</td>
<td>Position within Department of Child Safety, Youth and Women with delegated responsibility for Youth Justice Services</td>
</tr>
<tr>
<td>basic entitlements</td>
<td>Removal of a young person’s personal belongings from their room with the exception of basic clothes and toiletries</td>
</tr>
<tr>
<td>behaviour development plan or BDP</td>
<td>Individualised plan implemented in a detention centre for a young person who displays risk factors that place other people or property at risk or whose behaviour indicates escalating behavioural issues</td>
</tr>
<tr>
<td>BYDC</td>
<td>Brisbane Youth Detention Centre, located in Brisbane</td>
</tr>
<tr>
<td>BYDC riot</td>
<td>Riot at Brisbane Youth Detention Centre on 30 January 2017</td>
</tr>
<tr>
<td>CCC</td>
<td>Crime and Corruption Commission</td>
</tr>
<tr>
<td>code black</td>
<td>Emergency code signifying a riot at a youth detention centre</td>
</tr>
<tr>
<td>code green</td>
<td>Emergency code signifying an escape at a youth detention centre</td>
</tr>
<tr>
<td>code olive</td>
<td>Emergency code signifying a young person on a roof at a youth detention centre</td>
</tr>
<tr>
<td>Community Visitors or CVs</td>
<td>Community Visitors from the Office of the Public Guardian are responsible for weekly visits to young people placed in youth detention centres</td>
</tr>
<tr>
<td>CYDC</td>
<td>Cleveland Youth Detention Centre, located in Townsville</td>
</tr>
<tr>
<td>CYDC riot</td>
<td>Riot at Cleveland Youth Detention Centre on 10 November 2016</td>
</tr>
<tr>
<td>CYDC young people</td>
<td>Three young people from Cleveland Youth Detention Centre who were transferred to Brisbane Youth Detention Centre following the CYDC riot</td>
</tr>
<tr>
<td>Detention Centre Operational Information System or DCOIS</td>
<td>An electronic system for capturing information about service delivery in youth detention centres</td>
</tr>
<tr>
<td>the department</td>
<td>Department of Child Safety, Youth and Women, the agency responsible for the administration of Youth Justice Services since 12 December 2017</td>
</tr>
<tr>
<td>Director-General</td>
<td>Chief Executive of the Department of Child Safety, Youth and Women</td>
</tr>
<tr>
<td>Term</td>
<td>Meaning</td>
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<tr>
<td>-------------------------------------------</td>
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</tr>
<tr>
<td>DJAG</td>
<td>Department of Justice and Attorney-General, the agency responsible for the administration of Youth Justice Services prior to 12 December 2017</td>
</tr>
<tr>
<td>Ethical Standards Unit or ESU</td>
<td>Manages complaints about misconduct and corrupt conduct by employees of the Department of Child Safety, Youth and Women</td>
</tr>
<tr>
<td>Executive Director</td>
<td>Position with responsibility for Brisbane Youth Detention Centre</td>
</tr>
<tr>
<td>incident report</td>
<td>Report in DCOIS created by a Shift Supervisor that records details of an incident at a detention centre and how the incident was managed</td>
</tr>
<tr>
<td>Incident Review Group or IRG</td>
<td>Internal group developed at Brisbane Youth Detention Centre with responsibility for reviewing the management and response of the centre to incidents involving young people</td>
</tr>
<tr>
<td>Intelligence Officer</td>
<td>Position at a youth detention centre with responsibility for gathering and assessing intelligence about potential incidents or risks to the safety or security of staff, young people and the centre</td>
</tr>
<tr>
<td>intelligence report</td>
<td>Report in DCOIS where detention centre staff record information that may identify a potential incident or risk to the safety or security of staff, young people and the centre</td>
</tr>
<tr>
<td>Manager Client Relations</td>
<td>Position at a youth detention centre with responsibility for complaints management. The responsibilities of the role were formerly part of the position of Manager Monitoring and Compliance</td>
</tr>
<tr>
<td>Manager Monitoring and Compliance or MMC</td>
<td>Position (since abolished) at a youth detention centre with responsibility for internal review, practice support and complaints management</td>
</tr>
<tr>
<td>Manager Practice Support</td>
<td>Position at a youth detention centre with responsibility for internal review and practice support. The responsibilities of the role were formerly part of the position of Manager Monitoring and Compliance</td>
</tr>
<tr>
<td>occurrence report</td>
<td>Report in DCOIS which is attached to a specific incident report and is completed by any detention centre staff member who was involved in an incident or was a witness to an incident</td>
</tr>
<tr>
<td>overnight lockdown</td>
<td>Period between 7.30pm and 7.30am when all young people at a youth detention centre are confined to their rooms</td>
</tr>
<tr>
<td>pool rooftop incident</td>
<td>Incident at Brisbane Youth Detention Centre on 24 November 2016 involving two young people who climbed onto the roof of a building adjacent to the pool</td>
</tr>
<tr>
<td>section</td>
<td>Term to describe a specific accommodation section within an accommodation unit at a youth detention centre</td>
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<tr>
<td>Term</td>
<td>Meaning</td>
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<tr>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Section Supervisor</td>
<td>Position at a youth detention centre with responsibility for the running of a section, management of daily activities and routines and the supervision of youth workers</td>
</tr>
<tr>
<td>separation</td>
<td>Placing a young person in a locked room by themselves for a reason prescribed under s.21 of the Youth Justice Regulation 2016</td>
</tr>
<tr>
<td>Shift Supervisor</td>
<td>Position at a youth detention centre with responsibility for the daily management of centre operations</td>
</tr>
<tr>
<td>Special Interest Young People (SIYP)</td>
<td>A register of young people who have been assessed as posing a risk to the safety and security of a youth detention centre</td>
</tr>
<tr>
<td>structured day</td>
<td>Daily routine for young people in detention and includes activities such as schooling and program delivery</td>
</tr>
<tr>
<td>Unit Manager</td>
<td>Position at a youth detention centre with responsibility for the management of accommodation sections and the supervision of Section Supervisors</td>
</tr>
<tr>
<td>young person or YP</td>
<td>A person under the age of 18</td>
</tr>
<tr>
<td>Youth Detention Centre Operations Manual</td>
<td>Manual outlining the Department of Child Safety, Youth and Women’s policies regarding youth detention service delivery</td>
</tr>
<tr>
<td>Youth Detention Inspectorate</td>
<td>Team within the Department of Child Safety, Youth and Women that conducts quarterly inspections and monitors Queensland’s youth detention centres under s.263(4) of the Youth Justice Act 1992</td>
</tr>
<tr>
<td>Youth Justice Act 1992</td>
<td>Queensland Act providing laws for children who commit, or who are alleged to have committed offences</td>
</tr>
<tr>
<td>Youth Justice Regulation 2016</td>
<td>Queensland Regulation made under the Youth Justice Act 1992</td>
</tr>
<tr>
<td>Youth Worker</td>
<td>Position at youth detention centres with responsibility for the day to day care of young people</td>
</tr>
<tr>
<td>Youth Justice Act 1992</td>
<td>Queensland Act providing laws for children who commit, or who are alleged to have committed offences</td>
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<td>Position at detention centres with responsibility for the day to day care of young people</td>
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Executive summary

Early in the afternoon of 30 January 2017, seven young people at Brisbane Youth Detention Centre (BYDC) were involved in a violent and destructive riot (the BYDC riot). The BYDC riot involved seven young people forcing their way onto the roof of one of the accommodation units causing significant damage to the centre’s infrastructure as well as injury to staff.

The riot commenced on the veranda of the unit, where the young people used cleaning equipment, such as brooms and mops, to intimidate staff and smash windows and light bulbs. A staff member was injured when they were hit by glass from a smashed window panel.

The young people gained access to a common area and continued destroying windows and other infrastructure. The young people gained access to the unit’s roof by way of a broken window. BYDC staff contacted the Queensland Police Service which sent police officers to the centre to manage the situation.

The young people remained on the roof of the unit for the remainder of the day and into the early hours of the following morning. While on the roof, the young people continued to cause significant damage to infrastructure, including throwing damaged items at staff attempting to manage the situation.

The young people progressively came down from the roof of their own accord with the last young people coming down at 2.51am on 31 January 2017. All seven young people who had been involved were placed in separation while BYDC staff attempted to restore order at the centre over the course of the next 24 hours.

Following the BYDC riot, the young people involved were spoken to by BYDC staff who tried to determine the reasons for their actions. The young people initially spoke of their dissatisfaction with a decision by unit staff to remove their possessions from their rooms the day before the riot, which they felt was unfair.

However, the young people also raised serious allegations regarding the actions of a number of BYDC staff. These allegations related to the perceived relationship between some BYDC staff and young people who had been transferred from Cleveland Youth Detention Centre (CYDC) in November 2016 (CYDC young people). The CYDC young people had been transferred following a violent riot at CYDC (the CYDC riot) which had resulted in significant injury to CYDC staff.

After their transfer to BYDC, the CYDC young people were accommodated together in the same unit. They quickly gained a reputation among the young people at BYDC as violent and willing to assault other young people. As a result, many young people at BYDC were fearful of the CYDC young people, and particularly the threat of being assaulted if they were placed in the same unit as the CYDC young people.

The young people involved in the BYDC riot alleged that some BYDC staff had used this fear to threaten young people with transfer to the unit if they misbehaved. They also alleged that some staff had told them that if they did not comply with instructions they would be assaulted by the CYDC young people.

The young people stated they took this threat seriously as they believed that some BYDC staff had purposely placed young people in situations where they would be assaulted by the CYDC young people. They also alleged that some staff had ‘paid’ the CYDC young people with soft drink to assault young people who misbehaved.
These perceptions meant that young people felt that the CYDC young people were favoured by staff and were provided with privileges that other young people at the centre did not receive. They also felt that the CYDC young people did not receive any consequences for their actions, even though they had been involved in multiple assaults on other young people, and that staff would not act to protect them from CYDC young people.

Ombudsman investigation

Between January 2017 and August 2017 the Office of the Queensland Ombudsman (the Office) received information to suggest that there had been significant problems and disruption at BYDC in the period following the transfer of the CYDC young people and the BYDC riot.

In particular, it was evident that the arrival of the CYDC young people at BYDC had a significant impact on the safety, security and normal functioning of the centre. Issues regarding the management of the CYDC young people, and how some BYDC staff interacted with them, were identified as factors that ultimately contributed to the BYDC riot.

By way of complaints received from young people, interviews conducted with young people, information provided by BYDC staff and the Youth Detention Inspectorate and referrals from the CCC, the Office identified a number of significant decisions and incidents at BYDC between November 2016 and the BYDC riot on 30 January 2017. These formed the basis for the investigation, and included:

• the development of risk management strategies for the CYDC young people following their transfer to BYDC
• a rooftop incident in November 2016
• allegations of threats and assaults on young people orchestrated by BYDC staff
• perceived preferential treatment of CYDC young people by staff
• concerns about safety and security at BYDC in the lead up to the BYDC riot.

The investigation also examined the aftermath of the BYDC riot, specifically the decision to separate the young people who were involved for a period of up to 10 days. A lack of available rooms following the BYDC riot meant that some of these young people were accommodated in rooms that were intended to be temporary holding areas for young people newly admitted to the centre. These ‘admission rooms’ did not have beds, running water or bathroom facilities. Some young people spent the entire length of their 10 day separation period detained in these rooms.

The following sections provide a summary of the issues examined by the investigation and the outcomes.

Development of risk management strategies for the CYDC young people

Upon arrival at BYDC, the CYDC young people were identified as an ‘extreme risk’ and a potential threat to the safety of both staff and other young people at BYDC.

BYDC staff developed a plan for the CYDC young people’s transition to BYDC and a strategy to ensure they could be safely accommodated in the centre’s general population. However, vital information regarding the risks posed by the CYDC young people, as well as the management strategies that were developed to ensure the safety of staff and other young people, were not adequately communicated to staff actually responsible for the daily supervision of the CYDC young people.
Pool rooftop incident

CCTV records showed that BYDC staff had used one of the CYDC young people to speak to two young people who had climbed onto a rooftop next to the pool on 24 November 2016 (the pool rooftop incident).

Given the fear of the CYDC young people within the broader BYDC population, the use of one of the CYDC young people in BYDC’s response to the pool rooftop incident failed to consider the significant risk he posed to the safety and security of the centre. Records made by BYDC staff about the pool rooftop incident also did not record the CYDC young person’s involvement, undermining confidence in the management of the event and compromising the review of the incident by both inspectors from the Youth Detention Inspectorate and this Office.

Allegations of threats and assaults on young people orchestrated by BYDC staff

A number of young people made complaints that some BYDC staff threatened young people with being transferred to the unit where CYDC young people were accommodated, and that young people were ‘set up’ by some staff to be assaulted by the CYDC young people.

The evidence indicated that during December 2016 and January 2017 there were a series of incidents involving the CYDC young people that appeared to cause considerable concern and anxiety among young people at BYDC. These included:

- assaults between the CYDC young people and other young people
- perceptions by young people that some BYDC staff were threatening to move young people to an accommodation unit so they would be assaulted by the CYDC young people
- the perceived use of the CYDC young people as ‘enforcers’ by some BYDC staff
- young people being ‘set up’ by BYDC staff to be assaulted by the CYDC young people.

BYDC staff interviewed during the investigation denied making any type of threats to transfer young people to any particular unit. However, some staff did acknowledge that they had heard rumours that these types of threats had been made, or that a young person had told them that they had been threatened by a staff member in this way.

While the investigation did not substantiate any specific allegation of a staff member threatening a young person with transfer to any particular unit, the weight of evidence indicates that threats of this nature were likely made by some BYDC staff. The reason for staff making such threats was not determined.

Perceived preferential treatment of CYDC young people by staff

Young people alleged that:

- the CYDC young people had items in their rooms that were not available to other young people, particularly soft drink
- these items were a form of payment from BYDC staff to the CYDC young people for assaulting other young people
- there were differences in the consequences for misbehaviour experienced by the CYDC young people compared with other young people.

These specific allegations were not substantiated. It was not possible to conclude with certainty that the CYDC young people had access to soft drink in their room during the relevant period between November 2016 and January 2017.
Despite this, the fact that other young people had observed these items in the CYDC young people’s rooms added to the perception of favouritism and special treatment that was present in the centre between December 2016 and February 2017.

There was evidence that the CYDC young people were not always subject to the same consequences as other young people, particularly regarding being placed in separation. This fuelled the perception among other young people that CYDC young people were in a privileged position at BYDC.

Concerns about safety and security at BYDC in January 2017

Throughout January 2017, intelligence reports generated by BYDC staff suggested that some young people were gathering makeshift weapons in anticipation of having to fight the CYDC young people. The intelligence also suggested that some young people were planning a significant event, such as an attempted escape, and were attempting to inform other young people of their plan.

Weapons and other contraband concealed by young people were increasingly being found by BYDC staff throughout January 2017.

Despite these concerns, there were no apparent strategies developed by BYDC management to address the young people’s concerns about the CYDC young people which were a significant factor that was contributing to their behaviour.

By the morning of 30 January 2017, BYDC staff were aware that there was a risk of a significant incident occurring. Staff discussed the intelligence at the daily management meeting at 8.30am that morning. The volume of weapons and contraband that had been found over the previous few days was laid out for participants to view.

At this meeting, staff discussed how to manage the risks, including the intelligence that had been received. Unfortunately, evidence from staff who attended this meeting about what was discussed and agreed cannot be reconciled as no records of the meeting were made, including any agreed outcomes or strategies to address the risk of an incident occurring. As a result, it is not clear that BYDC established or implemented adequate strategies to manage the identified risks. Consequently, this may have been a missed opportunity to prevent a serious incident from occurring.

The BYDC riot occurred later on the day of 30 January 2017.

Use of separation at BYDC

Following the BYDC riot, the seven young people who had been involved were placed in separation for a period of up to 10 days. Separation of a young person in youth detention is effectively a form of solitary confinement. It generally involves the involuntary placement of a young person in a locked room.

In relation to the separation of the seven young people, the investigation examined:

• whether BYDC considered relevant factors for each young person in deciding whether their continued separation was necessary
• whether relevant approvals under the Youth Justice Regulation 2016 (YJ Regulation) were sought for the separations
• the management of each young person’s separation.

The investigation found that the separation of the young people had been approved by the relevant decision-maker. However, there were significant failures in the recording of approvals obtained for separations and in the proper application of agency policy relevant to the separations.
The investigation found that there was insufficient evidence recorded to justify the continued separation of all seven young people for the full 10 day period. Due to inadequacies in the available records, it is not possible to determine whether a young person was separated in accordance with agency policy and whether they were appropriately managed.

**Use of the admission rooms to accommodate young people**

During their separation, a number of the young people were accommodated in the BYDC admission rooms. The admission rooms contain a small bench seat, but no other furniture. There are no bathroom facilities or running water. Young people accommodated in the admission rooms overnight slept on a mattress placed on the floor.

The investigation found that:

- young people were required to ask a staff member to be let out of their room to be taken to the toilet. During the night, there may have been delays in escorting young people to the toilet because of staffing requirements
- young people received drinking water in plastic cups or water bottles and had to request additional water from staff
- there was a lack of appropriate temperature control and ventilation in the admission rooms which caused young people to complain about excessive temperatures.

Because of the lack of essential facilities, the admission rooms are clearly unsuitable for accommodating young people for any significant period of time, and particularly overnight.
Recommendations

Recommendation 1

The Director-General of the department:

a) identify and implement necessary improvements to the process for developing and documenting risk management strategies for managing high risk young people
b) review methods of communicating risk management strategies to staff working with high risk young people to ensure they have a sufficient knowledge of documented plans to manage particular high risk young people.

Recommendation 2

The Director-General of the department ensure that a directive prohibiting the use of young people in response to incidents is published in all Queensland youth detention centres.

Recommendation 3

The Director-General of the department provide further guidance and training to all staff in Queensland youth detention centres regarding:

a) when to seek approval to move a young person/young people throughout the centre
b) assessing risk prior to and during movement of a young person/young people throughout the centre
c) accurately recording movements and the associated approvals.

Recommendation 4

The Director-General of the department provide further guidance and training to youth detention centre staff about incident reporting, including:

a) when an occurrence report is to be submitted, regardless of having been requested to provide one
b) what information is to be documented in an incident report and an occurrence report.

Recommendation 5

The Director-General of the department amend current policy and procedure regarding the review of incidents at a detention centre to ensure that where CCTV footage of an incident is available, that footage is reviewed.

Recommendation 6

The Director-General of the department amend the Youth Detention Centre Operations Manual to provide more detailed guidance about the items permitted to be in the possession of young people and the reasons for any restrictions. The Manual should also outline any specific exemptions or special circumstances regarding items permitted to be in the possession of young people.
Recommendation 7

The Director-General of the department review the process for gathering and analysing intelligence at detention centres to ensure that intelligence can effectively inform operational outcomes. As part of this review, the Director-General should ensure the following issues are addressed:

a) clarifying which officer at a youth detention centre is responsible for collating and assessing intelligence and assessing risk to the safety of the centre, staff and young people based on that intelligence
b) clarifying which officer at a youth detention centre is responsible for deciding the appropriate operational action in response to the assessed risk to the safety of the centre, staff and young people based on that intelligence
c) how operational responses to intelligence are communicated to detention centre staff
d) how the operational action in response to intelligence is recorded.

Recommendation 8

The Director-General of the department review the current internal review capacity at youth detention centres and ensure the following:

a) detention centres have a review group that is responsible for conducting internal reviews of significant incidents that occur at the centre
b) membership of the review group is multidisciplinary and includes, at minimum, representatives from management, operational, casework and behaviour support teams as well as staff responsible for oversight and compliance
c) appropriate records are kept of meetings held by the review group
d) reviews include a consideration of the root cause of each incident as well as the centre’s response
e) appropriate outcomes from reviews are disseminated to staff to encourage a culture of continuous improvement.

Recommendation 9

The Director-General of the department ensure that the responsibility for managing complaints at detention centres is appropriately prioritised to ensure high priority or high risk complaints are dealt with in a timely way.

Recommendation 10

The Director-General of the department immediately prioritise enhancing the CCTV coverage at BYDC to maximise coverage of the centre, particularly in the accommodation unit common areas, in the interests of protecting both staff and young people.

Recommendation 11

The Director-General of the department implement body worn cameras that provide both a visual and audio record for all operational staff working in youth detention centres.
Recommendation 12

The Director-General of the department ensure all directives at a youth detention centre are:

a) communicated in a way that ensures all staff are made aware of them
b) available in a single location which is easily accessible to all staff.

Recommendation 13

The Director-General of the department amend the separation policy to require approval from the chief executive’s delegate where a young person is separated for a continuous period of 24 hours, regardless of the reason for this separation.

Recommendation 14

The Director-General of the department provide comprehensive training to all youth detention staff with the delegation to place a young person in separation for any period of time about:

a) the circumstances when a young person may be placed in separation for any period of time
b) when approvals for separation must be sought, including how the approval must be sought
c) the specific requirements for a separation that continues past 24 hours
d) the potential consequences for non-compliance with the requirements under s.21 of the Youth Justice Regulation
e) the staff member’s responsibility to make adequate records about the separation.

Recommendation 15

The Director-General of the department develop and implement a procedure regarding the administration of separation, which has a particular focus on strategies to ensure the safety and wellbeing of young people while separated. Once implemented, all detention centre staff should be trained in the requirements of the procedure.

The procedure should, at minimum, address the following issues:

a) mandate a minimum period that a young person placed in continuous separation must be outside their room each 24 hour period
b) require staff to accurately and clearly record the time a young person spends out of their room for any reason during periods of separation, including for the purposes of using the bathroom, making phone calls, attending visits or exercising
c) ensure there is an adequate system to allow staff to make records of a young person’s out-of-room time and that staff are trained and demonstrate competency in its use
d) require young people placed in separation for longer than 24 hours to be visited and assessed by a registered health practitioner and a case worker, and for further visits to occur on each subsequent day the separation continues.
Recommendation 16

The Director-General of the department review the legislative and regulatory framework regarding the use of separation in youth detention centres and determine whether they are effective and sufficient to protect the safety and rights of young people. At minimum, this should include:

a) a review of the provisions of the Youth Justice Regulation and relevant departmental policies and procedures
b) a comparison with the regulatory and policy requirements and safeguards for separate confinement under the Corrective Services Act and Corrective Services Regulation
c) a comparison regarding how separation is regulated in other Australian jurisdictions
d) a review of the adequacy of recordkeeping systems, recordkeeping requirements and the capacity of staff to efficiently and effectively use these systems
e) a review of current training provided to youth detention centre staff.

Recommendation 17

The Director-General of the department ensure that:

a) young people are not accommodated in rooms at a detention centre that do not have access to a bathroom, clean drinking water and adequate temperature control and ventilation unless in exceptional and limited circumstances
b) a policy and procedure is developed and implemented to regulate the specific use of the admission rooms, including the adequacy of staffing while these rooms are in use
c) staff are provided with adequate training about the requirements developed regarding the use of the admission rooms.
1 Introduction

This report documents the findings of investigations conducted by the Office of the Queensland Ombudsman (the Office) into a series of events at the Brisbane Youth Detention Centre (BYDC) between November 2016 and February 2017.

A number of separate investigations commenced as a result of complaints received from young people detained at BYDC and the referral of allegations from the Crime and Corruption Commission (CCC) throughout 2017. I have decided to prepare a report on these investigations.

The events described in this report stem from a riot in Cleveland Youth Detention Centre (CYDC) in Townsville in late 2016 (the CYDC riot) and the consequential transfer of three high risk young offenders from CYDC to BYDC (CYDC young people). The events that unfolded at BYDC after the transfer of these three young people were challenging and exposed the complexity of managing high risk young people in youth detention centres.

1.1 Background

On 30 January 2017, the Office received complaints from two young people detained at BYDC.

The first complaint was from a young person who stated that he and the majority of young people in one of the accommodation units had their possessions removed from their rooms and placed in garbage bags outside their doors. The young person stated this action was taken by BYDC staff because the section had been damaged by a young person removing a screw from a door hinge.

The second complaint was from a young person who stated that he had been told by a BYDC staff member that he was being transferred to a different accommodation unit. The young person said that he had previously been accommodated in that unit but he had been in a fight with three other young people so he had been transferred to another unit. The young person said he told the BYDC staff member that he feared for his safety if he was transferred back to his original unit, but the staff member had stated ‘that’s not my problem’. The young person refused to name the officer who made the comment as he alleged that the officer would arrange for other young people to assault him.

The Office contacted BYDC to obtain information to assist with the assessment of these two complaints. Just hours after these complaints were received by this Office, the two young people were involved in a serious riot at BYDC (the BYDC riot).

The BYDC riot caused significant damage to an accommodation unit, with the seven young people involved breaking their way onto the roof, where some of them remained until the early hours of the following morning.

On 13 February 2017, investigators from the Office attended BYDC and interviewed the two young people. Both young people advised that the issues they had raised on 30 January 2017 had not been resolved.

On 14 February 2017, the Office received a complaint from a third young person. This young person made a number of allegations about the conduct of staff at BYDC, including:

- he and the young people involved in the BYDC riot on 30 January 2017 feared for their safety at BYDC
- staff at BYDC had threatened to place him and the other young people involved in the BYDC riot in the section with the CYDC young people so they would be assaulted by them
• two staff members in particular had made these threats to him repeatedly over the past few weeks
• he was aware of a young person who had run away from staff while being taken to the section where the CYDC young people were accommodated
• staff pay the CYDC young people with soft drinks to assault young people who misbehave
• when a young person had his nose broken by one of the CYDC young people, staff had offered the CYDC young person cordial before the assault occurred.

On 14 February 2017, I referred the young person’s allegations to the CCC under s.38 of the Crime and Corruption Act 2001 on the basis that information provided involved, or may have involved, corrupt conduct.

On 9 March 2017, the CCC referred two issues back to the Office for investigation:

1. the allegation of threats made by staff to young people in one of the accommodation units at BYDC for the purpose of behaviour management
2. the allegation that staff procure young people to assault other young people.

On 14 March 2017, I wrote to the Director-General of the Department of Justice and Attorney-General (DJAG), who at the time had responsibility for Youth Justice Services, advising of my intention to investigate the complaints received from the three young people.

Separately, on 24 January 2017, the Office also received a complaint from a fourth young person regarding the use of separation at BYDC. In his complaint the young person stated that he had been accommodated in the admission rooms at BYDC for an extended period of time. While accommodated in the admission rooms he was unable to access basic amenities, including a toilet.

During their visit to BYDC on 13 February 2017, investigators from the Office inspected the admission rooms, but were unable to interview the young person as he had been released from detention.

Following this inspection, investigators held concerns about the suitability of using the admission rooms for accommodating young people for protracted periods of time. Investigators also became aware that some of the young people who had been involved in the BYDC riot had been accommodated in the admission rooms for 10 days following the incident.

On 20 March 2017, I wrote to the Director-General of DJAG to advise that I was commencing an investigation into the use of the admissions rooms for the accommodation of young people in January and February 2017.

While the investigation was ongoing, on 15 May 2017 the CCC referred a further issue to the Office for investigation. This referral related to an allegation that staff at BYDC used one of the CYDC young people to threaten young people who had climbed onto a rooftop at BYDC on 24 November 2016 (the pool rooftop incident).

On 31 May 2017, I wrote to the Director-General of DJAG to advise that I was also commencing an investigation into this allegation. I also advised that all the allegations that had been received by that time would be investigated together.

On 7 August 2017, I received a final referral from the CCC relating to a complaint that had been made by a young person’s mother to BYDC in January 2017. The young person’s mother alleged that BYDC staff had arranged for the young person to be assaulted by one of the CYDC young people. As this incident was already being investigated as part of the allegation that staff at BYDC procured young people to assault other young people, this complaint was also formally added to the ongoing investigation.
In light of the background described above, the scope of the combined investigation was:

- the management of privileges in one of the accommodation sections in the lead up to the BYDC riot, including the implementation of changes and how these changes were communicated to young people
- allegations of threats being made by staff to young people in one of the accommodation sections to manage behaviour
- an allegation that staff procure young people to assault other young people
- an allegation that staff at BYDC facilitated one of the CYDC young people to intimidate other young people during the pool rooftop incident on 24 November 2016
- the use of the admissions rooms for the accommodation of young people at BYDC in January and February 2017.

This report sets out my findings arising from the investigation of the above matters and my analysis of the administrative actions at BYDC across the relevant time period.

1.2 Ombudsman jurisdiction

I am empowered to investigate the administrative actions of Queensland public sector agencies. Administrative action includes the failure to make a decision or to do an act.¹

The Department of Child Safety, Youth and Women (the department) is the agency currently responsible for the administration of Youth Justice Services in Queensland. On 12 December 2017, Youth Justice Services transferred from DJAG to the department as part of machinery of government changes.

Accordingly, prior to this date, all investigation actions including correspondence and information requests were sent to the Director-General of DJAG.

I am satisfied that both departments are agencies in accordance with the definition prescribed in the Ombudsman Act 2001 (Ombudsman Act).² I therefore have jurisdiction to investigate this matter.

For further information about my jurisdiction and investigative powers please refer to Appendix A.

1.3 De-identification

I have removed all references to a person’s name and any other identifying features from this report.

For departmental staff members, I have referred to either their position at the time of the events under investigation or by the generalised title, BYDC officer. For more senior BYDC officers, where appropriate I have referred to them as a senior BYDC officer. Where appropriate, and to further protect the identity of less senior staff members, I have removed references to a staff member’s gender.

This report refers to a number of young people who were involved in the events referenced in the report. I have referred to all young people generally to protect their identity. As a further confidentiality measure, I have also removed references to any particular unit which may indicate where a young person was accommodated while they were in BYDC.

¹ Ombudsman Act, s.7(1)(b).
² ibid, s.8(1)(a).
1.4 Procedural fairness

Section 55(2) of the Ombudsman Act provides that I must not make adverse comment about a person in a report unless I give that person an opportunity to make submissions about the adverse comment. The person’s defence must be fairly stated in the report if I still propose to make the comment.

To comply with my procedural fairness obligations, I initially prepared a proposed report containing proposed opinions and proposed recommendations.

On 5 July 2018, I provided extracts of the proposed report to a number of departmental officers. All departmental officers provided a response to the proposed adverse comment made against them. In some instances, I amended the proposed report in response to the submissions received. Where appropriate, the responses provided by departmental officers have been incorporated into this report.

Pursuant to s.26(3) of the Ombudsman Act, on 23 October 2018 I provided a copy of the proposed report to the Director-General of the department. The Director-General provided his response on 7 December 2018.

1.4.1 The department’s response to the proposed report

The Director-General provided a response to each of the opinions and recommendations made in the report. He did not explicitly accept or reject any of the opinions or recommendations.

For each recommendation, the department either noted the work currently underway to action the recommendation, or indicated the proposed action it intends to take. Given the department did not specifically reject any recommendation, I have taken the view that all recommendations have been accepted. For each recommendation, I have provided the department’s response and, if appropriate, my comments about the response.

For each opinion, the department acknowledged that the opinion had been made. For a number of opinions, the department either provided some additional comment about the subject matter of the opinion or raised objections about the subject matter. In this report, I have only provided the department’s response to an opinion where an objection to the opinion was raised or additional comment provided. In these instances, I have also provided my comments about the department’s response.

I thank the Director-General for his response to the proposed report.

1.4.2 Disclosure of confidential information

In its response, the department raised concerns about potentially identifying information about young people, staff and security processes at youth detention centres being included in the report. These concerns were set out as follows:

a) whether the disclosed information could identify a young person mentioned in the report and this could prove harmful to the specified young person or others

b) whether the disclosed information sets out the positions of persons interviewed during the investigation process, which could identify the staff member and prove harmful to the specified staff member or others and to the overall culture and wellbeing of the centre

c) if the disclosed information identifies security practices relating to the management of a youth detention centre which could prove harmful to the good order and security of a detention facility
d) whether the disclosed information identifies the existence, non-existence and quality of monitoring or CCTV footage within BYDC which could prove harmful to the good order and security of the detention facility.

I make the following comments regarding each of these four areas of concern.

**Identifying information about young people**

As outlined in section 1.3, I have de-identified each of the young people mentioned in this report. In response to the department’s concerns, I have made additional amendments to further remove any potential identifying details about any young person.

I acknowledge that a young person may be able to identify themselves by the information contained in this report. Departmental staff who had involvement in the matters outlined may also be able to identify the young people mentioned.

However, I note the view recently expressed by the Right to Information Commissioner in a decision regarding a right to information (RTI) request for CCTV footage from a youth detention centre. The Commissioner stated the following:

> I acknowledge that the children involved in the relevant incidents may still recognise themselves as being referred to or depicted ... There may also be some detention centre staff and perhaps other children who were detained in the centre at the same time who are aware of the incidents and the identities of those involved. However, this identification relies upon special knowledge. Importantly, this small cohort of persons is already aware that the children in question are being, or have been, dealt with under the YJ Act. As such, the [information] is not ‘confidential information about a child’ for those persons because they are already aware of the child’s identity and their status under the YJ Act. It is not confidential or secret information vis-à-vis them. The ordinary dictionary meaning of ‘confidential’ is ‘secret; intended to be kept secret’.

I have taken this view by the Right to Information Commissioner into account in determining the extent to de-identify the young people mentioned in this report.

I am satisfied that no young person could be identified by the information contained in this report by any person who did not already have ‘special knowledge’ about a young person’s circumstances.

**Identifying information about departmental staff**

As outlined in section 1.3, I have referred to departmental staff either by their position at the time of the events under investigation or by the generalised title, BYDC officer. I acknowledge that some staff may be able to be identified by their position title. However, as outlined above, if I have made potential adverse comment about any staff member in this report, that staff member was provided with an opportunity to respond to that comment and where appropriate their response has been included in this report.

I reject the assertion that the identification of a staff member by their position title could prove harmful to that staff member or others and to the overall culture and wellbeing of the centre.

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Identifying information about security practices

I have carefully considered all instances where the department has raised concerns that I have included identifying information about security practices in detention centres. In response, I have made some amendments to the information contained in this report about the security practices at BYDC.

All information about security practices contained in this report is of a general nature or is already publicly available. I am of the view that there is no information included in this report which could prove harmful to the good order and security of a detention facility.

Identifying information about CCTV

I have carefully considered all instances where the department has raised concerns that I have included identifying information about the existence, non-existence and quality of monitoring or CCTV footage within BYDC. In response, I have made some amendments to the information contained in this report about the CCTV coverage at BYDC.

The information about the quality and coverage of CCTV at BYDC that is contained in this report is of a general nature and has also been previously publicly reported by the Youth Detention Inspectorate and the Independent Review of Youth Detention. I am of the view that there is no information included in this report which could prove harmful to the good order and security of BYDC.

1.5 Report structure and timeline of key events

This report has been broken into three parts:

1. Part 1 deals with BYDC’s management of the CYDC young people who were transferred to BYDC in November 2016, and the pool rooftop incident that occurred shortly thereafter.
2. Part 2 deals with the department’s response to a number of assaults, complaints, related allegations concerning the procurement of assaults and other intelligence available in the lead up to the BYDC riot on 30 January 2017.
3. Part 3 deals with the separation and accommodation of young people in the admissions rooms at BYDC in January and February 2017 following the BYDC riot.

Figure 1 depicts a timeline of the relevant events at BYDC during the time period considered by this investigation.
### Figure 1: Chronology of events

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 November 2016</td>
<td>Certain young people involved in the CYDC riot (CYDC young people) are transferred to BYDC and accommodated separately.</td>
</tr>
<tr>
<td>22 November 2016</td>
<td>The CYDC young people express their frustration at being accommodated separately at BYDC and begin displaying aggressive and threatening behaviour which results in staff withdrawing from the common area. Following this incident the young people are transferred to the general population.</td>
</tr>
<tr>
<td>13 December 2016</td>
<td>On their return to their accommodation after involvement in a rooftop incident, two young people are assaulted by CYDC young people, who are unhappy that their programs were interrupted as a result of the actions of the young people. During mediation in response to the assault, one of the young people strikes a CYDC young person in the face.</td>
</tr>
<tr>
<td>30 December 2016</td>
<td>After being transferred the previous evening, a young person is assaulted by a CYDC young person.</td>
</tr>
<tr>
<td>10 November 2016</td>
<td>The CYDC riot occurs, resulting in significant harm to staff and damage to the centre.</td>
</tr>
<tr>
<td>24 November 2016</td>
<td>Two young people climb onto the roof of a building adjacent to the pool. A CYDC young person is escorted to the incident and speaks to the young people while they are on the roof.</td>
</tr>
<tr>
<td>29 January 2017</td>
<td>As a result of contraband that was found, the young people in an accommodation unit are advised they will be placed on basic entitlements, meaning all non-essential bedding and toiletries are removed from their rooms.</td>
</tr>
<tr>
<td>28 January 2017</td>
<td>A search is conducted which finds significant contraband, including makeshift knives, in young people’s rooms.</td>
</tr>
<tr>
<td>30 January 2017</td>
<td>The BYDC riot occurs resulting in harm to staff and significant damage to the centre.</td>
</tr>
<tr>
<td>31 January – 10 February 2017</td>
<td>The seven young people involved in the BYDC riot are held in separate accommodation.</td>
</tr>
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<td>30 January 2017</td>
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**Figure 1**

- **14 November 2016**: Certain young people involved in the CYDC riot (CYDC young people) are transferred to BYDC and accommodated separately.
- **22 November 2016**: The CYDC young people express their frustration at being accommodated separately at BYDC and begin displaying aggressive and threatening behaviour which results in staff withdrawing from the common area. Following this incident the young people are transferred to the general population.
- **13 December 2016**: On their return to their accommodation after involvement in a rooftop incident, two young people are assaulted by CYDC young people, who are unhappy that their programs were interrupted as a result of the actions of the young people. During mediation in response to the assault, one of the young people strikes a CYDC young person in the face.
- **30 December 2016**: After being transferred the previous evening, a young person is assaulted by a CYDC young person.
- **10 November 2016**: The CYDC riot occurs, resulting in significant harm to staff and damage to the centre.
- **24 November 2016**: Two young people climb onto the roof of a building adjacent to the pool. A CYDC young person is escorted to the incident and speaks to the young people while they are on the roof.
- **30 January 2017**: The BYDC riot occurs resulting in harm to staff and significant damage to the centre.
- **29 January 2017**: As a result of contraband that was found, the young people in an accommodation unit are advised they will be placed on basic entitlements, meaning all non-essential bedding and toiletries are removed from their rooms.
- **31 January – 10 February 2017**: The seven young people involved in the BYDC riot are held in separate accommodation.
1.6 Investigation methodology

This investigation was conducted informally under s.24(1)(a) of the Ombudsman Act.

Evidence was primarily gathered through information requests to the Director-General of DJAG and interviews with staff and young people. Specifically, investigators undertook the following actions:

• interviewed the seven young people involved in the BYDC riot
• interviewed two other young people accommodated in an accommodation unit when their rooms were placed on basic entitlements
• interviewed one of the CYDC young people
• interviewed the now former Assistant Director-General, Youth Justice Services
• interviewed the now former BYDC Executive Director and the now former BYDC Deputy Director
• interviewed a Principal Inspector from the Youth Detention Inspectorate
• interviewed the following BYDC staff members:
  - Manager Client Relations\(^4\)
  - Manager Practice Support\(^5\)
  - Intelligence Officer
  - two Psychologists
  - two Unit Managers
  - a Shift Supervisor
  - 17 Section Supervisors and Youth Workers who were identified as relevant to the issues being investigated
  - Structured Day Co-ordinator
• analysed relevant documentation provided by DJAG and the CCC.

The above information was analysed to form an opinion about each of the allegations under investigation. Where possible, I have also made recommendations to rectify any matters of identified maladministration.

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\(^4\) The position was formerly titled the Manager Monitoring and Compliance. This report refers to the Manager Monitoring and Compliance as this was the relevant position during the time period considered by this investigation.

\(^5\) ibid.
Management of CYDC young people upon their arrival at BYDC

This part addresses events at BYDC in the weeks following the transfer of the CYDC young people to BYDC after the CYDC riot. As discussed later in the report, these events had a significant impact on safety and security issues at BYDC during the following months.

Chapter 2 addresses the planning process undertaken by BYDC staff to safely transition the CYDC young people.

Chapter 3 addresses the pool rooftop incident which occurred just two days after the CYDC young people were transferred into the BYDC general population. The incident involved two young people who climbed onto a roof adjacent to the pool area during structured day activities and a subsequent decision by BYDC staff to involve one of the CYDC young people in the response to this incident.
2 Development of risk management strategies for the CYDC young people

This chapter will discuss the initial transfer of the CYDC young people to BYDC as a result of their involvement in the CYDC riot.

2.1 Background

The CYDC riot occurred in the afternoon of 10 November 2016 and involved 20 young people gaining control of the centre. During the course of the CYDC riot the young people were responsible for violent and destructive behaviour resulting in both property damage and physical and psychological injuries to staff.\(^6\)

Three young people (the CYDC young people), were identified as the main instigators and perpetrators of the CYDC riot.

An investigation report completed by the Office of the Chief Inspector, Queensland Corrective Services, regarding the circumstances surrounding the CYDC riot examined the criminal history and behaviour of each of these young people while in detention.

The report noted that one of the young people was the ‘primary instigator’ of the CYDC riot and had multiple admissions to youth detention with a history of violent criminal offending. The report noted that the young person had a history of ‘manipulation, aggression and standover tactics to get his needs met’.\(^7\)

The report noted that a second young person was a ‘close associate’ of the primary instigator and had been involved in ‘a large amount of incidents’ while in youth detention. This young person was identified as ‘a young person who bullies and stands over others, attempts to manipulate people and situations, threatens violence to get what he wants’.\(^8\)

The report noted that during periods of youth detention, the third young person had ‘displayed ongoing inappropriate behaviour and attitude which threatens the safety and security of the centre’. Leading up to the CYDC riot, this young person had been involved in serious incidents at CYDC including violent behaviour towards CYDC staff.\(^9\)

2.2 Accommodation decisions about the CYDC young people

Considering the seriousness of the CYDC riot, the extent of the damage and the severity of injuries to staff, the now former Assistant Director-General\(^10\) decided to transfer the CYDC young people to BYDC. This transfer occurred on 14 November 2016.

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\(^6\) Office of the Chief Inspector, *Investigation into the circumstances surrounding the incident at the Cleveland Youth Detention Centre on 10 November 2016*, p.6.
\(^7\) ibid., p.26.
\(^8\) ibid., p.27.
\(^9\) ibid., pp.26-27.
\(^10\) The Assistant Director-General left the position in February 2018.
During an interview with investigators, the Assistant Director-General noted that his choices about how to manage these young people after the CYDC riot were limited:

I could do nothing but move [the CYDC young people] from Cleveland. There were no options other than to do that. I wouldn't have had a detention centre in Townsville, it would have got closed down ... The community had a massive backlash against those young people staying at Cleveland - the local Townsville people as well. The unions said no one will come to work if ... these kids stay here because of what they did. So frankly, there was no wriggle room for that decision.

Staff at BYDC only had a few days to prepare for the arrival of the three CYDC young people, including determining how these young people would be accommodated at the centre. The now former BYDC Executive Director (Executive Director) told investigators that there was ‘significant angst’ among BYDC staff about the transfer of the three CYDC young people. However, he was also of the view that it was important for BYDC to support the CYDC staff, considering the traumatic event they had just experienced.

Upon arrival at BYDC on 14 November 2016, the CYDC young people were initially accommodated in a unit that was separate from the other accommodation areas. While in this unit, they were not permitted to mix with any other young people at the centre.

During this period, their behaviour and interactions with staff were monitored, risk assessments were conducted and discussions were held about their future accommodation and individual needs. Records show that their behaviour was generally stable, demonstrating compliance with section routines and respectful interactions with staff. The only significant issue that unit staff had to manage during this time was the CYDC young people’s frustration at the time taken to transition them into the centre’s general population.

This frustration came to a head on 22 November 2016. The CYDC young people began kicking the veranda grill and pacing the unit’s common area in an agitated manner. The incident further escalated when one of the young people placed his socks over his fists and another young person paced the section swinging a guitar.

Unit staff withdrew from the common area. A number of staff later entered the common area to engage with the CYDC young people and attempt to calm them down. The young people expressed their frustration at being segregated since they had arrived at BYDC.

Staff eventually managed to de-escalate the situation.

Later that afternoon, the CYDC young people were transferred to a general accommodation unit at BYDC. Two of the young people were placed together in one section of the unit and the third young person was placed in the other section.

The decision to accommodate the CYDC young people together in the same unit was the subject of significant disagreement between staff. The decision appears to have been made by the Unit Manager. During interview, the Unit Manager stated that this decision was based on a desire to confine the level of risk to one unit as well as to allow the CYDC young people to support each other.

However, other staff felt that the level of risk to staff and other young people associated with accommodating the CYDC young people in the same section was unacceptable. In particular, the BYDC Intelligence Officer was opposed to the decision:

I fought black and blue for that not to happen. [The Operations Manager] and I ... we really didn’t want those boys to be accommodated together. The risk was just ridiculous, and [the Unit Manager] and [another Unit Manager] really wanted them together ...
Apparently [unit staff] had put their hands up to say, 'We'll have them.' The risk was extreme, to keep them together ... and I felt that the centre wasn't separating those issues from the risk.

The Intelligence Officer also stated that the incident on 22 November 2016 (the same day that the young people were transferred to the general population) was extremely serious and should have prompted further consideration about the risks of accommodating the young people in the same unit.\(^{17}\)

There'd been a major incident ... where they threatened staff - where the Section Supervisor made the staff retreat into the office, for their safety, because the boys took their socks off, wrapped round their hands and said to the staff, 'Come on, come on, we'll get you.' So, they still got put in [general population] after that, together ... I don't think I've ever heard of, in the 13 years I've been there, of a Section Supervisor telling their staff to retreat to the office, because of their safety. I've never heard it ... it was quite significant. They were angry. They wanted out of [segregation], and for whatever reason, they decided, 'Well, come on, bring it on,' and they literally wrapped their socks around their hands, like boxing gloves and threatened staff, 'Come on, take us on.' Clearly intimidation, but they still [were] all put ... together.

The Executive Director told investigators that he did not have any direct involvement in the decision to place the CYDC young people together.\(^{18}\) During interview, he did not express an opinion about whether placing the CYDC young people in the same unit was the correct or preferable decision, although he did agree that there was significant disagreement between staff regarding the CYDC young people's accommodation options and their involvement in the centre's daily routines and structured day activities.\(^{19}\)

During interview, the Assistant Director-General also declined to express a view about whether the decision was correct as he stated it was an operational decision.\(^{20}\)

In my view, the decision to accommodate the three CYDC young people together in the same unit in the general population was significant. It had serious ramifications, particularly in relation to the incidents that arose during the following months and the perceptions formed among other young people about staff favouritism towards the CYDC young people. These issues are explored further in Chapter 4.

2.3 Planning and risk management strategies for the CYDC young people

Prior to the placement of the CYDC young people in the general population, BYDC officers had identified that all three young people were an 'extreme risk' and were a potential threat to the safety of both staff and other young people. It was also identified that one of the young people held significant influence over the other two young people, and was able to manipulate both of them to commit acts of violence.\(^{21}\)

During interview, the Assistant Director-General spoke about the risks the three CYDC young people, particularly the young person identified as the primary instigator of the CYDC riot, presented and the difficulty in accommodating them in the youth detention environment:\(^{22}\)

\[The young person identified as the primary instigator of the CYDC riot] is in anyone’s imagination a dangerous prisoner ... I’ve got to say it, if he was in an adult system he’d be classified as a dangerous prisoner. But in our system, he can walk openly ...

\(^{17}\) Interview with the Intelligence Officer, 31 July 2017, transcript p.85.
\(^{18}\) Interview with the Executive Director, 30 October 2017, transcript p.20.
\(^{19}\) ibid., transcript pp.20-21.
\(^{20}\) Interview with the Assistant Director-General, 15 November 2017, transcript p.24.
\(^{21}\) ibid., pp.10, 22 and 23.
\(^{22}\) ibid., pp.8 and 10.
Now the level of fear that [this young person] puts into a place like the Brisbane Youth Detention Centre is significant. Not only for the young people concerned, but also the staff. ... Those things all filter down to the staff.

The degree of risk and the potential for the CYDC young people to cause considerable disruption to the order and security of the centre indicated a need for careful planning and communication with unit staff regarding their transition, accommodation, participation in centre routines and risk management strategies.

The department provided investigators with two relevant documents for each of the CYDC young people outlining the strategies developed to manage their transition into BYDC:

- A section based operation framework titled Assessment Phase into BYDC – Section Routines Framework, prepared for each of the CYDC young people on 14 November 2016 (their arrival date) and updated on 16 November 2016 and 22 November 2016. The Routines Framework outlines important information and restrictions for each young person, including their participation in structured day, restricted articles, movement control, required staffing and not to mix information.

- A Support Plan, which provides relevant information about each of the CYDC young people, including information about previous behaviours and strategies for managing their high risk behaviours.

In addition to these documents, the department told investigators that ‘... there was extensive management planning, however much of this occurred in morning briefs which aren’t documented’. During an interview with investigators, the former BYDC Deputy Director confirmed this:

> There was lots of competing ideas about how to manage them, and which section to put them in. Lots of meetings occurred – it was almost day by day. Morning brief[ing] often extended into a case discussion. We didn’t minute morning briefs, but we were [discussing how to manage the young people] day by day, basically, at that point.

A number of BYDC officers advised investigators that significant effort was spent putting together a plan for the CYDC young people’s transition to BYDC and developing strategies to ensure they could be safely accommodated in the general population. However, without documentation of this planning process, investigators were unable to confirm the outcomes of these meetings, the strategies implemented or which officers were involved.

**Opinion 1**

Extensive planning discussions about how to manage the CYDC young people were not documented by BYDC officers, despite the extreme risk the CYDC young people posed to the safety and security of the centre.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

It does not appear that staff from the accommodation unit where the CYDC young people were eventually placed had any significant involvement in the development of the frameworks outlined above. During interview, none of the staff from this unit identified any involvement in the planning process for the CYDC young people’s transition to the general population. The framework documents indicate that planning was the responsibility of members of the Special Interest Young People (SIYP) multidisciplinary team. According to

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23 Email from DJAG to the Office of the Queensland Ombudsman, 28 September 2017.
24 The Deputy Director left BYDC in April 2017 for another position within the department.
25 Interview with the Deputy Director, 27 October 2017, p.21.
the Youth Detention Centre Operations Manual, membership of the SIYP multidisciplinary team is the responsibility of the Executive Director, but does not generally include unit staff.26

If unit staff were not involved in the risk management planning for the CYDC young people’s transition to the general population, the communication of these plans was of critical importance. In this regard, there are a number of noteworthy strategies documented in the frameworks outlined above:

- The CYDC young people were initially restricted from participating in structured day activities and were to be managed ‘in section’ (that is, restricted to the relevant section of their unit). These restrictions were to continue until appropriate transition and staffing arrangements were negotiated with the Department of Education in relation to their attendance at the school within BYDC.

- The CYDC young people were restricted from mixing as a group. This was an important risk management strategy given that one of the young people had been identified as holding a significant and negative influence over the other two young people, including having previously orchestrated incidents involving both young people at CYDC.

- Unit staff were to be briefed at the commencement of their shift about the management strategies in the section framework, as well as their responsibility to report behaviour and intelligence concerns to the Section Supervisor.

Investigators asked staff from the accommodation unit where the CYDC young people were placed about their knowledge of any specific plans or management strategies that were in place for the CYDC young people while accommodated in their unit. Generally, unit staff did not demonstrate any detailed knowledge of specific management strategy or plans for the CYDC young people. 27

In particular, none of the youth workers from the unit appeared aware of, or indicated they had read, the Section Routine Framework that had been developed for each of the CYDC young people. This is despite the specific instruction in each of the Section Routine Frameworks that unit staff were to be briefed at the commencement of their shift in relation to the management strategies outlined in the framework.

The only unit staff member who spoke about restrictions on the movement and mixing of the CYDC young people which were outlined in the Section Routine Frameworks was a Section Supervisor.28 This Section Supervisor also indicated awareness about restrictions on access to education programs by the CYDC young people while they were being risk assessed.29 In contrast, another Section Supervisor told investigators that the CYDC young people were managed the same as any other young person in the unit.30

It was also apparent to investigators that many staff were not aware of the ‘extreme risk’ that the CYDC young people had been assessed as presenting. There appeared to be a lack of appreciation by some staff that the CYDC young people had a history of violent, unprovoked attacks, particularly targeted at staff. This was evident during the incident on 22 November 2016 when threats of violence from the CYDC young people resulted in staff having to withdraw from the common area. Despite the seriousness of this incident and the fact that it occurred because the CYDC young people were frustrated at being segregated, they were transferred to the general population soon after.

26 Youth Detention Operations Manual, Chapter 1 – Care and management of young people, p.41.
27 Interview with a Section Supervisor, 14 September 2017, transcript p.34; Interview with a Section Supervisor, 4 October 2017, audio 17:25; and Interview with a BYDC officer, 4 October 2017, audio 9:51.
28 Interview with a Section Supervisor, 12 September 2017, transcript pp.31-32.
29 Ibid., p.11.
30 Interview with a Section Supervisor, 14 September 2017, transcript p.34.
Given this, it appears that the transfer of the CYDC young people into the general population immediately after this incident occurred suggests some minimisation by staff of the seriousness of this incident and the danger it posed to the safety of unit staff.

The evidence provided by relevant BYDC staff demonstrates that vital information regarding the risks posed by the CYDC young people and the management strategies that had been developed to ensure the safety of staff and other young people was either not communicated to relevant unit staff, or was not adequately emphasised.

Further supporting this view was the fact that one CYDC young person was engaged in structured day activities within two days of entering general population without any evidence of consideration of the restrictions set out in the Section Routine Frameworks.

During interviews, BYDC management emphasised the effort that went into developing strategies to manage CYDC young people. However, staff who worked directly with these young people were unable to demonstrate an awareness of these strategies. In such circumstances, the risk assessments and strategies developed in response to the need to accommodate the CYDC young people at BYDC appear to have been of little value.

**Opinion 2**

While BYDC did develop and document frameworks and plans for managing the CYDC young people, BYDC failed to:

a) communicate these frameworks and plans to staff working in the unit where the CYDC young people were accommodated

b) ensure these frameworks and plans were adequately implemented.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

**Recommendation 1**

The Director-General of the department:

a) identify and implement necessary improvements to the process for developing and documenting risk management strategies for managing high risk young people

b) review methods of communicating risk management strategies to staff working with high risk young people to ensure they have a sufficient knowledge of documented plans to manage particular high risk young people.
In response to Recommendation 1 and the issues raised in this chapter, the Director-General of the department advised:

This recommendation is closely aligned with, and will be actioned through the implementation of recommendations made by the Independent Review of Youth Detention Centres in Queensland [Youth Detention Review]. Specifically, Work Program 3 - Positive behaviour management and incident prevention.

The department is actively exploring how to better assist young people to manage their misbehaviour, specifically through restorative practices, the expansion of the on-centre behaviour support teams, the introduction of strengthened rewards and incentives programs and the review of the existing behaviour development model. The new model will ensure an effective, therapeutic and trauma-informed approach to managing the behaviour of all young people. In addition to this, training is currently being delivered to a range of professional and operational staff by the Queensland Centre for Mental Health Learning.

The department is also undertaking work to validate an evidence based risk assessment tool, which has been developed with the intention of providing a proactive strategy to assist with reducing the likelihood of serious incidents occurring in Queensland youth detention centres. This tool will provide a consistent framework for understanding and managing the individual risk needs of young people.

To support the above processes, appropriate implementation strategies for the new models will be developed – including processes that ensure staff are aware of and know how to access and use the new plans and assessments in their day to day management of young people.

Once developed, the new behaviour development model will be incorporated into the existing Detention Centre Operational Information System (DCOIS). DCOIS is available to all operational staff (and others) within youth detention centres and at a minimum has been designed to enable staff to access pertinent information relevant to their role and to the management of young people.

Given the nature of the youth detention environment, there may be young people who require specific management to reduce risks to themselves, other young people, centre staff and property. If a young person is assessed as posing a risk to the safety and security of the centre they will become subject to the Special interest Young Person (SIYP) list.

All young people transferred from CYDC were subject to this process. Risk-related information was available to staff and management plans were reviewed by the SIYP multi-disciplinary panel to inform their safe care and management.

I note the Director-General’s response.

However, I observe, as outlined above, that the SIYP panel process did not appear to work effectively in regard to the CYDC young people in the circumstances.
3 Pool rooftop incident

This chapter discusses the pool rooftop incident which occurred at BYDC on 24 November 2016.

3.1 Background

The following chronology of the pool rooftop incident has been gathered from a review of the incident report, associated occurrence reports, CCTV of the incident and interviews with relevant BYDC staff and young people.

At approximately 11.20am on 24 November 2016, two young people absconded from a program during structured day activities and climbed onto the pool fence before making their way across to the roof of a nearby building. A code green (escape or abscond) followed by a code olive (young person on roof) was called. CCTV cameras were focused on the pool area to ensure continual footage of the pool rooftop incident.

After the code olive was called, a Shift Supervisor became the designated incident controller, assuming operational control and responsibility for key leadership and decision-making during the incident.

Immediately prior to the incident, a number of young people, including one CYDC young person, were participating in structured day activities. When the code green was called, emergency processes commenced with all young people gathering at set meeting points across the centre in order to be escorted and secured in their rooms.

At 11.34am, approximately 14 minutes after the initial code green was called, CCTV footage shows a CYDC young person being escorted by a Section Supervisor into the pool area to a spot underneath where the young people were located on the roof. The CYDC young person appeared to begin talking to the young people on the roof. The Section Supervisor positioned himself in a doorway near the CYDC young person.

A number of BYDC staff members can be seen on the CCTV footage walking in and around the pool area while the CYDC young person was talking to the young people on the roof.

Almost immediately, one of the young people on the roof moved away from the conversation with the CYDC young person, but the other young person continued to engage. After speaking to the CYDC young person for approximately two minutes, this young person also moved away but appeared to still engage in periodic conversation.

After approximately five minutes, both young people moved to the other end of the roof, ending the conversation with the CYDC young person. At approximately 11.40am the CYDC young person was escorted out of the pool area by the Section Supervisor. The incident ended at approximately 3.00pm after the two young people voluntarily came down from the roof.

Following the incident, an incident report and 16 supporting occurrence reports were completed by relevant staff. However, neither the incident report nor any of the occurrence reports mentioned the CYDC young person’s involvement.

The role of incident controller during the pool rooftop incident was shared between two Shift Supervisors. Only one of these Shift Supervisors is mentioned in this chapter.
The CCTV footage was preserved soon after the incident, although the CYDC young person’s involvement had not been identified at that time.

It was not until inspectors from the Youth Detention Inspectorate (an internal departmental team that reports to the Director-General and conducts quarterly inspections and monitoring of youth detention centres) conducted their quarterly inspection of BYDC in February 2017 that the CYDC young person’s involvement in the pool rooftop incident was raised by BYDC staff and young people. The Youth Detention Inspectorate subsequently produced an inspection report dated March 2017 which was provided to the Assistant Director-General noting the following:32

... this incident saw young persons ... scale the sports centre roof via the pool fence. Inspectors were advised by staff and young people that [the CYDC young person] ... had been used by staff to intimidate the two BYDC young people down from the roof (a mere 14 days after that riot, and only 2 days after placement in the BYDC general population).

... Review comments on DCOIS [Detention Centre Operational Information System] state that CCTV footage for the incident had been downloaded. BYDC has not advised the Inspectorate whether the footage had been viewed at the time of the incident and/or whether any concerns were identified.

After the inspection inspectors requested and obtained footage of the incident. The following concerns were readily apparent (and were referred to the ADG YJ [Assistant Director-General Youth Justice] once BYDC had confirmed the identity of [the CYDC young person]):

• Staff apparently using a young person to perform a staff role – wellbeing and duty of care issues abound;
• [The CYDC young person] allegedly having [been involved in] the worst riot in Queensland youth detention history only two weeks beforehand;
• Young people and staff raised concerns that [the CYDC young person] had tried to threaten [the two young people] off the roof, but ended up asking the pair how they had gotten up there – a clear security risk for a copycat riot at BYDC ...;
• None of the numerous staff present during the incident referred to [the CYDC young person] in their reports;
• There is no entry in the [unit] logbook indicating [the CYDC young person’s] absence or return to [his] unit at the relevant times and there is no reference to [the CYDC young person’s] presence at the pool area [or] in officer reports related to the matter. Intel Officers at BYDC are of the view that this action by [the Section Supervisor] was a significant factor in the build up to the subsequent ‘code black’ event [BYDC riot] at BYDC on [30 January 2017]. Duty of care issues are noted as staff may have potentially been using the YP to do a staff role suggesting a wider enforcement issue and security risk as [the CYDC young person] was [involved in] the CYDC riot on 10/11/16.

The Youth Detention Inspectorate referred the specific allegations against the Shift Supervisor who had been the incident controller and the Section Supervisor to the CCC on 19 April 2017. This referral stated:33

The Informant raises concerns that on 24/11/2016, [the Section Supervisor] under the instruction of [the Shift Supervisor], assisted [the CYDC young person] to be brought down to the pool area which was the location of an ‘in progress roof incident’ with a view to intimidating the offending [young people] off the roof. Section logs do not reflect [the CYDC young person’s] absence or return to [his] unit at the relevant times and there is no reference to [the CYDC young person’s] presence at the pool area [or] in officer reports related to the matter. Intel Officers at BYDC are of the view that this action by [the Section Supervisor] was a significant factor in the build up to the subsequent ‘code black’ event [BYDC riot] at BYDC on [30 January 2017]. Duty of care issues are noted as staff may have potentially been using the YP to do a staff role suggesting a wider enforcement issue and security risk as [the CYDC young person] was [involved in] the CYDC riot on 10/11/16.

33 Department of Justice and Attorney-General, Report suspected corruption, 19 April 2017.
On 15 May 2017, the CCC referred the following allegations about the conduct of the Shift Supervisor and the Section Supervisor during the pool rooftop incident to this Office for investigation:

1. It is alleged [the Shift Supervisor] ordered another custodial officer, [the Section Supervisor], to move a young person [a CYDC young person] to threaten another young person who was protesting on a roof. The threats were designed to have the young person come off the roof. The [CYDC young person] had been one involved in the riots at the Cleveland Youth Detention Centre. No record of his use was made.

2. It is alleged [the Section Supervisor] facilitated the movement of a youth detainee known as a [CYDC young person] to another area within the detention centre with the purpose of threatening another two young people who were conducting a roof top protest. No record was made of the movement of this young person.

### 3.2 Involvement of the CYDC young person in the response to the pool rooftop incident

Investigators from this Office interviewed a number of BYDC staff and young people in order to determine:

- which officer or officers made the decision to involve the CYDC young person in the response to the pool rooftop incident
- the purpose for involving the CYDC young person in the response to the pool rooftop incident
- what the CYDC young person said to the two young people while they were on the roof.

#### 3.2.1 Who made the decision to involve the CYDC young person in the response to the pool rooftop incident?

In order to determine who made the decision to involve the CYDC young person, a number of BYDC staff, including the Shift Supervisor and the Section Supervisor, were interviewed by investigators.

Investigators interviewed two staff members who reported having conversations with the Shift Supervisor where the Shift Supervisor allegedly confirmed their role in involving the CYDC young person in the incident response.

Firstly, the Intelligence Officer, who was monitoring a separate incident nearby at the same time as the pool rooftop incident, stated that they overheard the Shift Supervisor make reference to having the CYDC young person taken down to the pool rooftop incident. The Intelligence Officer told investigators they approached the Shift Supervisor while the incident was occurring to question why the Shift Supervisor had involved the CYDC young person and that the Shift Supervisor had bragged about the decision.

Secondly, a BYDC Psychologist stated that they became aware of the CYDC young person’s involvement after the incident. In March 2017, the Psychologist was attending an SIYP meeting with the Shift Supervisor and other staff members, where the conflict between the CYDC young people and other young people at BYDC and the emerging perceptions of favouritism were being discussed. The Psychologist raised the CYDC young person’s involvement in the pool rooftop incident and told the Shift Supervisor ‘... it’s behaviour like that that has reinforced that [staff favouritism of the CYDC young people] for these boys’.

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35 Interview with the Intelligence Officer, 31 July 2017, transcript pp.10-11.
36 ibid., p.11.
The Psychologist told investigators that the Shift Supervisor confirmed that they had made the decision to use the CYDC young person in the pool rooftop incident and had said ‘yes I did that, I’ve been doing it for years [because] it can help if you’ve got a [young] person to talk down [from a roof] another [young] person’.38

Investigators then interviewed the Section Supervisor who stated they were assembling young people immediately after the code olive was called when they were approached by the Shift Supervisor, who was both the Section Supervisor’s supervisor and the incident controller.39 The Section Supervisor stated that the Shift Supervisor asked them to escort the CYDC young person to the pool so he could talk to the young people on the roof.40

The Section Supervisor told investigators they escorted the CYDC young person to the pool area so he could talk to the two young people on the roof and then remained within earshot of the conversation between the young people at all times. At the conclusion of the conversation, they escorted the CYDC young person back to his accommodation unit so he could be secured in his room.41

In response to their involvement, the Section Supervisor stated they had not ‘used YP’s [young people] to encourage peers off any roofs in my youth detention career spanning 20 years’.42 The Section Supervisor further emphasised they had no role in the decision to use the CYDC young person as part of the incident response and was following directions from their supervisor, the Shift Supervisor.43

... I was merely following my supervisors’ direction to take him to the pool ... as the direction came from the S/S [Shift Supervisor] Incident Controller I concluded that the direction to move [the CYDC young person] formed part of the direction re [the CYDC young person] ... I follow directions from my supervisors, as I would expect no less from my subordinates ...

During interview, the Shift Supervisor told investigators they could not recall specifically directing the Section Supervisor to escort the CYDC young person to where the pool rooftop incident was occurring so he could speak to the young people on the roof.44 The Shift Supervisor recalled they approached the Section Supervisor to ask the Section Supervisor attend the pool rooftop incident to try to persuade the young people to come down from the roof, and that the Section Supervisor took the CYDC young person.45 The Shift Supervisor stated they had no direct engagement or communication with the CYDC young person and did not ask the CYDC young person to assist with the pool rooftop incident.46

The Shift Supervisor was also unable to recall which officer had been responsible for the decision to use the CYDC young person and provided investigators with a number of explanations about how the CYDC young person may have become involved in the response to the pool rooftop incident.

Specifically, the Shift Supervisor told investigators that the decision to use the CYDC young person in the response to the incident may have been the Section Supervisor’s decision.47 The Shift Supervisor then stated they did not want to ‘drop [the Section Supervisor] into it, because I really can’t remember ...’.48 The Shift Supervisor then told investigators they also may have been provided with permission to use the CYDC young person by the Deputy Director.49

38 ibid., p.58.
39 Interview with the Section Supervisor, 14 September 2017, transcript p.11.
40 ibid., p.15.
41 ibid., pp.11 and 15.
42 Letter from the Section Supervisor to the Ombudsman, 14 August 2018.
43 ibid.
44 Interview with the Shift Supervisor, 17 November 2017, transcript p.11.
45 ibid., p.10.
46 Letter from the Shift Supervisor to the Ombudsman, 16 August 2018.
47 Interview with the Shift Supervisor, 17 November 2017, transcript p.12.
48 ibid.
49 ibid.
The Shift Supervisor did concede that ‘as the incident controller, [the Shift Supervisor] permitted [the Section Supervisor] to allow the CYDC young person to assist [the Section Supervisor] in terms of promoting a peaceful resolution and de-escalation of the [pool rooftop] incident’. 50

In response to the allegation by the Shift Supervisor, the Deputy Director told investigators they had not been aware of the CYDC young person’s involvement in the pool rooftop incident until they were advised of it during an interview with investigators from this Office. 51

Finally, investigators interviewed the CYDC young person and asked him about his involvement. The CYDC young person stated he became involved after he realised that his structured day activities were being impacted by the incident and because the young people on the roof were from his section, he offered to help staff persuade them to come down. The CYDC young person denied that any staff member asked him to speak to either young person on the roof. 52

In analysing the available evidence outlined above, I reach the following conclusions:

• the only officers identified as being involved in the decision to use the CYDC young person during the pool rooftop incident were the Shift Supervisor and the Section Supervisor

• witnesses who could recall the use of the CYDC young person during the pool rooftop incident, or who had subsequently had discussions about the pool rooftop incident, identified the Shift Supervisor as the decision-maker and the Section Supervisor as the officer who escorted the CYDC young person to the pool area

• evidence from the Section Supervisor is consistent with them having escorted the CYDC young person to where the pool rooftop incident was occurring

• evidence from the Section Supervisor is consistent with witness accounts that the Shift Supervisor made the decision to use the CYDC young person during the pool rooftop incident response

• evidence from the CYDC young person was that he volunteered to assist and was not asked; however, the decision and action to escort him to where the incident was occurring rested with BYDC staff

• the only contrary evidence that suggests the decision to use the CYDC young person may have been made by someone else was from the Shift Supervisor, who identified both the Section Supervisor and the Deputy Director as potential alternative decision-makers.

Having regard to these conclusions, I form the following opinion.

**Opinion 3**

Based on the available evidence, it is likely that:

a) the Shift Supervisor allowed a CYDC young person to speak to two young people on the roof as part of the response to the pool rooftop incident

b) the Section Supervisor escorted a CYDC young person to where the pool rooftop incident was occurring and this was done with the Shift Supervisor’s knowledge and approval.

50 Letter from the Shift Supervisor to the Ombudsman, 16 August 2018.
51 Interview with the Deputy Director, 27 October 2017, transcript p.42.
52 Interview with a CYDC young person, 19 April 2018, transcript p.6.
In response to Opinion 3 the Director-General of the department advised:

The department proactively refers all matters of alleged misconduct to the Professional Standards unit for subsequent assessment and referral.

I note the Director-General’s response.

3.2.2 Why was the CYDC young person involved in the pool rooftop incident?

In light of the findings above, the investigation considered the reasons for the CYDC young person’s involvement in the pool rooftop incident. Determination of this issue is necessary to address the allegation raised in the CCC referral that staff involved the CYDC young person in the pool rooftop incident for the purpose of threatening the young people on the roof to come down.

In response to this allegation, I considered the following evidence:

- the absence of any documentary evidence regarding the reason for the CYDC young person’s involvement or referencing his involvement in any way
- the Section Supervisor’s evidence that the CYDC young person was nearby when they were approached by the Shift Supervisor and that the CYDC young person was accommodated in the same section as the two young people on the roof
- the Section Supervisor’s denial that the CYDC young person was involved for the purpose of threatening the young people on the roof
- the Shift Supervisor’s inability to recall making the decision to involve the CYDC young person in response to the incident
- the Shift Supervisor’s evidence they had used young people to respond to rooftop incidents in the past where there was a rapport between the young people, and that peer persuasion had been effective in resolving these incidents
- the CYDC young person’s evidence that his involvement was largely at his initiative in an effort to resume structured day activities as soon as possible and to minimise the impact of the incident on his section
- the CYDC young person’s denial he was asked by any staff member to attend the pool rooftop incident.

A number of BYDC staff advised investigators that using young people to speak to other young people involved in rooftop incidents had occurred previously at the centre with some success. However, these staff emphasised that the young people chosen in these instances were young people who had a family connection or close rapport with the young person on the roof.

In particular, the Shift Supervisor told investigators they had previously used young people in responding to rooftop incidents where there was strong rapport to help convince a young person to safely come down from a roof:

In the matter of a roof incident, the best possible scenario is to get them [the young person] down as quickly as possible, and we haven’t got really any specific practices in getting kids off roofs. Obviously, we’ve got a large number of people. It’s probably mitigating risk to the young people, obviously, that are on the roof, damage to centre

53 Interview with the Section Supervisor, 14 September 2017, transcript p.18.
54 ibid., p.14.
55 See for example Interview with the Section Supervisor, 14 September 2017, transcript p.23 and Interview with the Deputy Director, 27 October 2017, transcript p.30.
56 Interview with the Shift Supervisor, 17 November 2017, transcript p.11.
property and also just making sure that all young people return to section safely, obviously, and staff safety as well ... there have been many incidents, previously, where I’ve used young people to - well, help encourage young people to get off, obviously through rapport or family members, to say, ‘Come on,’ sort of thing.

The Shift Supervisor further stated that this tactic had proved successful in peacefully resolving roof-top incidents:

... the assistance of young people in similar situations ... has been highly successful in terms of negotiating peaceful outcomes with other young person's [sic] when they are distressed and when they have been involved in similar incidents. When [I have] acted in a similar or identical manner in the past, [my] superior officers including the Executive Director and Deputy Director have commended [me] with respect to [my] actions and efforts and the peaceful outcomes [I] achieved without the use of any force.

The Deputy Director told investigators that the Shift Supervisor had previously had success in using a young person to encourage another young person to come down from a roof. However, the Deputy Director acknowledged that it was a controversial technique and that it was important that there was a good rapport between the young people involved.

The Executive Director denied any knowledge of staff engaging young people to assist during rooftop incidents. The Executive Director did recall one incident when a young person told another young person to come down from the top of some shipping containers, but denied he had ever heard of staff using a young person during a rooftop response.

I note that although the CYDC young person and the young people on the roof were accommodated in the same section, there is no other evidence that the CYDC young person had any rapport or familial relationship with either young person on the roof that may have justified his involvement. With regard to this issue, I also note that:

- during interview, one of the young people on the roof denied to investigators that he knew the CYDC young person at the time of the pool rooftop incident
- the CYDC young person had been accommodated in the same section as the young people on the roof for less than two days before the pool rooftop incident occurred. Before this time, the CYDC young person had been segregated and had not mixed with any young people since his arrival at BYDC on 14 November 2016
- no BYDC officers were able to provide evidence of any rapport between the CYDC young person and the young people on the roof.

However, despite the clear lack of any rapport between the young people, there is no clear evidence that the CYDC young person’s involvement in the pool rooftop incident was for the explicit purpose of threatening or intimidating the young people on the roof. I note that the use of young people in response to rooftop incidents appears to have occurred in the past with the knowledge of the Deputy Director.

Accordingly, I cannot be satisfied based on the evidence available that in this case the CYDC young person’s involvement was directed by a staff member for an improper purpose.

**Opinion 4**

The allegation that BYDC staff involved a CYDC young person in the pool rooftop incident for the purpose of threatening the young people on the roof is not substantiated.

57 Letter from the Shift Supervisor to the Ombudsman, 16 August 2018.
58 Interview with the Deputy Director, 27 October 2017, transcript pp.30-31.
59 Interview with the Executive Director, 30 October 2017, transcript p.38.
60 Interview with a young person, 14 July 2017, transcript p.7.
3.2.3 Interaction between the CYDC young person and the young people on the roof

The investigation sought to determine whether the CYDC young person made threats towards the young people on the roof. Investigators therefore attempted to ascertain what transpired during the interaction between the CYDC young person and the young people on the roof.

There is no audio recording of the conversation between the CYDC young person and the young people on the roof. The CCTV footage of the incident appears to show the Section Supervisor standing within earshot of the CYDC young person as he was speaking with the young people on the roof. The CCTV footage also shows that one of the young people refused to engage in conversation with the CYDC young person and walked away to the other end of the roof. The other young person appears to engage in conversation with the CYDC young person for approximately five minutes.

One of the young people told investigators that during their conversation, the CYDC young person asked him to come down from the roof. He also stated that the CYDC young person told him that he was going to climb up onto the roof and ‘slap’ both him and the other young person.61

I note that the evidence provided to investigators by this young person is consistent with the information he provided to a BYDC Unit Manager on 11 April 2017 when he was questioned about the pool rooftop incident at the request of inspectors from the Youth Detention Inspectorate. During that conversation, the young person advised the Unit Manager that the CYDC young person had threatened to get onto the roof and hit him if he did not get down.62

This is also consistent with evidence provided by the other young person to the same Unit Manager, who stated that the CYDC young person had threatened them if they did not get off the roof.63 This young person was unable to be interviewed by investigators about the pool rooftop incident as he had been released from BYDC.

During interview, the Section Supervisor confirmed they were within earshot of the conversation between the CYDC young person and the young people on the roof at all times. He recounted their conversation as follows:64

He [the CYDC young person] just said to [the young people on the roof], he said, ‘Just come down, because we don’t want to get locked down.’ In an incident like that, because all the staff need to … attend there, all the kids have to be locked down. That’s the whole Centre. The whole Centre has to lock down.

In general, how long they stay there [on the roof], that’s how long they’re staying in [their rooms]. And [one of the young people] says, ‘Oh, I’ll come down soon. Half an hour, an hour.’ That’s what he said. And that was it. I said, ‘All right, then.’ Then we left. That’s all it was. There was nothing else … He was just saying, ‘Please come down. We don’t want to get locked down.’ That’s all it is.

The Section Supervisor was specifically asked whether they heard the CYDC young person make any threats towards the young people on the roof. The Section Supervisor stated they had heard the whole conversation between the young people and denied that the CYDC young person had made any threats:65

No, there was nothing malice in it. It was just talk. You know … and as I said, [a young person on the roof] was saying, ‘Ok, I’ll come down … soon.’ That’s what he said.

61 Interview with a young person, 14 July 2017, transcript p.4.
62 Email from a Unit Manager to the MMC, 11 April 2017.
63 Ibid.
64 Interview with the Section Supervisor, 14 September 2017, transcript pp.29-30.
Despite CCTV footage showing other BYDC officers in the vicinity of the incident, all other BYDC staff members interviewed denied overhearing the conversation between the young people.

At interview, the CYDC young person provided an account of his involvement. When asked what he said to the young people on the roof, he stated that he just asked them to come down.\textsuperscript{66} He could not recall anything else that he said to the young people during the course of the conversation.\textsuperscript{67}

Given the conflicting accounts of the conversation between the CYDC young person and the young people on the roof during the pool rooftop incident, I am unable to make a finding as to the exact nature of the exchange. While it is accepted that the CYDC young person did request that the young people come down from the roof, I am unable to substantiate whether this request included accompanying threats.

\begin{quote}
\textbf{Opinion 5}

There is insufficient evidence to establish whether the CYDC young person made threats towards the young people on the roof during the pool rooftop incident.
\end{quote}

\subsection{3.2.4 The risks of involving the CYDC young person in the response to the pool rooftop incident}

The CYDC young person involved in the pool rooftop incident had a history of violent and intimidating behaviour towards other young people and staff, both at BYDC and CYDC. Two weeks prior to the pool rooftop incident, he had been involved in one of the most serious riots in the history of youth detention in Queensland at CYDC. Accordingly, significant risks to the security of BYDC, as well as the safety of staff and other young people, were associated with using the CYDC young person in the response to the pool rooftop incident.

The risks posed by the CYDC young person were reflected in his Section Routine Framework. This framework assessed him as an ‘extreme risk’. I have made comment about the adequacy of communication of this assessment to unit staff generally in Chapter 2.

The CYDC young person had only been at BYDC for 10 days when the pool rooftop incident occurred, and had only been accommodated in the general population for two days. I am of the view that this is an inadequate period of time for staff to have formed a considered view about how the CYDC young person would react when responding to a significant incident.

In particular, staff did not have sufficient time to develop a rapport with the CYDC young person which may have provided them with more control and insight into the predictability of his behaviour. I also note that only two days prior to the pool rooftop incident, the CYDC young people had threatened staff in a separate incident while they were still segregated.

The Section Supervisor who escorted the CYDC young person to the pool area disputed these findings. The Section Supervisor stated they had become familiar with the CYDC young person when he had been detained in BYDC previously:\textsuperscript{68}

\begin{quote}
He [the CYDC young person] came from CYDC in similar circumstances [previously], to my recollection he was polite and respectful because we showed him the same. He said he preferred BYDC staff to CYDC as we treated him like a young man. When [the CYDC young person] was admitted to [general population] on 22 November 2016 most staff knew him from his previous stay and were familiar with approaches, triggers and what was important to him.
\end{quote}

\textsuperscript{66} Interview with a CYDC young person, 19 April 2017, transcript p.4.

\textsuperscript{67} Ibid., p.5.

\textsuperscript{68} Letter from the Section Supervisor to the Ombudsman, 14 August 2018.
Given the rapport built with the CYDC young person during this previous stay at BYDC, the Section Supervisor stated there was no risk in escorting the CYDC young person to the pool area.\(^69\)

I reject the assertion that the use of [the CYDC young person] in the response to the incident failed to take into account ‘the significant risk he posed to the safety and security of the centre’. I dispute not only the assertion that [the CYDC young person] did constitute a ‘significant risk’ but also that the use of him in the incident posed a risk to the safety and security of the centre. My 20 years of experience in this job provides me with the confidence that the decision I made was the right choice. Furthermore, the rapport that I had with [the CYDC young person] was not just built on the 22nd of November, 2016. [The CYDC young person] had resided in my [accommodation unit] previously … Therefore, the rapport and respect that [the CYDC young person] presented was enough for me to make that judgement call, bearing in mind the safety and security risks involved.

I disagree with this view, having regard to the issues outlined in this chapter. I also note again the views expressed by the Assistant Director-General,\(^70\) the information outlined in the Chief Inspector’s report about the CYDC riot\(^71\) and the Section Routine Framework prepared by BYDC staff,\(^72\) regarding the identified risks posed by the CYDC young person.

**Opinion 6**

The decision to use the CYDC young person in the response to the pool rooftop incident failed to consider the significant risk he posed to the safety and security of BYDC.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

In response to Opinion 6 the Director-General of the department advised:

The department proactively refers all matters of alleged misconduct to the Professional Standards unit for subsequent assessment and referral.

I note the Director-General’s response.

Significantly, it appears that the CYDC young person’s participation in the pool rooftop incident, in circumstances where there was no established rapport with the other young people involved, led some young people to form a view that the CYDC young person had a certain standing and relationship with staff. In particular, it raised the profile of the CYDC young person and the other CYDC young people within BYDC and encouraged a perception among many young people that they were favoured by staff.

The use of the CYDC young person in this incident, in combination with further events that occurred over the following weeks, had significant flow on effects for the events at BYDC during December 2016 and January 2017. These consequences are discussed further in Part 2 of this report.

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\(^{69}\) ibid.

\(^{70}\) See section 2.3.

\(^{71}\) See section 2.1.

\(^{72}\) See section 2.3.
3.3 The use of uninvolved young people in rooftop incidents generally

Prior to the pool rooftop incident there was no written policy in place at BYDC about the use of uninvolved young people in incidents. While investigating the pool rooftop incident, it became clear that the use of young people as ‘negotiators’ during rooftop incidents at BYDC had occurred previously and with the knowledge of some senior staff, including the Deputy Director.\textsuperscript{73}

However, the Executive Director denied any knowledge of uninvolved young people being used in previous incident responses. During interview, the Executive Director stated that in his view, this practice was inappropriate:\textsuperscript{74}

\begin{quote}
I was pretty astounded that that should occur and it wouldn’t be something that would normally happen and it wouldn’t be something that I would consider to be appropriate to happen.
\end{quote}

The Assistant Director-General also denied any knowledge of the practice of using uninvolved young people to assist in a rooftop incident:\textsuperscript{75}

\begin{quote}
Well it’s never been the practice to use a child to get down another child from the roof ... I’ve never seen it happen. I don’t know if it’s ever been done before. It’s not a common practice to go and get a young person to get another person down from the roof. But once a code’s called and a person’s on the roof, there are certain procedures that have to go into place. None of those incorporate the use of a young person.
\end{quote}

In response to the Youth Detention Inspectorate’s March 2017 Quarterly Report, which noted the use of the CYDC young person in the pool rooftop incident, the Executive Director issued a directive on 21 April 2017. The directive applied to all operational staff and stated the following:

\begin{quote}
I am directing that young people should not be used to negotiate with other young people during incidents and this practice is to cease immediately. Any further continuance of this practice will be considered misconduct, and referred to appropriate authorities for investigation.

It has come to my notice that staff have been using some young people to negotiate with other young people during an incident, particularly roof incidents. The reasoning behind this is that some young people not involved in the incident may be able to influence the others to cease their behaviour.

While young people may be able to assist in some circumstances, it remains the responsibility of staff to negotiate and de-escalate behaviours, and not young people. By arranging and/or facilitating this, staff are placing those young people at risk of abuse, and empowering them with an authority and influence that is neither appropriate nor acceptable.

The practice also places staff at risk of potential complaint, and diminishes their standing, integrity and trustworthiness as regarded by young people.

During interview, the Executive Director clarified that he issued the directive in the absence of a specific policy or procedure to make it clear to staff that the use of young people during codes was unacceptable.\textsuperscript{76}
\end{quote}

\textsuperscript{73} Interview with the Deputy Director, 27 October 2017, transcript pp.30-31; and Interview with the Intelligence Officer, 31 July 2017, pp.12-13.
\textsuperscript{74} Interview with the Executive Director, 30 October 2017, transcript p.41.
\textsuperscript{75} Interview with the Assistant Director-General, 15 November 2017, transcript pp.33-34.
\textsuperscript{76} Interview with the Executive Director, 30 October 2017, transcript p.46.
I think we won’t find in any policy or practice document, explicitly stating that that’s not to occur. Part of the reason why I produced the directive, because then that put it beyond doubt that that’s not appropriate and shouldn’t occur because it’s not in policy. So you know it’s one of those things that you assume shouldn’t happen, so you don’t need to explicitly write it in a document and if you were to write in those documents everything that you’re not explicitly not meant to do, they’re documents about things you should do, not necessarily about things you shouldn’t do.

While the directive from the Executive Director has addressed the issue of using young people in incidents at BYDC, it is also important that it is made clear that this practice is unacceptable in youth detention centres generally.

**Recommendation 2**

The Director-General of the department ensure that a directive prohibiting the use of young people in response to incidents is published in all Queensland youth detention centres.

In response to Recommendation 2 the Director-General of the department advised:

As outlined by the Ombudsman, the BYDC Executive Director issued a directive in April 2017 in response to the Youth Detention Inspectorate’s March 2017 Quarterly Report. This addressed the issue of BYDC staff utilising young people in response to incidents and ensured staff were explicitly aware that this practice is neither appropriate nor acceptable. Since this time, there have been no other identified incidents where staff have engaged uninvolved young people. It should be noted that the practice of engaging uninvolved young people has never been sanctioned by the department. It is accepted that the provision of a similar directive would ensure absolute clarity across both youth detention centres.

Since July 2018 the department has strengthened policies and procedures to support a dedicated command post to be utilised during incidents as part of recommendation 8 of the Chief Inspectors review of Brisbane Youth Detention Centre (BYDC) finalised on 12 May 2017. A command post provides a mechanism for incident response staff and management to coordinate, plan and discuss the ongoing response during an incident.

In response to recommendations made by [the Youth Detention Review] complex incident management and command training has been delivered, in partnership with the Queensland Police Service (QPS) to operational youth detention staff at CYDC. This training will also be provided to BYDC staff and includes specialist training related to:

- Situational awareness
- Role of intelligence during an incident
- Decision making under stress
- Role of incident controller
- Incident Handover

This has been complemented by updated local agreements with the QPS to improve critical incident management and clarification about when and how the QPS can support the centre to manage complex incidents.

I note the Director-General’s response.

As part of the implementation of this recommendation, it will be important for the department to ensure that the restrictions placed on the use of young people during incidents have been clearly outlined to staff at BYDC and CYDC and any other location where young people are detained.
3.4 Accuracy of record keeping

This subsection examines the adequacy of movement and incident records for the pool rooftop incident.

3.4.1 Movement records

One issue outlined in the CCC referral was that BYDC section logs did not reflect the CYDC young person’s absence from his unit during the time he was involved in the pool rooftop incident. Further, there was no record of his involvement in the incident report or in any of the 16 occurrence reports of the incident.

At the time of the pool rooftop incident, the CYDC young person was recorded in his section’s log as being out of the section at structured day activities. There are no other records documenting his involvement in the pool rooftop incident. The Section Supervisor told investigators that this was because the CYDC young person had not returned to his section from structured day activities before he was escorted to the pool rooftop incident. After the CYDC young person finished speaking to the young people on the roof, he was escorted back to his section and at that time the section log was updated.\(^{77}\)

The CYDC young person’s movements were also not recorded in the base log, which records all young people’s movements around BYDC. The Section Supervisor told investigators that this was because movements between structured day activities did not require approval from base, only approval from the Structured Day Coordinator.\(^{78}\) Further, the Section Supervisor stated that after the code olive was called, all young people at structured day activities were being moved in order to be taken back to their sections. This movement did not require approval or recording in any log.\(^{79}\)

I am satisfied that the section logs reflect that the young people from the section were attending structured day activities. However, the above explanation in respect of the base log exposes a gap in the recording of young people’s movements throughout the centre.

The Youth Detention Centre Operations Manual requires that before moving a young person across a detention centre, staff must radio the control room/base and request clearance to move the young person. Once the control room/base is satisfied that the movement will present no security issues, permission can be given for the movement to start and be recorded in the base log.\(^{80}\)

During interview, the Manager Monitoring and Compliance (MMC) further emphasised the importance of seeking control room/base approval before moving young people around the centre for safety and security reasons.\(^{81}\)

There was evidently no approval sought from the control room/base before moving the CYDC young person to the pool rooftop incident. Without this approval, I am of the view that staff could not have been certain that they would not encounter any safety or security risks while escorting him to the pool area.

\(^{77}\) Interview with the Section Supervisor, 14 September 2017, transcript p.21.
\(^{78}\) ibid.
\(^{79}\) ibid.
\(^{80}\) Youth Detention Centre Operations Manual, Chapter 4 – Security Management, p.42.
\(^{81}\) Interview with the MMC, 24 July 2017, transcript p.20.
Opinion 7

The failure to seek approval from the control room/base prior to escorting the CYDC young person to the pool rooftop incident, particularly given the extreme risk he posed at the time, had significant potential to adversely impact the safety and security of BYDC.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

Recommendation 3

The Director-General of the department provide further guidance and training to all staff in Queensland youth detention centres regarding:

a) when to seek approval to move a young person/young people throughout the centre
b) assessing risk prior to and during movement of a young person/young people throughout the centre
c) accurately recording movements and the associated approvals.

In response to Recommendation 3 the Director-General of the department advised:

This recommendation will be actioned through the implementation of recommendations made by the [Youth Detention Review]. Specifically, Work Program 3 – Positive behaviour management and incident prevention.

Procedural requirements as they relate to youth detention centre internal escorted movements are outlined in the Youth Detention Centre Operations Manual (YDCOM). These requirements specifically state that the movement of young people during a code in progress (unless securing in a classroom/section) is not permitted. Youth detention centre staff have an obligation to check the daily youth detention bedstate and familiarise themselves with information as it relates to high risk young people, conflicts and restrictions.

The department requires that all movements of young people in youth detention centres is based on thorough risk assessments and must be approved by the base operator. In seeking this approval, staff must provide information relating to the number of young people, number of escorting staff, place of origin and destination. The base operator is responsible for relaying any logistical or operational requirements and approving the movement. The department accepts that the movement of an uninvolved young person during a code in progress is not aligned with operational procedures. The department refers all matters of alleged misconduct to the Professional Standards unit for subsequent assessment and referral.

Annual mandatory competencies training is provided to all youth detention operational staff, and includes refresher sessions on the legislative and operational requirements for incident management and risk assessment. The components and deliverables of mandatory competency training is currently under review. The provision of the QPS complex incident management and command training (discussed in recommendation 2) will further ensure staff are aware of their responsibilities when responding to an incident.

I note the Director-General’s response.
3.4.2 Incident records

Immediately following the pool rooftop incident, an incident report was created and 16 staff were asked to complete an occurrence report recording what they had witnessed during the incident. Neither the incident report nor any of the 16 occurrence reports recorded the CYDC young person’s involvement in the pool rooftop incident.

While it is acknowledged that not all 16 staff who completed an occurrence report attended the pool rooftop incident at the same time as the CYDC young person, CCTV footage shows six BYDC staff present while he was in attendance. It is not possible to identify these staff from the CCTV footage.

A BYDC officer was the appointed scribe for the pool rooftop incident. The scribe is responsible for providing a complete record of everything that occurs during an incident. The notes completed by this BYDC officer did not record that the CYDC young person was present at the pool rooftop incident or that he had engaged in conversation with the young people on the roof for a period of five minutes. When asked by investigators, the BYDC officer was unable to recall witnessing the CYDC young person speaking to either young person.\(^{82}\)

However, the BYDC officer stated they were unaware of the CYDC young person’s involvement in the pool rooftop incident and they did not deliberately omit any information about the CYDC young person in their incident report.\(^{83}\) The BYDC officer further confirmed that the presence of the CYDC young person at the pool rooftop incident would have been a significant event which they would have recorded had they witnessed it.\(^{84}\)

The BYDC officer also noted that there was a sequence of events during the pool rooftop incident they were involved with before they were able to commence their role as scribe. These included ensuring all young people were returned to their units, securing the incident area, being allocated a position by the incident controller and finding a pen and paper to record what occurred during the incident.\(^{85}\)

The BYDC officer acknowledged that better training about report writing would be beneficial for all staff, particularly training which communicates and increases staff understanding of the standards required of incident reports and the communication required between staff to ensure reports are complete and accurate.\(^{86}\)

Another BYDC officer told investigators that they witnessed the CYDC young person being escorted to the pool area during the incident. Despite this, the BYDC officer did not record the CYDC young person’s presence at the pool rooftop incident in their occurrence report.

During interview, this BYDC officer stated they did not record the CYDC young person’s involvement because they did not consider it significant to the incident.\(^{87}\) The BYDC officer further clarified that although they had witnessed the CYDC young person being escorted to the pool area, they did not see it as a potential risk:

\[I\text{ didn’t see it as a risk. It didn’t make the incident any worse as far as I was concerned. For whatever reasons they brought him down, I’m not privy to that, but to me it didn’t have a significant result over the incident and it never harmed at all or made it any worse than what it already was.}\]

\(^{82}\) Interview with a BYDC officer, 15 September 2017, interview audio 19:14.

\(^{83}\) Letter from a BYDC officer to the Ombudsman, 1 August 2018.

\(^{84}\) Interview with a BYDC officer, 15 September 2017, interview audio 20:06.

\(^{85}\) Letter from a BYDC officer to the Ombudsman, 1 August 2018.

\(^{86}\) Ibid.

\(^{87}\) Interview with a BYDC officer, 23 August 2017, transcript p.27.
The BYDC officer stated they would never deliberately or knowingly omit crucial details from an incident report and they genuinely believed at that time that the CYDC young person’s involvement was a matter of no consequence and of so little importance that its inclusion in the report was unnecessary.⁹⁸ The BYDC officer also stated that at the time they were unaware why the CYDC young person was being escorted to the pool area, which was all they had witnessed.⁹⁹

The BYDC officer agreed that further training for officers about the requirements of drafting reports would be advantageous to ensure such omissions do not occur in the future.¹⁰⁰

The Section Supervisor did not complete an occurrence report regarding their involvement in the pool rooftop incident. The Youth Detention Centre Operations Manual requires that all staff who are involved in or are witness to an incident must submit an occurrence report by the end of their shift unless exceptional circumstances (such as if the staff member is injured during the incident) apply.¹⁰¹

The Section Supervisor stated they were of the view at the time that the CYDC young person’s involvement in the incident was ‘insignificant, and not worthy of mention’.¹⁰² The Section Supervisor conceded this may demonstrate a need for greater training for staff regarding completing incident reports and the expectations of what should be included in a report.¹⁰³

The Section Supervisor also told investigators they did not complete an occurrence report because they were not assigned one to complete by a Shift Supervisor.¹⁰⁴ I am of the view that this is not a satisfactory reason for not completing an occurrence report. Given the Section Supervisor’s significant role in the response to the pool rooftop incident, in my view they should have completed an occurrence report even though they had not been formally assigned one.

The Shift Supervisor did submit an occurrence report; however, it made no mention of the presence of the CYDC young person during the incident. During interview, the Shift Supervisor was unable to provide an explanation about why they did not record the use of the CYDC young person during the pool rooftop incident.¹⁰⁵

The Executive Director stated his view was that it was the Shift Supervisor’s responsibility as incident controller to record the CYDC young person’s involvement as it had been a significant event that had occurred during the pool rooftop incident.¹⁰⁶ I am also of the view that as incident controller it was the Shift Supervisor’s responsibility to ensure there was an accurate record of what had occurred during the pool rooftop incident.

Failure to report the CYDC young person’s involvement in the pool rooftop incident in both the incident report and 16 occurrence reports is concerning. The record of the pool rooftop incident on the department’s official database, the Detention Centre Operational Information System (DCOIS), is incomplete as it does not record a significant event that occurred during the incident.

During interview with investigators, the Executive Director commented about the lack of any record of the CYDC young person’s involvement by staff generally, stating that:¹⁰⁷

Yes, well they [staff] won’t record it because it’s not appropriate behaviour.

⁸⁹ Letter from a BYDC officer to the Ombudsman, 6 August 2018.
⁹⁰ ibid.
⁹¹ ibid.
⁹³ Letter from the Section Supervisor to the Ombudsman, 14 August 2018.
⁹⁴ ibid., 14 August 2018.
⁹⁵ Interview with the Section Supervisor, 14 September 2017, transcript pp.25-26.
⁹⁶ Interview with the Shift Supervisor, 17 November 2017, transcript p.17.
⁹⁷ Interview with the Executive Director, 30 October 2017, transcript p.45.
⁹⁸ Interview with the Executive Director, 30 October 2017, transcript p.45.
However, the Executive Director also made the point that at the time of the incident there was no policy or procedure that directly restricted the use of young people during rooftop responses. I also note that young people had previously been used to respond to rooftop incidents, including with the knowledge of the Deputy Director, and seemingly without any express disapproval.

In summary, at least two staff members admitted to having witnessed the use of the CYDC young person during the pool rooftop incident (the Shift Supervisor and a BYDC officer), and yet they did not record it in their occurrence reports. A further staff member (the Section Supervisor) did not complete an occurrence report despite having a significant involvement in the response to the incident. A number of other staff members are visible on CCTV footage and also clearly witnessed the CYDC young person’s involvement, but this was not recorded in any of the 16 occurrence reports for the pool rooftop incident.

I reject any assertions that the use of the CYDC young person during the pool rooftop incident was not significant. It is remarkable and concerning that multiple staff considered the use of a young person to respond to a rooftop incident as not significant enough to record.

Incident reports and occurrence reports should provide a complete record of what occurs during an incident. These records are important for accountability, review purposes and responding to any complaints which may arise as a result of an incident.

### Opinion 8

The incident report and occurrence reports for the pool rooftop incident did not provide a complete record of what occurred during the incident in that:

a) there was no mention of the CYDC young person’s involvement despite a number of staff admitting to witnessing him at the pool rooftop incident

b) an occurrence report was not completed by all staff involved in responding to the pool rooftop incident.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

### Recommendation 4

The Director-General of the department provide further guidance and training to youth detention centre staff about incident reporting, including:

a) when an occurrence report is to be submitted, regardless of having been requested to provide one

b) what information is to be documented in an incident report and an occurrence report.

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99 Letter from the Executive Director to the Ombudsman, 10 August 2018.
In response to Recommendation 4 the Director-General of the department advised:

This recommendation is closely aligned with, and is being actioned through the implementation of recommendations made by [the Youth Detention Review]. Specifically, Work Program 3 – Positive behaviour management and incident prevention.

The department is committed to safely resolving incidents and ensuring responses are clearly documented. Existing reporting procedures require comprehensive incident management records to be recorded and reviewed. In response to the [Youth Detention Review], youth justice have recently strengthened policies and procedures for incident management and associated reporting. These changes were effective from July 2018 and include:

- Additional detail about the role and functions of the incident controller.
- More specific detail about how to write an occurrence report.
- Revised roles and responsibilities for creating, reviewing and approving level 1, level 2 and behavioural incident reports.
- Clearer guidelines about contacting families/guardians following an incident and ensuring this communication is culturally appropriate.

The role of Client Services in the identification and assessment of emotional and psychological harm following an incident has also been clarified. To support this, a new ‘harm assessment report’ is currently being trialled.

Youth Justice have provided various information sessions and workshops at each youth detention centre to communicate these changes and provide support to staff where required.

In direct response to a specific recommendation made by the [Youth Detention Review], specialised incident report writing training was provided to CYDC operational staff in April and May 2018. In light of the recommendation made by the Ombudsman, the department will make this workshop available to BYDC staff to ensure staff are equipped with the necessary skills to provide accurate and complete incident records.

I note the Director-General’s response.

### 3.5 Adequacy of internal review processes

The inaccuracy and incompleteness of incident records for the pool rooftop incident meant that BYDC’s internal review systems did not identify that the CYDC young person was involved in the pool rooftop incident.

This point was of particular concern to the Assistant Director-General, who told investigators that the involvement of the CYDC young person in the pool rooftop incident should have been identified by BYDC’s internal review systems before complaints were made to the Youth Detention Inspectorate.\(^\text{100}\)

So there’s a role specifically that looks at every incident in detention. Now that role should have questioned the use of [the CYDC young person] …

... that’s what I was not happy about. Why did it take an inspector to come and tell me about this? You have internal compliance ... it’s indefensible. It should have been picked up in people viewing incidents. Whether they put it in the incident log or not, if someone was watching the video, because they watch the videos of every incident in a room, every

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\(^{100}\) Interview with the Assistant Director-General, 15 November 2017, transcript p.26.
incident in a hallway, every incident on the roof – they should have seen that [the CYDC young person] was walking with other youth workers down to this incident.

I note that the role referred to by the Assistant Director-General with responsibility for reviewing incidents at BYDC is the MMC (now the Manager Practice Support).101

The MMC stated they had reviewed the incident report and occurrence reports following the incident and found no issues of concern.102 The MMC noted that:

... the [incident] report – having progressed through the Shift Supervisor, the Unit Manager and the Deputy Director, did not record the presence of [the CYDC young person] at the incident site ... As I was not present on site [on the day of the pool rooftop incident] and as I had not been asked to take over the management of this incident or review specific elements of it, I approached [the review of] this incident according to the agreed and consistent approach taken across both centres and in accordance with ... policy and procedure ... I did not know about [the CYDC young person’s] involvement or presence at the incident at this time.

The MMC stated they did not review the CCTV footage when they reviewed the incident report because they had no reason to suspect there were any concerns with how the incident had been managed.104

On this point, I note that under departmental policy there was no requirement for the MMC to review the CCTV footage of the incident because only incidents graded as a Level 1 incident require the MMC to review available CCTV footage.

Incidents that occur in a detention centre must be graded as a Level 1, Level 2 or behavioural incident. Level 1 incidents include critical and other incidents that result in serious adverse outcomes to people, property or the order or security of the youth detention centre.105 Level 2 incidents include incidents that have a moderate to high impact on people, property or the order and security of the centre. Behavioural issues involve misbehaviour or anti-social behaviour by a young person that has little to no impact on others.106

Having regard to these review requirements, the MMC stated:

The incident was not a Level 1 incident and there was no usage of level 3 or level 4 force. Consequently, I was not required to review the CCTV footage unless I identified a reason to do so or I received direction to do so. It has never been policy or practice or other requirement that my role review CCTV ‘of every incident in a room, every incident in a hallway, every incident on a roof’ as recorded as having been stated by the Assistant Director-General ...

The MMC told investigators that inspectors from the Youth Detention Inspectorate requested they review the CCTV footage of the pool rooftop incident in February 2017 and that was when they identified the CYDC young person’s involvement.108 The MMC stated they then advised the Deputy Director that the incident should be considered by BYDC’s Incident Review Group (IRG). IRG’s subsequent review resulted in the incident being referred to the department’s Ethical Standards Unit (ESU).
The MMC also disputed the Assistant Director-General’s statement that it was their role to review ‘every incident in detention’.109

The comments made by the ADG regarding my role and actions are not consistent with published information for my role and responsibilities and have never been addressed with me ...  

The MMC noted that multiple management levels at BYDC are responsible for reviewing and approving an incident report, including the Section Supervisor, the Shift Supervisor, the Unit Manager and the Deputy Director. The MMC noted that no issues regarding the accuracy of the incident report were identified by the Unit Manager or Deputy Director at the time the incident report was finalised.110

The Executive Director told investigators during interview that he generally reviewed the CCTV footage of all incidents at BYDC,111 but he did not get the opportunity to review footage of the pool rooftop incident because he went on leave the week after the incident occurred.112 While the Executive Director stated that it was not part of his role to review CCTV footage of individual incidents, he undertook the task to provide assistance to the MMC due to the large amount of CCTV footage that had to be reviewed.113

Accordingly, for these reasons the CCTV footage of the pool rooftop incident was not viewed by BYDC staff until concerns were raised about the CYDC young person’s involvement by the Youth Detention Inspectorate in February 2017.

It should also be noted that the Executive Director questioned whether the CYDC young person’s involvement would have been identified even had the CCTV footage been reviewed as part of BYDC’s interview review processes, due to the poor quality of the CCTV footage. I agree that the quality of the CCTV footage of the incident is poor and I address the issue of CCTV coverage at BYDC further at section 6.3 of this report.

In this instance, the established internal review systems at BYDC failed to identify that a significant event had occurred during the pool rooftop incident until prompted by the Youth Detention Inspectorate. It appears that this occurred primarily because:

• records of the pool rooftop incident were not complete because the CYDC young person’s involvement was not recorded
• a significant number of BYDC staff failed to identify that the use of the CYDC young person during the pool rooftop incident was a concern which should have been documented
• the CCTV footage was not reviewed following the pool rooftop incident because there was no policy or procedure requirement that any BYDC officer review the footage.

The MMC also raised an additional issue that was relevant at the time of the pool rooftop incident regarding an organisational change which resulted in their removal from the internal BYDC quality assurance structure. The MMC stated that in May 2016 their role was directed to report to the Chief Inspector, Youth Justice, meaning they was no longer part of the BYDC internal quality assurance processes or part of the BYDC management team.114

The MMC stated that this change may have contributed to BYDC’s internal review processes failing to identify the CYDC young person’s presence at the pool rooftop:115

I was also informed [in February 2017] that some staff had concerns around the presence of [the CYDC young person] during the incident, and when I questioned why they had

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109 Letter from the Manager Practice Support to the Ombudsman, 7 August 2018.
110 ibid.
111 Interview with the Executive Director, 30 October 2017, transcript p.9.
113 Letter from the Executive Director to the Ombudsman, 10 August 2018.
114 Letter from the Manager Practice Support to the Ombudsman, 7 August 2018.
115 ibid.
not divulged their concerns to me at the time, their response was that they did not think it appropriate given I was no longer on staff, and they assumed that approval had been given at management levels.

It is worth noting that at the time of the pool rooftop incident in November 2016, it appears the MMC position at BYDC was in the middle of an organisational change which resulted in disruption regarding the purpose and reporting structure of the role. This may have affected the ability of the MMC to identify and address practice issues and non-compliance during incidents. It may also have affected the ability of the MMC to engage with BYDC staff about how incidents were managed and address any issues that arose.

I note that the MMC position has now reverted to its previous place within the organisational structure of BYDC.

Having regard to these issues, I am of the view that further consideration needs to be given to the type of incidents where CCTV footage should be viewed as part of a detention centre’s internal review systems.

**Opinion 9**

The internal review systems at BYDC failed to identify the CYDC young person’s involvement in the pool rooftop incident.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

**Recommendation 5**

The Director-General of the department amend current policy and procedure regarding the review of incidents at a detention centre to ensure that where CCTV footage of an incident is available, that footage is reviewed.

In response to Recommendation 5 the Director-General of the department advised:

This recommendation is closely aligned with, and is being actioned through the implementation of recommendations made by the [Youth Detention Review]. Specifically, Work Program 5 – incident footage and investigation.

The department is committed to protecting the safety of young people and staff in youth detention. To this end, youth detention centres employ a range of dynamic, procedural and physical security measures to minimise incident risks. This includes the use of surveillance technology.

Youth Justice has recently made a number of policy and procedural changes to strengthen the extraction, review and storage of CCTV and surveillance technology in youth detention centres. These changes include the development of a new policy relating to the use of surveillance technology and client privacy.

Clarification has been provided around the relevant extraction criteria, review, retention and disposal of CCTV footage. This includes clear roles and responsibilities as they relate to the management of video records, which have also been clarified in recent changes to incident management and review procedures.

I note the Director-General’s response.
Events leading up to the BYDC riot

On 30 January 2017, seven young people from one of the accommodation units at BYDC were involved in the BYDC riot. During the BYDC riot, the seven young people involved forced their way on to the roof of the unit causing significant damage.

One staff member was injured when a glass panel on the veranda was broken. While on the roof, the young people damaged infrastructure including air conditioning units, windows and other items. The young people also threw materials from the roof at staff below and verbally abused them. This riot was so severe that assistance was sought from the Queensland Police Service to manage the incident.

The young people progressively came down from the roof with the last two young people coming down at 2.51am on 31 January 2017. All seven young people who had been involved in the BYDC riot were placed in separation.

A comprehensive review of the BYDC riot was conducted by the Chief Inspector, Youth Justice and completed in April 2017. The review identified a number of operational issues in the lead up to and in the management of the BYDC riot. The Chief Inspector made 16 recommendations to address these issues. The review by the Chief Inspector is comprehensive and accordingly this report does not address any further issues relating to BYDC’s handling of the actual BYDC riot.

Instead, this part of the report examines the events at BYDC between the pool rooftop incident on 24 November 2016 and the BYDC riot on 30 January 2017.

In particular, this part discusses a number of issues that the investigation determined were contributing factors to the BYDC riot, or could have served as a warning of what was to unfold. This part also includes an analysis of BYDC management’s response to the escalating concerns that were evident at BYDC throughout December 2016 and January 2017.
4 Allegations of threats and assaults on young people orchestrated by BYDC staff

On 30 January 2017, the Office received a complaint from a young person at BYDC. The young person was subsequently involved in the BYDC riot only hours after contacting the Office.

In his complaint, the young person stated that he had been told by a BYDC staff member that he was being transferred to the accommodation unit where the CYDC young people were accommodated. The young person said that he had previously been accommodated in this unit where he was involved in a fight with three other young people and as a result had been transferred to his current unit. The young person said he told the BYDC staff member that he feared for his safety if he was transferred to the unit, but the staff member had stated ‘that’s not my problem’. The young person refused to name the officer who made this comment as he alleged the officer would arrange for other young people to assault him.

This Office immediately referred this information to BYDC for action by the centre.

On 14 February 2017, the Office received a complaint from another young person who had also been involved in the BYDC riot. This young person made a number of allegations about the conduct of staff at BYDC. These included:

- he and the young people involved in the BYDC riot feared for their safety at BYDC
- staff at BYDC had threatened to place him and the other young people involved in the BYDC riot in the section with the CYDC young people so they would be assaulted by these young people for their involvement in the BYDC riot
- he was aware of a young person who had run away from staff and as a consequence, the young person was taken to the section where the CYDC young people were accommodated
- staff pay the CYDC young people with soft drinks to assault young people who misbehave. He saw this occur when a young person had his nose broken by one of the CYDC young people after the young person was moved to the unit where the CYDC young people were accommodated. Staff had offered the CYDC young person cordial before the assault occurred.

Investigators spoke with a number of BYDC staff and young people about these allegations. DCOIS records for the relevant period were also requested and reviewed. The evidence gathered demonstrates that during December 2016 and January 2017 there were a series of incidents involving the CYDC young people that appeared to cause considerable concern and anxiety among other young people at BYDC. These included:

- assaults and incidents between the CYDC young people and other young people
- perceptions that BYDC staff were threatening to move young people to where the CYDC young people were accommodated so they would be assaulted by them
- the perceived use of the CYDC young people as ‘enforcers’ by some staff
- that the CYDC young people had items in their rooms that were not available to other young people
- there were differences in the consequences for misbehaviour experienced by the CYDC young people compared with other young people.
Taken together, it became apparent to investigators that by January 2017 there was a growing perception among young people at BYDC that the CYDC young people posed a threat to their safety, that the CYDC young people were given preferential treatment by BYDC staff, and that young people could not rely on staff to protect them.

This chapter will discuss the allegations and circumstances giving rise to this perception.

### 4.1 Assaults and incidents between the CYDC young people and other young people

During December 2016 and January 2017, all three CYDC young people were accommodated in the same accommodation unit. Two of the young people were placed in one section of the unit and the other young person was placed in the other section.

While accommodated in this unit, the CYDC young people were involved in a number of assaults and incidents with other young people. A chronology of the assaults and altercations involving the CYDC young people during December 2016 and January 2017 is provided below at Figure 2.

**Figure 2: Chronology of incidents involving the CYDC young people**

- **9 December 2016**
  - A young person is involved in a physical altercation with a CYDC young person.
  - As the young person is being escorted to his room, another CYDC young person also attempts to assault him.
  - At the same time in the other section of the unit, another CYDC young person becomes aggressive and chases a young person around the section, threatening to assault him.

- **13 December 2016**
  - On their return to section after involvement in a rooftop incident, two young people are assaulted by CYDC young people, who are unhappy that their programs were interrupted as a result of the young people’s actions.
  - During mediation in response to the assault, one young person strikes a CYDC young person in the face.

- **18 December 2016**
  - A CYDC young person assaults another young person.

- **30 December 2016**
  - After being transferred to a section the previous evening, a young person is completing chores when he is assaulted by a CYDC young person.

- **5 January 2017**
  - Young people are participating in pool activities when a CYDC young person becomes involved in a verbal exchange with another young person. The CYDC young person strikes the other young person in the face causing him to fall to the ground.
  - Two other CYDC young people begin moving towards the young person in an aggressive manner. One CYDC young person wraps socks around his knuckles and both young people tell staff they are not afraid to assault them.
Two of these incidents were the subject of complaints received by this Office:

1. the assault of two young people by two CYDC young people on 13 December 2016
2. the assault of a young person by a CYDC young person on 30 December 2016.

The complaints contained allegations that these assaults had been orchestrated by staff. Details of these assaults and the specific allegations raised in the complaints are discussed below.

The other incidents outlined in Figure 2 provide some insight into the behaviour of the CYDC young people in the weeks prior to the BYDC riot, and demonstrate how a fear of the CYDC young people could have spread throughout BYDC.

4.1.1 Assault of two young people on 13 December 2016

The following chronology of events is based on information taken from the incident report, associated occurrence reports and interviews with relevant staff and young people:

- On 13 December 2016, a group of young people were being escorted back to their section by a Section Supervisor after completing a gym session. While being escorted, two young people ran from the group. A code green (escape/abscond) was called.

- One of the young people was intercepted by staff, handcuffed and escorted away, while the other young person ran towards the sports centre and climbed onto a nearby water tank. A code olive (young person on roof) was called.

- The Section Supervisor escorted the remaining six young people from the gym back to their section and secured them in their rooms, as per the standard lockdown procedures following a code olive incident.

- The Section Supervisor told investigators they spoke with the young people who had been locked down as a result of the incident and advised them they would attempt to resolve the incident quickly so the day could return to normal.\footnote{Interview with a Section Supervisor, 4 October 2017, transcript pp.3-4.}

  I said [to the young people] ‘The quicker I get them down, the quicker it will go back to normal’. ... I said ‘Everything’s all good, we’ll mediate and we’ll just sort this all out when we get back’.

  ...I said ‘I’m gonna go get him down so we can come out of lock down’. ... They said ‘okay no worries’.

- The Section Supervisor then attended the water tank and sought approval from a more senior BYDC officer to return both young people who had run away to their section after the incident had been resolved so the matter could be managed in section.\footnote{Occurrence report 5822748; and Interview with a Section Supervisor, 4 October 2017, transcript p.10.}

\footnote{ibid.}

  The senior BYDC officer approved this request.

- After some negotiation, the young person climbed down from the water tank and was handcuffed and escorted to their section’s separation room. After the other young person also arrived back at the section, both young people were secured in their rooms.\footnote{Occurrence report 5822858; and Interview with a Section Supervisor, 4 October 2017, transcript p.10.}

- The Section Supervisor then directed staff to move all the young people in the section from their rooms to the common area to participate in a restorative group discussion as a result of the incident. The Section Supervisor advised investigators that this was normal practice when the actions of a young person had resulted in negative consequences for the other young people in the section, such as being locked down.\footnote{Occurrence report 5822858; and Interview with a Section Supervisor, 4 October 2017, transcript p.10.}
• A CYDC young person was one of the last young people to come out of his room and join the group in the common area. This CYDC young person approached one of the young people who had run away and verbally expressed his annoyance that his programs had been disrupted due to the incident. The Section Supervisor and a BYDC officer directed the CYDC young person to move away from the other young person and take a seat. The CYDC young person ignored this direction and punched the other young person.

• During this altercation, the other young person who had run away went to stand up, apparently to assist his friend. One of the other CYDC young people grabbed this young person’s leg, pulled him off the couch and struck him on the chin. Staff intervened and secured both CYDC young people in their rooms.121

• After a time, all four young people involved were given the option to mediate.122 During the mediation, the young person who had initially been assaulted lunged at the CYDC young person who had attacked him and struck him in the face. Both young people were secured in their rooms.

• Following the failed mediation, both of the young people who had been assaulted by the CYDC young people were transferred to other units, while the two CYDC young people remained in the section.

When interviewed by investigators, one of the young people who was assaulted by the CYDC young people made specific allegations regarding what took place after he came down from the water tank and following his arrival in the section. He alleged that:

• as he was being escorted from the water tank, the Section Supervisor said to him ‘Now, we’re going to get the Cleveland boys to bash you’123

• when he arrived back at his section, the Section Supervisor opened the doors to the CYDC young people’s rooms and they came out and ‘bashed him’ while he was sitting on the couch.124

The Section Supervisor denied these allegations at interview stating:125

That honestly didn’t happen at all. The only time those two boys were assaulted was when we were all, the whole section, was sitting on the couch.

I note that there is no CCTV footage of this incident as the unit common areas at BYDC are not covered by CCTV. This makes it difficult to determine exactly what transpired. I will discuss the issue of CCTV coverage at BYDC further in Chapter 6.

With regard to the young person’s allegation, DCOIS records indicate that the Section Supervisor did not escort the young person back to his section after he came down from the water tank. Accordingly, it is unlikely the Section Supervisor could have threatened the young person with being assaulted by the CYDC young people at this time. I have not been able to substantiate whether any other staff member made any threatening comment towards the young person while he was being escorted back to his section.

Further, during the assault the young person alleged that staff yelled ‘stop’ but did not take any physical action to intervene.126 This allegation is not consistent with the occurrence reports or the evidence given by unit staff to investigators. Staff consistently reported that as soon as the altercation between the CYDC young person and the young person became physical, staff intervened and secured the CYDC young person in his room. The reports of

121 Occurrence report 5822857.
122 Occurrence report 5823208.
123 Interview with a young person, 29 March 2017, transcript p.4.
124 Ibid., p.5.
125 Interview with a Section Supervisor, 4 October 2017, transcript p.9.
126 Interview with a young person, 29 March 2017.
Chapter 4

the incident do state that staff first issued a verbal direction to the CYDC young person when he confronted the young person, but this was before the altercation became physical.

The Section Supervisor told investigators they reacted within a few seconds and pulled the CYDC young person away from the other young person and secured him in his room. Another BYDC officer told investigators they intervened in the fight ‘straight away’ and escorted the CYDC young person away from the young person and secured him in his room while other staff secured the other CYDC young person in his room.

Again, the lack of CCTV footage makes it difficult to determine the appropriateness of officers’ reactions to the incident.

The suggested cause of the assault documented in the incident report is that the CYDC young people were frustrated at being locked down due to the actions of the two young people. When questioned at interview about the cause of the assaults, the Unit Manager stated:

My understanding is that [a CYDC young person] didn’t like his programs being interrupted. Now [a CYDC young person] ... he’s quite emotional and quite reactive ...

One of the CYDC young people’s Support Plan clearly documents his tendency to escalate quickly and resort to violence in order to solve problems. However, this appears to be the first instance that unit staff were made aware of the CYDC young people’s dislike of young people that caused codes. Without this information, it would have been difficult for staff to fully assess the risk of the situation in order to prevent the assaults from occurring.

I have carefully weighed up the available evidence including DCOIS records and interviews with young people and relevant BYDC officers and determined that, on the balance of probabilities, BYDC officers did not set up the two young people to be assaulted by the CYDC young people.

Opinion 10

On the available evidence, the allegation that the assault of two young people by two CYDC young people was orchestrated by staff cannot be substantiated.

4.1.2 Assault of a young person on 30 December 2016

The following chronology of events is based on information taken from the incident report, associated occurrence reports and interviews with relevant staff and young people:

• On 29 December 2016, a young person had been separated in a padded room as a result of his behaviour. Due to concerns about his wellbeing, the on-call Unit Manager approved the transfer of the young person to another unit. The on-call Unit Manager stated the transfer was approved because it was ‘inappropriate and inhumane for the young person to be housed in a room with no natural light’. The on-call Unit Manager also stated they were advised by staff that the young person had ‘been distressed and to the point where [he] had attempted to escape to the roof by damaging the roof of another cell’.

127 Interview with a Section Supervisor, 4 October 2017, transcript p.11.
128 Interview with a BYDC officer, 4 October 2017, interview audio at 17:50.
129 Interview with a Unit Manager, 5 May 2017, transcript p.33.
130 DCOIS separation log, 29 December 2016.
131 Interview with the on-call Unit Manager, 4 May 2017, transcript p.9.
132 Letter from the on-call Unit Manager to the Ombudsman, 16 August 2018.
133 ibid.
• The on-call Unit Manager told investigators that due to the limited room availability across the centre, the section where two of the CYDC young people were accommodated appeared to be the only available option as the young person did not have any ‘not-to-mixes or issues with kids in [that section] or no intel regarding it’. The on-call Unit Manager also decided that this section was the most appropriate because it was the only section where the young person did not have a history of conflict with any other young person.

• The young person was transferred during the evening on 29 December 2016 and placed in the unit’s separation room due to lack of any available rooms.

• At interview, the Section Supervisor in the section the young person was transferred to provided his recollection of events in the lead up to the assault on the morning of 30 December 2016:

  ... I came on shift that morning and I was given the hand over that [the young person] was in [the section]. That we were to manage him there. So I didn’t have a room for him because my section was full at that time. So obviously we don’t leave him in [the unit’s separation room]. So I had him come out and I said, [the young person], you’ll just have to stay in the common area/lounge. I’ll put you on chores. I don’t have a room for you at the moment. Management have to make a decision on where they’re going to accommodate you ... or we have to wait ‘til they repair a room.’

So he was on chores with two other boys; [a CYDC young person] was one of those on chores ...

• Occurrence reports for the incident indicate that immediately prior to the assault, a BYDC officer was collecting laundry bags and the Section Supervisor was in the section office. Neither the BYDC officer nor the Section Supervisor witnessed the assault; however, both heard what was described as an audible ‘whack’.

• In response to this noise, the BYDC officer turned to observe the CYDC young person standing over the other young person who was on the ground. The Section Supervisor also responded to the noise and observed the CYDC young person standing over the other young person who had slumped down in the corner of the kitchen and was holding his nose.

• As a result of the assault, the young person sustained a fractured nose. He was assessed by a nurse and later transferred to the Ipswich Hospital Emergency Department for treatment. The CYDC young person remained in the section after having been secured in his room.

During an interview with investigators the young person alleged that immediately prior to the assault, the Section Supervisor had said to the CYDC young person ‘I’ll go out the back and get you some cordial’. This allegation was put to the Section Supervisor at interview who stated:

Yes I did say that ... Because he asked for cordial to put in the water bottles. The kids have water bottles and [the young person] was drying the dishes and he was all happy on one side, [the CYDC young person] was on the other side. And I was in the office at the time and then [the CYDC young person] just called out, I came out and said ‘What’s up?’ and

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134 Interview with the on-call Unit Manager, 4 May 2017, transcript p.9.
135 Letter from the on-call Unit Manager to the Ombudsman, 16 August 2018.
136 Occurrence report 5881469; and Occurrence report 5881470.
137 Occurrence report 5881469; and Occurrence report 5881470.
138 Occurrence report 5881470.
139 Occurrence report 5881469.
140 Incident report 5881471.
141 ibid.
142 Interview with a young person, 14 July 2017, transcript p.12.
143 Interview with the Section Supervisor, 12 September 2017, transcript p.13.
he says ‘Sir, is there any cordial?’ the kids like to top their water bottles up with cordial. We've got a section fridge. And yeah, so he asked for that and I went off the floor to get the cordial bottle which was only in the office. So I only went into the office. I only had my back turned for not even a moment. I walked into the office and I heard the whack and when I came out, yeah [the young person] was slumped down and [the CYDC young person] was standing over him.

While the Section Supervisor stated they could not confirm the CYDC young person’s intention in requesting cordial, the Section Supervisor noted it could have been to distract them, creating an opportunity for the CYDC young person to confront the other young person.\textsuperscript{144}

Accordingly, while the young person’s allegation that the Section Supervisor left to get cordial for the CYDC young person was confirmed by the Section Supervisor, there is insufficient evidence that the Section Supervisor colluded with the CYDC young person to carry out the assault. I note that, given this incident occurred in the common area of the section, there is no CCTV footage available for this incident.

Unfortunately, Ombudsman investigators were unable to interview the CYDC young person regarding this incident.

I have carefully weighed up the available evidence including DCOIS records and interviews with young people and relevant BYDC officers and determined that, on the balance of probabilities, the assault of the young person by the CYDC young person was not set up or orchestrated by BYDC officers.

However, I note that one of the possible causes of the assault was identified in the incident report as follows:

Possibly due to [the young person’s] involvement in numerous Emergency Codes which has caused disruption to peers across the Centre, [the CYDC young person] questioned [the young person] if he was the one responsible for all these Codes to which [the young person] confirmed he was – subsequently [the CYDC young person] has then punched [the young person] directly in the nose ...

In my view, staff could have given more thought to the fact that the CYDC young person was known to dislike young people who participated in behaviour that caused the centre to be locked down. This was clearly documented in the incident report for assaults on other young people. This factor could have been considered before placing the young person, who had a history of behaviour causing lockdowns, in the same section as the CYDC young person.

In making this point I also acknowledge that the intent in moving the young person to the section where two of the CYDC young people were accommodated appears to have been to provide him with more suitable accommodation.

\textbf{Opinion 11}

On the available evidence, the allegation that the assault of a young person by a CYDC young person was orchestrated by staff cannot be substantiated.

\textsuperscript{144} ibid., p.15.
4.1.3 Threats made to young people by BYDC staff

Young people and staff told investigators that the CYDC young people arrived at BYDC with the reputation of having been the ‘ringleaders’ in the CYDC riot. This reputation appeared to instil a degree of fear at BYDC.

One BYDC officer described the CYDC young people as follows:145

... These were big boys. Fit, strong, athletic big boys ... So they come down here. BYDC has never been subjected to three boys like that ever. I’ve been there since 2001 and we’ve never had three high profile boys come down ...

The CYDC young people’s subsequent involvement in the assaults of other young people appears to have had the effect of consolidating this reputation and increasing the level of fear felt by other young people at BYDC.

Young people interviewed as part of this investigation alleged that staff were threatening them with transfer to the unit where the CYDC young people were accommodated. However, in many cases the young people refused to name staff or were unable to particularise the timeframe or circumstances within which the threat was allegedly made, making it difficult to investigate the allegations.

In instances where the young people had named the staff member, these allegations were put to the relevant staff member at an interview. All staff interviewed as part of this investigation were also questioned generally about whether they were aware of any staff making threats of this nature to a young person.

All staff denied making any type of threats. However, some staff did acknowledge that they had heard rumours that these type of threats were occurring, or that a young person had told them that they had been threatened by a staff member in this way. However, young people had refused to name the staff member. In particular:

• A Section Supervisor stated they had been told by young people that staff in one of the units were threatening them with transfer to the unit where the CYDC young people were accommodated but could not advise which staff had made the threats.146 The Section Supervisor also stated ‘I wouldn’t be surprised if [staff from other units] does the same thing’147 though they were unable to confirm that this had occurred.

• A BYDC officer stated they had heard that staff had told young people they would be sent to [the CYDC young people’s] unit, but that this had been said jokingly.148

Throughout December 2016 a number of young people had been assaulted and injured by the CYDC young people. As described in this chapter, the young people who were assaulted believed staff were colluding with the CYDC young people or that they had failed to act protectively. These assaults were known throughout the centre, which heightened the fear many young people had of the CYDC young people.

In the circumstances, any threats made towards young people to move them to the same unit as the CYDC young people could reasonably be expected to give rise to significant distress and anxiety. A BYDC officer acknowledged that given the fear many young people had of the CYDC young people, particularly for those young people who had been assaulted by them, threats of this nature could have had a detrimental impact regardless of whether it was meant as a joke.149

145 Interview with a BYDC officer, 12 September 2017, transcript p.10.
146 Interview with a Section Supervisor, 14 September 2017, transcript p.35.
147 Ibid.
148 Interview with a BYDC officer, 13 September 2017, transcript p.20.
149 Interview with a BYDC officer, 13 September 2017, transcript p.21.
The Assistant Director-General advised investigators of a meeting he had with one young person who alleged that a staff member had threatened to move him so the CYDC young people would ‘sort him out’. The Assistant Director-General stated that the young person refused to name the particular staff member who had threatened him, stating: “I’ve got to live back there. I’m not telling you who it is.” The Assistant Director-General held a firm view about allegations of this kind:

Now my reaction to that was that’s totally inappropriate. It’s not right. If I have any evidence of that, I will do something about it. … So I don’t take kindly to those types of allegations. … But any case where anyone would actually say that, in my view, is a complete breach of the code of conduct. And I did say to [the Executive Director] I would consider taking serious action against anyone who’s ever made that threat in jest. It wouldn’t satisfy me in jest, it’s not good enough. So [the Executive Director] was quite clear. I made it very, acutely clear to him that I wanted that. And then I asked him if he’d found any evidence of that, later on I’m pretty sure. He couldn’t produce any evidence to me. Because I wanted anyone referred to our ethical standards unit as soon as we had any evidence.

So people knew my position on it. If there was ever any evidence of that, they would have had distinct, strong action taken against them.

While the investigation did not substantiate any specific allegation of a staff member threatening a young person with transfer to any particular unit, the weight of evidence indicates that threats of this nature may have occurred. In reaching this view, I have relied on:

- the fact that there were a number of similar allegations made by young people about being threatened by staff, including reports of similar allegations made at the relevant time to staff and the Assistant Director-General
- the acknowledgement by at least one staff member that threats of this nature were likely to have been made, whether jokingly or not.

**Opinion 12**

Based on the available evidence, it is likely that between December 2016 and January 2017:

a) some staff made comments to young people that would lead a young person to believe they may be moved to a particular unit where their safety may be at risk from the CYDC young people
b) there was knowledge among some staff at BYDC that young people held fears about being transferred to a particular unit because of the risk of being assaulted by the CYDC young people.
4.2 Perceived preferential treatment of young people by staff

This section of the report addresses the allegation made by young people that the CYDC young people received preferential treatment from staff.

4.2.1 Products and other items provided to the CYDC young people

A number of young people told investigators that the CYDC young people often had items in their possession that were not ordinarily accessible to young people. The young people alleged that, in some instances, these items were a form of payment from BYDC staff to the CYDC young people for assaults on other young people. In particular, the young people alleged that staff had paid the CYDC young people with soft drink.

As the investigation did not commence until after the critical time period between November 2016 and February 2017, it is not possible to conclude with certainty whether the CYDC young people had access to soft drink in their rooms during this period.

However, investigators were provided with photographs taken during the Youth Detention Inspectorate’s quarterly inspection of BYDC in March 2017 which showed an empty 1.25L soft drink bottle in a CYDC young person’s room and two full 1.25L soft drink bottles in another CYDC young person’s room. Investigators confirmed that soft drink was not available for purchase by young people in the centre at the particular time.

A number of staff were asked at interview about how the CYDC young people may have had access to soft drink. A number of explanations were provided to investigators, including that:

- soft drinks are included in ‘Gold Packs’ which are distributed to each young person every Friday, although investigators subsequently confirmed that these packs only contain a 600ml bottle of soft drink
- young people are required to purchase their own water bottles and if a young person is unable to afford a water bottle a staff member may give them a bottle of their own, which may be an empty soft drink bottle
- it was previously a common practice at BYDC for staff to bring food and drink items, including soft drink, into the centre to offer as prizes for young people who win games
- staff had at times brought food into the centre to have ‘cook ups’ with the young people as a reward for good behaviour.

During interview, a CYDC young person denied having received soft drink from staff; however, he stated that he did have access to soft drink in the visits area if it was brought in by his family.

There was general agreement from staff that if a young person was in possession of a 1.25L bottle of soft drink, it was likely that a staff member had given it to them. However, in light of the various explanations provided by staff, as well as the period of time that has passed before the Youth Detention Inspectorate took the photographs of the soft drink bottles, it is not possible to conclude that an empty 1.25L soft drink bottle in a CYDC young person’s room is evidence of favouritism or staff paying him to assault other young people between November 2016 and February 2017.

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153 Interview with a BYDC officer, 13 September 2017, transcript p.18; and Interview with a Section Supervisor, 12 September 2017, transcript p.16.
154 Interview with a BYDC officer, 15 September 2017.
155 Interview with a BYDC officer, 11 August 2017; and Interview with a BYDC officer, 13 September 2017, transcript p.18.
157 Interview with a CYDC young person, 19 April 2018, transcript p.10.
However, the fact that other young people had observed these items in the CYDC young people's rooms may easily have added to the perception of favouritism and special treatment that was present in the centre between December 2016 and February 2017.

Another item photographed by the Youth Detention Inspectorate during their March 2017 inspection of BYDC was a large stereo system in a CYDC young person's room.

At interview, a number of staff were asked about the use of the large stereo in units. A BYDC officer told investigators that young people are provided with a small stereo to keep in their rooms. 158 However, the officer also stated that staff from their unit would never allow a large stereo in a young person's room, as this could pose a security risk by young people turning up the volume to conceal other noises in the section 159.

I note that this particular unit is viewed as a privileged section among young people, yet unit staff would not allow young people to have a large stereo in their rooms, while unit staff where the CYDC young people were accommodated were apparently allowing this to occur.

While young people did not specifically raise concerns with this Office about the large stereo in a CYDC young person's room, there is potential for this to have contributed to the perception of favouritism and to the elevation of the status of the CYDC young people. A Principal Inspector from the Youth Detention Inspectorate told investigators: 160

… they play gangster rap with all the vocabulary. ... my impression was, it sends a message, walking past a unit, the ghetto blaster’s blaring loudly. It sends a message that 'We run this unit. Listen to our beats. You guys, you don't get stereos and things like we do.'

Overall, it appears that there were gaps in the management of the items that found their way into BYDC during December 2016 and February 2017 and the origin of certain items in the centre cannot be confidently determined.

I note that on 4 May 2017, in response to these concerns, the Executive Director issued a directive prohibiting staff from bringing food and drink items into the centre for young people, except in special, pre-approved circumstances. Specifically, the directive states:

Reasons for these restrictions include the potential perception of favouritism, jealousy, misuse by bartering or gambling, and emotional trauma by young people who are not included.

The above extract from the directive clearly sets out the inherent problems with insufficient oversight of young people's possessions. I agree with the stated reasons. However, in my view a local directive from the Executive Director concerning food and beverages is inadequate, particularly as it applies only to BYDC.

I also note that the Youth Detention Centre Operations Manual provides limited guidance on the items permitted to be in possession in units beyond discussing illegal items and those items the young person brings with them on admission to the centre. 161 Accordingly, I am of the view that additional guidance is required about the items permitted to be in the possession of young people and the reasons for any restrictions.

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158 Interview with a BYDC officer, 13 September 2017, transcript p.19.
159 Interview with a BYDC officer, 13 September 2017, transcript p.19.
160 Interview with a Principal Inspector, 2 June 2017, transcript pp.15-16.
161 Youth Detention Centre Operations Manual, Chapter 1 – Care and management of young people, p.99.
Opinion 13

The Youth Detention Centre Operations Manual provides inadequate guidance and control about products and items permitted to be possessed by young people in youth detention.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

Recommendation 6

The Director-General of the department amend the Youth Detention Centre Operations Manual to provide more detailed guidance about the items permitted to be in the possession of young people and the reasons for any restrictions. The Manual should also outline any specific exemptions or special circumstances regarding items permitted to be in the possession of young people.

In response to Recommendation 6 the Director-General of the department advised:

This recommendation is closely aligned with, and is being actioned through the implementation of recommendations made by [the Youth Detention Review]. Specifically, Work Program 3 – Positive behaviour management and incident prevention.

As outlined by the Ombudsman, the BYDC Executive Director issued a directive in May 2017 relating to the provisions of food and, drink and other items to young people in the centre. This directive stipulated that staff are not permitted to bring food, drink, gifts or other items into the centre for young people, except for special, pre-approved circumstances. Reasons for these restrictions included the potential perception of favouritism, jealousy, and misuse by bartering or gambling, and emotional trauma by young people who were not included.

The department has reviewed the operational guidance in relation to personal items that can be in the possession of young people as part of Recommendation 5 of the Chief Inspectors review of BYDC, completed on 12 May 2017. As a result, operational procedures have been strengthened to clearly define the property permitted by young people in YDC’s. The Chief Inspector further recommended that operational staff conduct regular room inspections to ensure personal property is in line with centre expectations.

Additionally, the behaviour developmental model in youth detention centres has been strengthened by an updated incentives scheme and clarified ‘buy-up’ entitlements. This approach aims to motivate young people to demonstrate positive behaviour and is based on the theoretical frameworks of Positive Behaviour Support, Trauma Informed Practice, and Restorative Practice and Cultural Safety.

I note the Director-General’s response.

4.2.2 Use of the CYDC young people as enforcers by staff

Through interviews with young people it became apparent that they had formed the view that BYDC staff were using the CYDC young people as ‘enforcers’. A number of factors appeared to have contributed to this view forming.

Firstly, the use of a CYDC young person in the pool rooftop incident soon after his arrival at BYDC appeared to elevate his already high profile reputation. The young people on the roof in this incident did not have any relationship with the CYDC young person and during
interview one of the young people indicated he was surprised when he saw that staff had brought the CYDC young person to speak with him while he was on the roof.\textsuperscript{162}

Secondly, soon after the pool rooftop incident two of the CYDC young people were involved in a number of assaults on young people, which other young people believed had been ‘set up’ by staff. Word of these assaults had spread throughout the centre and fuelled the fear of the CYDC young people. The perception that staff had orchestrated these assaults left young people feeling vulnerable and unprotected.

The fear of being moved to the unit where the CYDC young people were accommodated appeared to infiltrate the entire centre and began to impact on daily operations. For example, a BYDC officer told investigators that since the arrival of the CYDC young people, the typical progression model at BYDC was unable to ‘run the way it used to run’.\textsuperscript{163}

The progression model was a system where young people progressed through different accommodation units, based on their behaviour while in detention. Young people were admitted and inducted into one unit and then progressed through subsequent units. Young people who demonstrated settled and positive behaviour in these units could progress to a particular unit, where additional privileges were available to them.

However, given the accommodation of the CYDC young people in one of the progression units, young people were attempting to bypass this unit by declaring a conflict with the CYDC young people, often despite never having interacted with them.\textsuperscript{164} One BYDC officer said that ‘90% of the time’ the reason young people in [a unit] did not want to be moved to [the unit where the CYDC young people were accommodated] was purely because of the CYDC young people’s reputation and not because they had any actual conflict with them.\textsuperscript{165}

The Intelligence Officer told investigators that some young people felt betrayed by staff because of the perception that the CYDC young people were being used as enforcers.\textsuperscript{166}

\begin{quote}
... the kids have told me this over the period of time, that they felt - they feel so hurt and so brushed aside by these [staff] that they consider almost their family ...

And that of all a sudden, this place that was supposed to be theirs one day, has now been given to these kids that have come from Cleveland, that no one knows. So they feel quite hurt about it ... And the kids started calling them [the CYDC young people] the enforcers. ... that was the term that was being used. These kids were the enforcers.
\end{quote}

Although specific allegations of staff orchestrating assaults and threatening young people were unable to be substantiated, it is clear that a number of young people believed this was occurring, which then increased the perception among young people that the CYDC young people were being used as enforcers by staff.

\subsection*{4.2.3 Consequences for involvement in serious incidents}

Through interviews with young people it became apparent that young people at BYDC felt that the CYDC young people were not subject to the same consequences as other young people after participating in an incident.

For example, after an extended stay in a unit which is separate from the other accommodation areas for causing damage to rooms, two young people spoke with a BYDC Psychologist who reported this discussion in an email dated 29 December 2016 to a number of staff including Unit Managers that:\textsuperscript{167}
They have a real sense of injustice and unfairness and reported feeling targeted. They made a distinct reference to the actions of the boys from Cleveland that resulted in injury to staff and asked why those boys were not [being placed in the separate unit] and they were.

An examination of the incident reports involving the CYDC young people revealed that they were often separated ‘in section’. This means that they were confined in their own room in their unit as opposed to being sent to the separate unit, which was typically used as a unit to separate young people involved in serious or disruptive incidents.

The inconsistency regarding whether the CYDC young people were sent to this unit following incidents they were involved in was noticed by other young people. One young person told investigators:

\[168\]
It happens to everyone [sent to the separate unit] but just them three [CYDC young people]. I don’t know why they’re just so special.

Of particular significance is an incident on 5 January 2017 when the three CYDC young people threatened youth workers as they tried to intervene in a dispute with another young person at the pool area.\[169\] Despite making threatening comments indicating they were not afraid to assault staff and demonstrating aggressive behaviour, including one of the CYDC young people placing socks over his fists, the young people continued to be managed ‘in section’.

Investigators were advised by some staff that the CYDC young people were specifically being managed ‘in section’ due to the numerous conflicts and the fear they instilled in other young people. For example, in relation to sending young people to the separate unit, a BYDC officer stated:\[170\]

So there was no way that we could house a lot of them young people up there [the separate unit] at the same time due to the fear, due to the not-to-mix and due to more incidents, mitigating risk to staff and young people. So they were managed in the unit, so they were managed on plans or in [their unit]. I think the only reason why that probably was to occur because of bed politics and that as well.

The Assistant Director-General specifically commented on the decision to allow a CYDC young person to remain in section after he had assaulted and injured another young person on 30 December 2017: \[171\]

No, I wouldn’t have thought keeping [the CYDC young person] in section - now it depends on if it was a fight or if it was just an out and out assault. ... But nevertheless, if someone sustained an injury, my view would be that [the CYDC young person] has to be separated out ...

I’m not sure what this ‘managed in the unit’ was, but can I suggest it wouldn’t have been, in my view, the appropriate way to deal with an incident where someone was hurt. I think that should have - he should have been separated out, there should have been a behavioural support plan put in place.

Irrespective of whether there was an intention to treat the CYDC young people differently or whether there were other factors that justified the approach taken, investigators established there was a clear view among young people at the centre that the CYDC young people were not subject to the same consequences as they were. This was seen as ‘favouritism’ towards the CYDC young people.

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\[168\] Interview with a young person, 3 April 2017, transcript p.15.
\[169\] Incident Report 5903336.
\[170\] Interview with a BYDC officer, 4 May 2017, transcript p.11.
\[171\] Interview with the Assistant Director-General, 15 November 2017, transcript pp.26-27.
4.3 Conclusion

The evidence provided to investigators identifies a clear perception among young people that staff were treating the CYDC young people favourably. The arrival of the CYDC young people undoubtedly impacted the operation of BYDC. These impacts were evident to young people, who identified differences in decision-making and management around the CYDC young people which ultimately gave rise to the perception that staff favoured them.

The Assistant Director-General told investigators that he was of the view that staff may have placated the CYDC young people, particularly one of the young people, by affording him additional privileges:

Had there been favouritism shown ...? In my frank view, it’s not unreasonable to think that ... at times they placated him [one of the CYDC young people] because they were fearful of him.

In light of the events that occurred at CYDC, it is understandable that staff may have been fearful of what the CYDC young people were capable of. However, such concerns could have been better managed by way of vigilance and comprehensive risk management planning, rather than placating or showing what could be regarded by other young people as favouritism.

Having regard to the issues discussed in this chapter, I am of the view that young people at BYDC became increasingly fearful of the CYDC young people following their arrival in November 2016, and formed the perception that they could not rely on staff to protect them from these young people.

Opinion 14

Between November 2016 and January 2017 there was a growing perception held by young people at BYDC that there were some staff who would not protect them from being harmed by the CYDC young people accommodated at BYDC.

In response to Proposed Opinion 14 the Director-General of the department advised:

The department believes the general use of the term ‘staff’ implies all staff at BYDC and this is an alleged perception and could be considered as unfounded and harsh.

I note the concerns raised by the Director-General. I have amended my opinion to clarify that the perception held by young people that they would not be protected from the CYDC young people related to ‘some staff’ and not all staff at BYDC.

172 ibid., p.9.
5 Concerns about safety and security at BYDC

The investigation identified strong indicators of an increasing level of fear and mistrust of staff by young people in the lead up to the BYDC riot in the form of intelligence, complaints and discovery of weapons and contraband which ultimately precipitated the BYDC riot. This chapter examines these indicators and BYDC’s identification and response to the concerns.

5.1 Intelligence addressing the safety and security of BYDC

Throughout January 2017, intelligence reports made by BYDC staff suggested that some young people were amassing makeshift weapons in anticipation of having to fight the CYDC young people. The intelligence also suggested that some young people were planning a significant event, such as an attempted escape, and were attempting to inform other young people of their plan. These intelligence reports were assessed and rated as reliable and accurate by the Intelligence Officer.

The first significant intelligence report about these matters was generated on 13 January 2017 and related to two units. The report stated:

A number of shivs [a fashioned knife like instrument] have been found in the last week. Intel from a number of sources suggest these shivs are being prepared for the return of structured day in order to protect themselves and fight [the CYDC young people].

In response to this intelligence, searches were carried out in these two units and weapons were found and confiscated.

Further intelligence was received on 15 January 2017 in relation to a discussion about weapons between two young people placed in another unit, which resulted in more contraband being found:

While [young people] were making morning Sunday breakfast in the section several [young people] were acting suspicious and making remarks to each other. These remarks included ‘Have you got that stuff for me bro’ & ‘It’s all good, I got it hidden’. Upon speaking with [a Section Supervisor] it was decided that a section room search would be conducted. The support seniors were called and after morning chores the room searches were conducted. [A BYDC officer] and [a BYDC officer] conducted the searches. A nail and a small sharpened part of a toothbrush holder were found in [a room] and a washer was found in [a room].

At the time these concerns were being raised, the Executive Director had just returned to BYDC after a period of leave. The Executive Director emailed the Assistant Director-General on 19 January 2017 outlining his concerns regarding the state of BYDC since the arrival of the CYDC young people in November 2016:

Centre staff are identifying a significant risk to staff and young people through the behaviour and attitude of [one of the CYDC young people] on centre.

174 Intelligence Report 5842, added 29 January 2017; and Intelligence Report 5840, added 29 January 2017.
175 Intelligence Report 5792, added 13 January 2017.
I have also mentioned to you the conflict that exists on centre between local young people and young people from CYDC.

... In order to avoid a critical incident on centre in the near future it may be necessary to consider arrangements for [the CYDC young person’s] ongoing placement.

He is the centre of major disruptions to the normal operations of the centre through gathering a group of young people to him for nefarious reasons. This behaviour appears to be more about attempting to harm other young people.

In the meantime, other young people are involving themselves in the progressive destruction of the centre. We have had an enormous amount of damage to rooms since the arrival of young people from Cleveland. While they have not been doing the damage, the destructiveness appears to have commenced since their arrival, or at least increased. This behaviour is young people testing the limits of the centre and demonstrations of bravado aimed at ‘impressing’ young people from Cleveland.

There are two groups of young people organising and arming themselves for some possible future melee. ... If this were to occur it would be dangerous for staff to intervene.

... Staff report that their [the CYDC young people] behaviours are more covert and subsequently more difficult to assess and manage.

If [the CYDC young person] is not able to be moved from [the] centre, to break the current dynamic and rising tensions, then it will be necessary to significantly curtail [his] movements, activities and contact with other young people.

There is no record of the Assistant Director-General’s response to this email. At interview, the Assistant Director-General told investigators:

I would have had a conversation - I would have rung him [the Executive Director] about that [the email].

... And I don’t keep notes of every conversation I have. I’m sorry. So all I can tell you is that this is not unusual for [the Executive Director] to send me something that - yeah, outlines his view of the risk. I mean, the actual fact is the last paragraph [of the email], which he says specifically curtailed [the CYDC young person’s] movements and activities in contact with other people, [that’s] exactly what he should have done. And that’s what I would have told him to do. So clearly, I was damned if I did or whatever. If I sent [the CYDC young person] back to Cleveland then I would have had the same issues but worse. If I kept [him] in Brisbane, I’m going to have this issue. That’s why I say it’s a systematic issue. It is a policy decision about people ... who are in a detention centre, that are dangerous people and are too dangerous to be in the place of detention of children.

I mean, my response to that is I’m sorry, [the Executive Director], and I know the conversation I would have had - he’s saying there, you’re going to have to manage him. And I can’t manage the daily operations of a detention centre from state level. That’s his responsibility. So frankly, that would have been my response. And the other issue is more about - what were people doing for the other children who were feeling threatened by [the CYDC young person]? So that’s more the question ... what protections were in place for other children?
The Assistant Director-General further stated that it was not necessary for him to respond to the Executive Director in writing because he was in daily contact with him during this period.\footnote{178 Letter from the Assistant Director-General to the Ombudsman, 7 September 2018.}

A number of staff interviewed claimed to have no knowledge that young people were feeling vulnerable and threatened by the CYDC young people until after the BYDC riot occurred on 30 January 2017. However, the email sent by the Executive Director to the Assistant Director-General provides evidence that by mid-January, a number of staff had at least raised concerns with the Executive Director about the changes in the behaviour of young people at BYDC.\footnote{179 Interview with the Executive Director, 30 October 2017, transcript p.17.}

The Executive Director’s email documents a significant shift in the dynamic of the centre by January 2017, which he linked to the arrival of the CYDC young people at BYDC. From both this email and the various intelligence reports, it was clear that BYDC staff had observed conflict between the CYDC young people and other young people, and that young people were arming themselves in preparation for a possible serious incident.

Some staff told investigators that they had attempted to address young people’s concerns about being accommodated with the CYDC young people on an individual basis. However, other than the Executive Director’s request that one of the CYDC young people be moved back to CYDC, the documentary evidence and interviews with staff do not indicate that any other strategies appear to have been attempted or implemented by management to address the young people’s concerns.

\begin{quote}
**Opinion 15**

By 19 January 2017 there was significant intelligence about the possibility of a serious incident at BYDC due to the young people’s fear of the CYDC young people, and there does not appear to have been any documented or integrated strategy to address this risk or allay the concerns of young people in BYDC.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.
\end{quote}

\textbf{5.2 Discovery of weapons and contraband in an accommodation unit}

On 28 January 2017, a random search of the section where the BYDC riot later occurred uncovered various contraband, including screws, hinges and brackets, a screw driver and two toothbrushes that had been fashioned into shivs. Throughout 29 January 2017 contraband continued to be found and confiscated from the young people in this section.

Consequently, during the afternoon of 29 January 2017, a Section Supervisor addressed all young people in the section about this behaviour. Due to the amount of contraband that had been found over the previous two days, the Section Supervisor made the decision to place all young people in the section on ‘basic entitlements’, meaning that everything except essential products were removed and placed in bags outside each young person’s room.\footnote{180 Interview with a Section Supervisor, 14 September 2017, transcript p.5-6.}
The Section Supervisor told investigators that this decision was made because removing excess products from the young people’s rooms would make it easier to ensure that young people were not concealing weapons.\(^{181}\)

This decision was poorly received by the young people in the section and two of the affected young people made complaints to this Office the next morning. In their complaints, both young people made general statements about having their privileges removed. One young person alleged that the young people were also not allowed to keep clothes in their room.

Further allegations of this nature were made by a number of young people when later interviewed by investigators. Young people stated that their rooms were stripped of all products and they had to retrieve clothing and toiletries from bags outside their doors (which would constitute ‘sterile room status’ rather than ‘basic entitlements’).

However, interviews with BYDC officers consistently indicated that the young people were put on ‘basic entitlements’ and were able to keep some items in their rooms, including one change of clothes and one of each hygiene product.

While there is insufficient evidence to confirm that the young people were put on ‘sterile room status’, it is clear that young people were required to remove the majority of products from their room. The Section Supervisor confirmed with investigators that placing the young people on ‘basic entitlements’ was a temporary measure until more formalised processes could be put in place to manage the contraband being concealed in rooms.

Investigators were told by the young people that they did not understand the reasons for this decision and that they felt they were being treated differently from other young people at the centre.

Investigators were also told that young people in the section saw the removal of items from their rooms as further evidence that they were being treated less favourably than the CYDC young people, since young people in their unit were able to keep all items in their rooms. This is particularly relevant in light of the fact that the young people held a firm view that the unit on basic entitlements was the ‘privileged’ unit at BYDC.

Following the imposition of ‘basic entitlements’ in the section on 29 January 2017, two separate intelligence reports about the section suggested the high likelihood of a code green (escape or abscond) occurring.

The first intelligence report, submitted by a Section Supervisor on 29 January 2017, recorded information that some of the young people were planning an escape attempt the next day and other young people were planning to destroy their rooms.\(^{182}\)

A further intelligence report, submitted by a Section Supervisor on 29 January 2017, also recorded information that some young people were planning an escape attempt the next day.\(^{183}\)

During interviews with investigators, a number of young people in the section admitted that they had planned to carry out a code green on 30 January 2017 in response to being directed to remove all personal belongings from their rooms. One young person told investigators:\(^{184}\)

> … they told us to grab all our stuff, put them in garbage bags out the front of our doors. And we feel uncomfortable with our personal stuff being out the front of our doors, like our letters and photos and all that, little sisters, girlfriends, family members and stuff. And that happened and then we had a little argument with them [BYDC staff] about it.

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\(^{181}\) ibid.

\(^{182}\) Intelligence Report 5842, added on 29 January 2017.

\(^{183}\) ibid.

\(^{184}\) Interview with a young person, 29 March 2017, transcript p.3.
And then - I don’t know, the next day we were only meant to do a code green, and that’s running. But they knew we were going to do it, so they locked us down and then I don’t know - we asked for some cleaning gear and yeah, we started smashing the windows and stuff.

In light of the security concerns in BYDC at the time, I consider the decision to place the rooms in the section on basic entitlements to have been reasonable.

However, it is important to consider the impacts that this decision had on the young people involved and whether any further enquiries about the reasons for the increased presence of contraband and weapons and plans for a code green should have occurred.

5.3 BYDC response to the intelligence reports and discovery of weapons

By the morning of 30 January 2017, BYDC staff were aware of the risk of a significant incident occurring in the section where the young people had been placed on basic entitlements. Staff discussed the intelligence at the daily management meeting at 8.30am that morning. The volume of weapons and contraband that had been found in the section over the previous few days was laid out for the meeting participants to view.

The Intelligence Officer was in attendance at this meeting and outlined to Ombudsman investigators a number of concerns about the risk of a serious incident occurring. The Intelligence Officer also told investigators that in their view, the meeting attendees did not give proper consideration to the seriousness of the intelligence that had been gathered:

… the discussion became about possessions in rooms and what should be in their room and what shouldn’t, which I was in disagreement, I wanted to deal with the intel. It got side-lined and [a Unit Manager] wanted to have a meeting with all the Section Supervisors to come down and discuss what should be in the rooms and what shouldn’t, rather than the fact that we’ve got all these issues [the threat of a code green]. That’s how I felt.

And [a Unit Manager] only wanted the section supervisors and the unit managers there. So effectively, we all had to leave and [a Unit Manager] invited the section supervisors down to have this meeting, which - they were in there for a very, very long time. I went down there several times to try and continue to have these discussions and I don’t think it was long after that that the code [green] was called …

… I think that we were heading for something anyway because of what was going on in the centre. We might have contained it that day and it might have happened a week later. Because we’re not really dealing with the underlying issue of the fact that these kids are disgruntled and why they are.

In response, the Unit Manager stated that the Intelligence Officer had been included in all relevant operational meetings:

… the intelligence officer who made the verbal report at the meeting on 30 January 2017 is included in every morning management briefing along with the Behaviour Support Team Leader, Casework Team Leader and other key stakeholder managers on centre. The intelligence officer was in attendance and was not expressly excluded at any time.

The focus of the second meeting was specifically with the operational staff from the [accommodation] Units in question to consult, gain further information and as to planning by way of response to the intelligence that had been presented and to the ongoing risks the team continued to manage.

185 Interview with the Intelligence Officer, 31 July 2017, transcript pp.42-43.
186 ibid, p.44.
187 Letter from a Unit Manager to the Ombudsman, 31 August 2018.
During interview, the Section Supervisor in the section where the young people had been placed on basic entitlements stated that the intelligence was discussed at the meeting, but there was no decision or strategy outlined for dealing with the risk:\(^{188}\)

They were saying there was potential for a major incident. They didn’t say what it was, but they said there’s potential for a major incident to happen on centre. And that was not just [one unit]. That was right across the centre. They said just be aware. So ... I went back to my unit. I spoke with my staff about what we shared at the meeting. [The young people] started cleaning out on the veranda and it kicked off. That was it.

...  

All that came out of it was be vigilant. That’s our job every day, is be vigilant and watch out for things. That’s what we do. That’s our job. So there was really - there was no action - no real - no action that I saw. Just said, okay, just be vigilant. Do your job. Keep an eye out. If anything happens, let us know. So yeah, that was it.

The Unit Manager also disputed the view of the Intelligence Officer that meeting attendees did not give proper consideration to the seriousness of the intelligence that had been gathered. The Unit Manager stated that:\(^{189}\)

a) in response to the concerns raised by the Intelligence Officer, a second operational meeting was called immediately to respond specifically to the intel’ that had been raised by the intelligence officer at the first meeting;

b) stemming from this meeting were risk mitigating solutions including additional searches of the boys rooms and confiscation of harmful objects by BYDC staff members;

c) prior to the incident, management staff members had facilitated planning and consultation with operational staff members regarding the introduction of the new offenders into the Centre and the tension caused by their arrival; and

d) additional psychologists had been sent into the … unit in response to concerns raised by some staff members.

Unfortunately, the different evidence from staff who attended this meeting, regarding what was discussed and agreed, cannot be reconciled as no records of the meeting were made, including any agreed outcomes or strategies to address the risk of an incident occurring. With regard to the lack of records, the Unit Manager stated:\(^{190}\)

Multi-disciplinary meetings and briefings are held daily, with reports often taking the form of verbal discussions without a formalised written document. The intel’ provided by the Intelligence Officer at the morning brief referred to was verbal. [I] refute the suggestion that because these meetings were not sufficiently minuted that proper consideration and action was not being taken by management at the centre to deal with the current risk level at the BYDC.

While certain actions may have been decided by management to manage the risk levels within the centre at these meetings, I again note that because of the lack of records, there is no evidence or confirmation that these decisions were made. While it was not necessary for formal minutes to be made of the discussions, there should have been at minimum notes taken outlining the security concerns discussed and the actions participants resolved to take to address the concerns.

There is no doubt that by 30 January 2017 conditions at BYDC, and in particular the unit where the young people had been placed on basic entitlements, suggested a risk of a serious incident occurring. BYDC management was aware of the likelihood of a serious incident as it was a significant point of discussion at the management meeting on 30 January 2017. However, it is not clear that BYDC identified and implemented adequate strategies to manage these risks.

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\(^{188}\) Interview with a Section Supervisor, 5 October 2017, transcript p.13.

\(^{189}\) Letter from a Unit Manager to the Ombudsman, 31 August 2018.

\(^{190}\) ibid.
Opinion 16

As a result of information in intelligence reports and an increase in weapons found in a number of units in January 2017, there were clear indicators that BYDC was at risk of a serious incident occurring. It is not clear whether sufficient action was taken by BYDC to consider these indicators and develop and document strategies to mitigate the risk of a serious incident occurring.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

5.4 Communication with young people

In the month following the BYDC riot, a number of conversations were held with young people by both the Office of the Public Guardian (OPG) Community Visitors (CVs) and BYDC staff which provided insight into the context of that event. It is notable that these discussions were only conducted with young people after the BYDC riot. Despite intelligence indicating significant tensions and anxieties among young people before the BYDC riot, it appears there was no concerted attempt by staff to explore the young people’s concerns at that time.

On 1 February 2017, the seven young people involved in the BYDC riot were visited by CVs as part of their regular visit to the centre. The young people spoke to the CVs about their displeasure about being placed on basic entitlements and having their privileges removed. The young people felt this decision was unfair and that they were being treated differently to other young people at BYDC. Young people also spoke about alleged mistreatment by staff, including staff humiliating them and swearing at them.

When speaking to the CVs, one young person claimed that his involvement in the BYDC riot was due to ‘inappropriate conduct by staff’. This young person stated that staff made statements such as ‘I can’t wait to put you with the Cleveland boys, they’ll sort you out’. The young person referred to assaults carried out by the CYDC young people and stated that ‘anyone who does a code gets put with the Cleveland boys to get bashed’. He also stated that staff told them that the CYDC young people ‘are going to bash us’. Two other young people also made references to threats and intimidation by staff as a reason for their involvement in the BYDC riot when speaking to the CVs.

A young person alluded to staff threatening young people; however, his example for this threatening behaviour was being sworn at. Another young person stated that he was involved in the BYDC riot because of how he and other young people ‘were being treated by staff’. He stated that staff ‘intimdate us’ by ‘staring at us’.

On 10 March 2017, three staff from BYDC facilitated a discussion with the young people who had participated in the BYDC riot. A record of this discussion states that the purpose of the discussion was ‘to attempt to have the boys identify their issues as to why they don’t feel safe in sections and attending structured day … and to hopefully allay their fears and ensure them that we would do all that we could to keep them safe...’.

191 Email from the Community Visitor to the Zonal Manager, 3 February 2017.
192 Ibid.
193 Ibid.
194 Ibid.
195 Email from a BYDC Psychologist to the Executive Director, the Deputy Director and MMC, 10 March 2017.
During this discussion the young people disclosed significant allegations, many of which have been discussed in this report. The following is an extract from an email that recorded the allegations made by the young people during this discussion:

- They reported that staff have made multiple threats to them that they will 'send them to [the unit where the CYDC young people were accommodated]' if they don't comply and that 'the CYDC boys will bash them'. Such threats have been made by staff such as [BYDC officers] (but they aren't the only ones).
- They feel they will be purposely placed in a situation by staff where they will be assaulted. Examples of this was when [a young person] was moved to [the unit where the CYDC young people were accommodated], and [a young person] reported that following an incident ... he was immediately placed back in [the unit with the CYDC young people] to be assaulted.
- They reported a lack of supervision – reported that they have witnessed instances where staff will leave the floor all at once giving others an opportunity to fight, or if they are on the floor they are slow to respond. Therefore, they feel that if they are attending structured day at the same time staff will not respond appropriately to protect them if an incident occurs. They feel that their protection will only come from each other.
- They believe that the CYDC boys are 'paid' with items like 2L soft drinks to carry out these acts. They admitted to receiving things from staff themselves (e.g. soft drinks) however, report that this is in the context of as a Christmas present or 'sponsored' gambling. But they believe that for these boys these items are payments.
- They report being approached daily by [unit] staff such as [a Section Supervisor] and [a BYDC officer] and told that they should all mediate and come to [the unit where the CYDC young people were accommodated], which increases their perception of being 'set up'.
- They don't feel that they receive the same consequences as those from CYDC (e.g. boys transferred to BYDC following riot and only spent one week in [the separate unit], compared to how long they were there).
- At different times throughout the discussion the boys did report that they would be willing to mediate but that they did not believe any reassurances from these boys would be genuine because even if they (CYDC boys) personally didn't have a problem with the boys, the staff would pay them to do something.

This engagement with young people clearly provided valuable information which could have given BYDC staff the opportunity to respond to the concerns and allay any fears held by the young people, potentially preventing the BYDC riot. However, these conversations with the young people took place after the BYDC riot had occurred.

5.5 Conclusion

The circumstances described in this part of the report reveal that a significant incident at BYDC was likely on, or shortly after, 30 January 2017 and ought to have been reasonably foreseeable.

An internal review conducted by BYDC's Incident Review Group (IRG), immediately following the BYDC riot, identified that there were highly credible pre-incident intelligence reports that indicated 'a very strong likelihood of a major event happening'. The IRG review found that this intelligence 'may have been better dealt with' and 'more consultation with young people to identify their issues should have occurred'.

I agree with these findings. Significant intelligence is gathered on a day to day basis in detention centres from a variety of sources, outlining potential threats and safety concerns to both staff and young people. For staff to be able to adequately respond to safety...
concerns and implement necessary preventative measures, centres must have adequate systems for aggregating intelligence, assessing risk and developing strategies to manage this risk.

Accordingly, I am of the opinion that the risk assessment of intelligence gathered at detention centres and the operational responses should be enhanced.

<table>
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<th>Opinion 17</th>
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<tr>
<td>The systems at BYDC for aggregating intelligence from a variety of sources, assessing risk and developing strategies to manage risk are not adequate.</td>
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<td>This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.</td>
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<th>Recommendation 7</th>
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<td>The Director-General of the department review the process for gathering and analysing intelligence at detention centres to ensure that intelligence can effectively inform operational outcomes. As part of this review, the Director-General should ensure the following issues are addressed:</td>
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<td>a) clarifying which officer at a youth detention centre is responsible for collating and assessing intelligence and assessing risk to the safety of the centre, staff and young people based on that intelligence</td>
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<tr>
<td>b) clarifying which officer at a youth detention centre is responsible for deciding the appropriate operational action in response to the assessed risk to the safety of the centre, staff and young people based on that intelligence</td>
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<td>c) how operational responses to intelligence are communicated to detention centre staff</td>
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<td>d) how the operational action in response to intelligence is recorded.</td>
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In response to Proposed Recommendation 7 the Director-General of the department advised:

The department is committed to continual improvement and ensuring the provision of youth justice services focuses on the safety and wellbeing of young people, staff and the community. Each youth detention centre has recently appointed additional Intelligence Officers to assist in the provision of intelligence services. These positions are responsible for the collection, evaluation, analysis and dissemination of intelligence information to appropriate internal and external stakeholders. The detention centre intelligence units are instrumental in proactively identifying and reporting strategic, and operational intelligence-related concerns to assist decision making and minimise potential risks to youth detention centres and the community.

The intelligence units lead and contribute to the development and implementation of incident prevention strategies and the management of comprehensive records used to support meetings and collaborative discussions regarding the operational management of detention centres.

Recent strengthening of incident management and review policies and procedures has further clarified roles and responsibilities as they relate to intelligence management. The department will consider the additional changes in light of the recommendations made by the Ombudsman to ensure operational responses to intelligence are effectively communicated and recorded.

I note the Director-General’s response.
6 Other matters arising from the investigation relating to BYDC

This chapter examines a number of other issues that arose during the investigation.

6.1 Review of incidents

As noted in section 5.5, on 14 February 2017 BYDC’s IRG conducted a review of the centre’s response to the BYDC riot. This review primarily focused on the management of the incident once it had commenced and only gave superficial or broad consideration to any factors that may have contributed to or caused the incident. While the IRG review did identify some of the possible root causes of the BYDC riot, there does not appear to have been any in-depth consideration of strategies to prevent an incident arising in similar circumstances in the future.

In addition, as noted in Part 2 of this report, the Chief Inspector, Youth Justice also completed a review of the BYDC riot on 12 May 2017 which did give some more in-depth consideration to some of the factors which may have contributed to the incident and made recommendations to address some of these issues.

I acknowledge that BYDC has implemented an internal review process by way of the IRG. A strong internal review capacity within youth detention centres provides the opportunity for centres to review what occurred during an incident, why it occurred and how an incident was managed. This process provides accountability and oversight, but also the opportunity to identify learnings and areas for practice or operational improvements.

I am of the view that there is an opportunity to build on the processes that have already been developed, to strengthen and enhance the internal review capacity within youth detention centres.

A review group should have capacity to review all serious or significant incidents that occur at a detention centre. Membership of the review group should be multidisciplinary, with representatives from the operational, casework and behaviour support teams, in addition to the Deputy Director, Intelligence Officer, Manager Client Relations and Manager Practice Support. This will ensure a range of perspectives and disciplines are represented.

In addition, a thorough root cause analysis of the incident should form part of the review process. A root cause analysis should not only identify the factors which may have contributed to an incident occurring, but also identify strategies to prevent a similar situation from arising in the future.

Opinion 18

The current internal review processes at youth detention centres are not adequate and do not sufficiently address strategies to prevent an incident arising again in similar circumstances.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.
Recommendation 8
The Director-General of the department review the current internal review capacity at youth detention centres and ensure the following:

a) detention centres have a review group that is responsible for conducting internal reviews of significant incidents that occur at the centre
b) membership of the review group is multidisciplinary and includes, at minimum, representatives from management, operational, casework and behaviour support teams as well as staff responsible for oversight and compliance
c) appropriate records are kept of meetings held by the review group
d) reviews include a consideration of the root cause of each incident as well as the centre’s response
e) appropriate outcomes from reviews are disseminated to staff to encourage a culture of continuous improvement.

In response to Proposed Recommendation 8 the Director-General of the department advised:

The department continuously supports, promotes and implements strategies to improve practices regarding the care and management of young people in detention. These practices also carry a primary consideration for the safety and security of all young people, visitors and staff.

The BYDC Incident Review Group (IRG) was established to complement the incident audit, assessment and review requirements outlined in operational policy and procedure. The IRG meets fortnightly to assess and review high level incidents to ensure practice compliance. The IRG proactively makes referrals to external agencies for further assessment and review.

Membership of the IRG is multidisciplinary and aims to promote consistent and evidence-based approaches to incident management and review to inform service improvement.

The department will consider the recommendations made by the Ombudsman and ensure current IRG processes give consideration to the root cause of incidents and continue to encourage a culture of continual improvement.

I note the Director-General’s response.

6.2 Complaints management

The position of Manager Monitoring and Compliance (MMC) was responsible for the management of complaints at BYDC. Upon receipt of a complaint, the MMC must assess it and determine the most appropriate course of action. In some cases, this may include referral of appropriate matters to the department’s Ethical Standards Unit (ESU) for investigation.

There were a number of complaints received by BYDC relevant to the allegations investigated by this Office. An examination of how these complaints were managed identified some concerns in relation to BYDC’s complaints management process, and in particular whether opportunities for identifying and addressing concerns regarding the actions of some unit staff were missed.
For example, on 1 January 2017 a young person’s mother made a complaint to his caseworker alleging her son had been ‘set up’ by unit staff to be assaulted. This complaint refers to the 30 December 2016 assault of a young person by a CYDC young person which was discussed at section 4.1.2. The caseworker forwarded this complaint to the MMC on 3 January 2017. After a period of leave between 4 and 17 January 2017, the MMC forwarded the complaint to ESU on 7 February 2017 without any further action taken by BYDC.

To explain the delay in referring the matter to ESU, the MMC advised investigators the complaint had only been received the day before they went on two weeks’ leave. Immediately following receipt of the complaint, the MMC attempted to contact the young person’s mother but was unable to do so. The MMC instead asked the young person’s caseworker to advise the young person’s mother that the complaint would be progressed when the MMC returned from leave.\footnote{Letter from the MMC to the Ombudsman, 9 August 2018.}

The MMC advised investigators that before their leave commenced, a risk assessment was conducted to ensure that the young person was no longer accommodated in the unit with the CYDC young person, that he was placed on the SIYP list\footnote{SIYP list is a register of young people who have been assessed as posing a risk to the safety and security of the youth detention centre.} and that he was placed on the not-to-mix list with the CYDC young person. The MMC stated that following this process they were confident that sufficient risk mitigation strategies were in place so that any risk to the young person was removed and that there was no urgency to immediately refer the matter to ESU.\footnote{Letter from the MMC to the Ombudsman, 9 August 2018.}

The MMC’s role was not backfilled while they were on leave over the next two weeks. During interview, the MMC told investigators that the role was rarely backfilled while they were on leave. As a result, the complaint was not progressed during the MMC’s absence, despite the seriousness of the allegations.

However, even after the MMC returned from leave on 18 January 2017, it does not appear that any action in relation to the complaint was taken until 7 February 2017 when the MMC referred the matter to ESU. In response to this delay, the MMC noted that they had considerable workload pressures and competing priorities during this period:\footnote{ibid.}

\begin{quote}
... as my position was not backfilled for that period, I returned from leave to face a backlog of 317 emails to be read and actioned. I was also faced with additional emails coming through as I was working. Records indicate that at that particular point in time, quarterly complaints and harm reports were due, Proactive Monitoring Review process reports were due, and updates on Performance Improvements Plans I was managing all had to be progressed amongst other priorities ... In addition to this, during this period a riot had taken place on 30 January and I was required to work excessive hours (up to 17 hour days) for a period after this disturbance. This meant that during this period, any competing priorities had to be risk managed including the referral to ESU.
\end{quote}

In summary, the complaint by the young person’s mother raised serious allegations about the conduct of BYDC staff, yet this matter was not referred to ESU for more than a month after it was received. I accept that the delay in referring this matter was largely the result of a single officer having responsibilities for the complaint function, this officer not being backfilled during a period of leave as well as being faced with considerable workload pressures upon return to work.

However, I am of the view that it is important that there be an appropriate mechanism for prioritising and progressing these matters regardless of leave arrangements and other resourcing constraints.

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199 Letter from the MMC to the Ombudsman, 9 August 2018.
200 SIYP list is a register of young people who have been assessed as posing a risk to the safety and security of the youth detention centre.
201 Letter from the MMC to the Ombudsman, 9 August 2018.
202 ibid.
Opinion 19
BYDC did not have adequate processes for managing complaints during the absence of the MMC in January 2017, which resulted in delays in progressing complaint matters.
This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

Recommendation 9
The Director-General of the department ensure that the responsibility for managing complaints at detention centres is appropriately prioritised to ensure high priority or high risk complaints are dealt with in a timely way.

In response to Proposed Recommendation 9 the Director-General of the department advised:
The department is committed to continually exploring new mechanisms and strategies to strengthen young people's confidence in the complaints management system and enable young people to have their concerns dealt with in a timely manner. Each youth detention centre now has a designated Client Relations Manager who provides high level support and advice to the Executive Director, to assist with management of complaints; incidents as they relate to the management and auditing of complaints; and the advice and reporting to internal and oversight agencies regarding complex and sensitive client support matters.

Client Relations Managers have a range of responsibilities, and are required to:
- Provide leadership throughout the department in relation to complaints management, harm and the management of complex young people.
- Lead, coordinate and conduct investigations of a sensitive, serious and complex nature into misconduct and incompetence matters as devolved by the department’s Professional Standards Unit, referred internally by oversight audit and review directorates or groups, or as directed by the Executive Director, and enhance the capacity of line managers to deal effectively with such issues.
- Provide advice, guidance, training and support to staff regarding the management of complaints, the identification and reporting of harm, and the management of complex young people.
- Maintain accurate confidential records of the management of all complaints, harm and advocacy matters, and undertake trend analysis for quarterly reporting.
- Act as an advocate for young people in the management of complaints by supporting them in a sensitive and confidential manner in making and resolving complaints, providing advice and support throughout that process, and ensuring they have access to a robust, transparent and responsive complaints management system.
- Provide authoritative, strategic and operational advice on the outcomes of misconduct investigations and official misconduct to the Executive Director or delegate including the provision of both written and verbal advice.
- Maintain secure workflow and record management systems in all investigative matters referred to the Executive Director including initial assessments, divisional and management actions, incident reviews and ensure that all accountability matters are dealt with expeditiously.
- Contribute to the centre’s Risk Management Plan.
The role of the Client Relations Manager is complex and ensures that complaint matters are progressed and referred in a timely and ethical manner. Complaints by young people and their advocates are regularly reviewed locally. Quarterly reporting regarding alleged instances of harm and breaches of principles 3, 15, 19 or 20 of the Youth Justice principles in accordance with section 37 of the Youth Justice Regulation 2016 are provided to the Office of the Public Guardian.

In response to recommendations made by [the Youth Detention Review], the department has also reviewed the youth detention complaints management policies and procedures to strengthen and clarify DCOIS record keeping requirements. New practices have been introduced to ensure complaints processes are child-friendly, culturally safe and immediately responsive to any safety or wellbeing concerns.

The department supports any review and oversight efforts to ensure that the complaints management system is accountable, transparent and is administered in a way that ensures young people can have confidence in the system to be responsive to their concerns. The department will continue to work with the Ombudsman and action any future findings or recommendations that relate to complaints.

I note the Director-General’s response.

A further complaint regarding concern with staff conduct was received by the MMC on 7 February 2017 from a BYDC Psychologist. This complaint outlined concerns that staff in the unit where the CYDC young people were accommodated may be ‘turning a blind eye to young people beating up other young people when they have caused disruption to the centre’. Specifically, the Psychologist stated they suspected this may have happened to one particular young person, referring to the assault where a young person had his nose broken by a CYDC young person on 30 December 2016.

Upon receipt, the email from the Psychologist was immediately referred by the MMC to BYDC’s Individual Performance Management group for consideration at its meeting on 8 February 2017. The MMC advised investigators that the minutes of this meeting noted the following:

[The MMC] provided a couple of emails from [a BYDC Psychologist] regarding some concerns [the BYDC Psychologist] has in regards to section bashings, staff turning their backs - natural justice, yp being set up, processes happening in [a] section. [The MMC] is going to see if [the BYDC Psychologist] can provide further information. IPM [Individual Performance Management group] agreed that this information would go to ESU but [the MMC] would provide [the Executive Director] with this advice and seek his approval before it is sent.

There is no evidence the allegations raised by the BYDC Psychologist were ever sent to the ESU.

The MMC advised that following the meeting they sought further information from the BYDC Psychologist before consulting with the Executive Director. As the BYDC Psychologist had not been able to provide any further substantial information, the MMC stated that the Executive Director was advised that:

… the matter would continue to be monitored by the Intelligence Officer who was aware of the issues and not referred to ESU given the admission in the correspondence [with the BYDC Psychologist] of a lack of evidence. There was no definitive commitment to forwarding the email correspondence to ESU.

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203 Email from a BYDC Psychologist to the MMC, 7 February 2017.
204 ibid.
205 Letter from the MMC to the Ombudsman, 9 August 2018.
206 ibid.
Given the correlation between the earlier complaint by a young person’s mother (which had been referred to ESU by the MMC the previous day) and the concerns raised by the BYDC Psychologist, I am of the view that the latter allegations should also have been referred to ESU. If nothing else, these were further concerns about the conduct of some unit staff that may have provided additional context for ESU in its investigation of the complaint by the young person’s mother.

### 6.3 CCTV coverage at BYDC

CCTV is very valuable when managing and reviewing incidents in youth detention centres.

The investigation identified insufficient CCTV coverage at BYDC, particularly in the common areas of the accommodation units, where the assaults allegedly ‘set up’ by staff occurred. Currently, any investigation of incidents in the common areas of units is solely reliant on accounts from staff and young people, which often mean the allegations are unable to be adequately investigated.

The lack of CCTV made it difficult to fully investigate some of the allegations raised in this investigation. The availability of CCTV would have made the investigation of these allegations more straightforward and potentially increased the certainty of any findings.

During interview, the MMC with responsibility for reviewing CCTV commented on the coverage and quality of BYDC’s CCTV compared with CYDC:

> We’ve got a major security upgrade [at BYDC] that we’ve been waiting on for five years, now, and it’s apparently going to start in December, January this year, which is replacing most of these cameras and putting in a lot more. Compared with Cleveland, it’s [CCTV at BYDC] shocking quality, and it’s old.

Issues with the CCTV coverage at BYDC have been raised previously. In particular, the Youth Detention Inspectorate has raised the issue multiple times in the past, most recently in its September 2016 quarterly report. The published executive summary of this report states:

> CCTV coverage at the centre is inadequate to properly review all incidents involving force and/or assaults, and thereby enhance the safety of staff and young people alike. There is a complete lack of surveillance cameras within the incident-prone common areas of accommodation units and also program areas.

In December 2016, the Independent Review of Youth Detention recommended that security cameras should be placed in all areas in detention centres where incidents involving use of force, violence, restraints or separation are known to have occurred. The Queensland Government accepted this recommendation, noting that BYDC was about to commence a security upgrade which would involve a significant expansion to the CCTV coverage at the centre.

While I acknowledge a security upgrade is currently underway, I note that issues with the quality of CCTV coverage have been a longstanding issue at BYDC. Addressing this issue should be prioritised as it is in the interests of protecting the safety of both staff and young people at the centre.

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207 Interview with the MMC, 24 July 2017, transcript p.13.
209 Department of Justice and Attorney-General, Government response to the independent review of youth detention, 2017, p.11.
Opinion 20

Despite the need for an upgraded CCTV system with enhanced coverage at BYDC being known for some time, there have not been adequate steps taken to implement the upgrade in a timely way.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

Recommendation 10

The Director-General of the department immediately prioritise enhancing the CCTV coverage at BYDC to maximise coverage of the centre, particularly in the accommodation unit common areas, in the interests of protecting both staff and young people.

In response to Proposed Recommendation 10 the Director-General of the department advised:

The enhancement of CCTV coverage at BYDC is a key deliverable in the $36.3 million security upgrade currently in progress. To date, more than 90 CCTV cameras have been installed or replaced in a staged implementation approach. The existing technology, including footage/vision quality and review monitors have been dramatically updated. Following the completion of the BYDC security upgrade, all areas of the centre, including accommodation areas will be eminently enhanced.

The improved CCTV coverage will be further augmented by the implementation of body worn cameras, which will also enable provision of audio evidence.

I note the Director-General’s response.

In addition, as part of its discussions about CCTV at BYDC, the 2016 report of the Independent Review of Youth Detention also noted that a trial of body worn cameras on detention centre staff to capture footage of incidents was underway:\(^{210}\)

It has also been submitted on behalf of the State that a body [worn] camera trial is currently underway, with positive anecdotal findings that there will be increased and improved coverage with sound recordings if body cameras are broadly implemented. The review considers this a positive development in relation to capturing audio and video of incidents involving staff or where staff are present.

As part of the Queensland Government’s response to this recommendation, it was also noted that:\(^{211}\)

Officer ‘body-worn cameras’ have been trialled in both centres and Youth Justice is of the view that this may be a cost effective option to ensure there is an audio and visual record of incidents where there is limited CCTV. Youth Justice will further consider the option of body-worn cameras in the context of this recommendation.

I support the use of body worn cameras in youth detention centres as an additional accountability and safety measure and to ensure a comprehensive record is made of any incident which later requires investigation or review.

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\(^{211}\) Department of Justice and Attorney-General, *Government response to the independent review of youth detention*, 2017, p.11.
Opinion 21
The use of body worn cameras by operational staff at youth detention centres would improve accountability and safety of staff and young people.

Recommendation 11
The Director-General of the department implement body worn cameras that provide both a visual and audio record for all operational staff working in youth detention centres.

In response to Proposed Recommendation 11 the Director-General of the department advised:

The department continues to support, promote and implement strategies to improve practices regarding the care and management of young people in detention. These practices also carry a primary consideration for the safety and security of all young people, visitors and staff.

Body worn cameras have been trialled in both centres with positive outcomes for incident reduction and young person de-escalation.

Specifications and business requirements for youth detention centres have been scoped and a preferred camera solution has been identified and purchased.

Both detention centres have recently undergone a full corporate Wi-Fi roll out and bandwidth upgrades to support body worn camera network requirements. The implementation of body worn cameras in detention centres will be finalised once additional ICT and facilities infrastructure is in place.

This process will rely upon a detailed consideration of the critical issues, impacts and outcomes that will result from implementation. Research and evidence reviews and an evaluation of the previous trial are currently in progress.

I note the Director-General’s response and urge the department to progress its current plans as quickly as possible.

6.4 Communication of BYDC directives to staff

In response to the incidents and allegations made regarding the CYDC young people, the Executive Director issued a number of directives including:

- a prohibition on the involvement of young people during responses to incidents issued on 21 April 2017
- a prohibition on staff bringing food and drink items into the centre for young people, except in special, pre-approved circumstances, issued on 4 May 2017.

These directives were emailed to BYDC staff. However, during interviews with investigators in late 2017 some staff appeared to have no knowledge of these directives or where to locate other directives issued by the Executive Director.  

212 Interview with a Section Supervisor, 4 October 2017, transcript pp.28-29; and Interview with a BYDC officer on 17 November 2017, transcript pp.25-26.
The purpose of a directive is undermined if it is not adequately communicated to staff. Directives should be communicated in such a way that ensures they are received, read and recalled by staff. Management and senior staff should also be fully briefed on directives to ensure that a consistent, centre-wide message is delivered. It is also important that there be a single location for all current centre directives which is readily accessible to staff, including new starters.

**Opinion 22**

BYDC staff were not sufficiently aware of the content of directives issued by the Executive Director, including where to access these documents.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

**Recommendation 12**

The Director-General of the department ensure all directives at a youth detention centre are:

a) communicated in a way that ensures all staff are made aware of them
b) available in a single location which is easily accessible to all staff.

In response to Proposed Recommendation 12 the Director-General of the department advised:

As identified by the Ombudsman, the Executive Director issued a number of directives via email to detention centre staff prohibiting certain practices during the period of time investigated. It is acknowledged that directives should be communicated in such a way that ensures they are received, read and recalled by staff. Youth detention centres conduct morning meetings with senior staff, who are fully briefed on directives as they arise. It is expected that this information is further communicated to section-based operational staff to ensure a consistent, centre-wide message is delivered.

Centre-wide emails are distributed electronically to all staff in the centre, however the primary role of section-based operational staff is to provide supervision and support to young people in accordance with relevant legislative provisions. Because of this, it is not uncommon for section-based operational staff to not access emails for extended periods of time. Information as it relates to operational practice updates are also disseminated through Section Supervisors, who meet daily with Youth Workers in a ‘morning brief’ forum.

Recent strengthening of centre-based communication strategies has resulted in the development of ‘printable’ fact sheets which are posted in sections and at various other staff locations around the centre, as it was identified that hard-copy documents are preferable to ensure updates are delivered. Each youth detention centre has a television in its key room, which is also used to communicate key information to staff. The department will consider alternative options for ensuring Executive Director directives are made available in these formats and readily accessible to section-based operational staff.

While this may not be standard practice across government, the youth detention centre environment is unique and some traditional communication channels remain the most practical and efficient.

I note the Director-General’s response.
The use of separation and the admission rooms at BYDC

This part of the report examines the decision-making concerning the separation of young people and the accommodation of young people in the admission rooms at BYDC.

Chapter 7 sets out the investigation findings about the lawfulness and reasonableness of the separation of the seven young people involved in the BYDC riot.

Chapter 8 focuses on the reasonableness of the use of admission rooms for extended accommodation of young people, particularly while they were separated following the BYDC riot.
7 The use of separation at BYDC

Separation of a young person in youth detention is effectively a form of solitary confinement. It generally involves the involuntary placement of a young person in a room from which they are not able to leave.

The Australian Children’s Commissioners and Guardians ‘Statement on conditions and treatment in youth detention’ adopts the following principle regarding the separation of young people in youth detention:213

The use of isolation [or separation] on a child or young person should be prohibited, except when necessary to prevent an imminent and serious threat of injury to the child or others, and only when all other means of control have been exhausted. Isolation should be used restrictively and only for the shortest appropriate period of time, and be publicly reported to an independent oversight mechanism. The use of isolation as punishment, or on a vulnerable child or young person, should be prohibited.

The ‘Statement on conditions and treatment in youth detention’ also makes the following points:214

• separation restricts the child or young person’s contact with other young people and participation in the youth detention centre’s ordinary routines
• children and young people in youth detention have complex needs and often suffer from mental health problems or have past experiences of trauma
• separation practices are known to have severely damaging psychological effects
• where children and young people are at risk of suicide or self-harm, separation is likely to increase their distress and suicidal ideation and rumination.

Accordingly, any decision to separate a young person in youth detention requires careful consideration. As a result, the YJ Regulation sets out the legislative requirements in relation to:

• the grounds for which a young person can be placed in separation
• the necessary approval timeframes for continuous separation of a young person
• the recordkeeping requirements for separation of a young person.

Firstly, this chapter outlines the legislative and policy requirements for separation of a young person in youth detention in Queensland.

Secondly, this chapter addresses the aftermath of the BYDC riot and the decision to place the seven young people involved in separation for a period of 10 days. This chapter will examine whether the use of separation in this context was both lawful under the YJ Regulation and reasonable in its administration.

7.1 Separation under the YJ Regulation

Separation means placing a young person in a locked room by themselves. The reasons for initiating separation are prescribed under s.21(1) of the YJ Regulation.215

213 Australian Children’s Commissioners and Guardians, Statement on conditions and treatment in youth detention, November 2017, Position statement 10.
214 ibid., p.20.
7.1.1 Grounds for separation

Section 21(1) of the YJ Regulation sets out the circumstances in which a young person may be placed in separation:

Separation of child in locked room

(1) A detention centre employee may separate a child in a locked room in a detention centre only—

(a) if the child is ill; or
(b) at the child’s request; or
(c) for routine security purposes under a direction issued by the chief executive; or
(d) for the child’s protection or the protection of another person or property; or
(e) to restore order in the detention centre.

7.1.2 Approval timeframes for continuous separation

Section 21(2) of the YJ Regulation provides specific time limits and approval requirements for young people placed in separation in response to an incident:

(2) A detention centre employee must not separate a child under subsection (1)(d) or (e) (a prescribed purpose)—

(a) if the separation is for more than 2 hours, including for more than 2 hours longer than the centre’s normal hours of overnight confinement—without the approval of the executive director for the detention centre; or
(b) if the separation is for more than 12 hours—without informing the chief executive; or
(c) if the separation is for more than 24 hours—without the chief executive’s approval.

In addition, s.21(3) of the YJ Regulation states that separate approvals must be sought from the chief executive for each 24 hour period a young person remains in separation:

(3) Also, if the separation for a prescribed purpose is for more than 24 hours, additional approval from the chief executive must be obtained for each 24 hour period of separation after the first 24 hours of separation.

Where the YJ Regulation refers to the ‘Chief Executive’ (the Director-General of the department), at the relevant time examined by this investigation these powers were delegated to the Assistant Director-General, Youth Justice Services.

7.1.3 Recordkeeping requirements for separation

Section 22 of the YJ Regulation outlines the requirements for staff to record the separation of a young person who is separated under s.21(1)(d) or (e) of the YJ Regulation:

Record of separation

(1) The chief executive must make a record that contains the following particulars for each child who is separated in a locked room in a detention centre for a prescribed purpose—

(a) the child’s name;
(b) the reason for the child’s separation;
(c) the name of the detention centre employee who supervised the child during the separation;
(d) the date and the length of time for which the child was separated.
7.2 Separation requirements under the department’s policies

There are a number of departmental policies that guide the administration of separation under the YJ Regulation. This guidance to staff describes the practical application of the regulatory requirements in the form of the following policies:

- the Youth Detention Centre Operations Manual (the manual)
- Policy YD-3-8 Use of separation in response to an incident (the separation policy)
- Policy YD-1-2 Behaviour development (the behaviour development policy).

7.2.1 When is separation lawful?

The separation policy states that for separation to be lawful under s.21(1)(d) or (e), one of the following must apply:

- following the use of intervention options from the Youth Detention Protective Actions Continuum to resolve an incident, the risk of further harm to people or property or the order of the youth detention centre remains
- during an incident (often an emergency situation) the safety and good order of the detention centre is put at risk and a lockdown of accommodation sections is required to ensure that the safety and security of people can be maintained.

The separation policy sets out further guidance for youth detention centre staff to determine whether the separation of a young person following an incident is lawful under the YJ Regulation:

1.3 When deciding whether to use separation in response to an incident, youth detention operational staff should consider the following questions to discharge their duty of care obligations and comply with the YJ Regulation.

- Would a reasonable bystander think that I am acting to protect a person or property or to restore order in a youth detention centre, or would it appear that I am taking disciplinary action?
- Have I given due consideration to the young person’s dignity, age, mental health, disability, safety and wellbeing?
- Have I considered the needs of the young person’s cultural background?
- Would separation be considered a reasonable response to the level of risk that exists to other people, property or the order of the detention centre?

1.4 If a young person is assessed to be calm and no longer poses a threat to people, property or the security of the centre, then the separation must cease.

1.5 The use of separation as a punishment for misbehaviour is not lawful ...

7.2.2 Continuous separation requirements

With respect to continuous separation other than for routine purposes, the separation policy mandates the following procedures for staff to ensure the separation remains lawful under the YJ Regulation:

3.1 Any use of separation that alternates a young person from a locked room to a common area over a period of time linked to the one event is only lawful in circumstances where risks exist in accordance with section 21(1)(d) or (e) of the YJ Regulation.

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216 Department of Justice and Attorney-General, YD-3-8, Use of separation in response to an incident, p.2.
217 ibid.
218 ibid., p.3.
3.2 For example, the continued use of separation may be used when managing an extremely violent young person or two or more young people who cannot interact (because of their violent behaviours towards each other) and when it is not possible to locate them in separate accommodation units. Given the nature of the youth detention environment, there will be instances where a young person poses an ongoing threat to (harm) other people even after an immediate response has been actioned to resolve the incident. The continued use of separation in this instance effectively keeps people safe while still providing the young person the opportunity to participate in section activities and programs.

3.3 The risks and the reasons for the continued use of separation for a young person must be documented on DCOIS and provided to the relevant delegated officer for approval.

3.4 Any young person subject to continued separation:
- must have their behaviours of concern thoroughly assessed and reviewed on an ongoing basis. This process must include regular communication between operational staff (shift supervisor, unit management) and therapeutic staff (behaviour support team, caseworkers and psychologists) to ensure that adequate justification exists to continue the separation and to ensure the young person’s continued wellbeing
- must be managed in conjunction with the behaviour development framework. This will include staff engaging therapeutically with young people subject to continued separation to understand and address the underlying causes of their behaviour.

3.5 The continued use of separations linked to the one event should rarely occur and if the situation can be dealt with in another way, this must be explored.

7.2.3 Calculating time spent in separation

The separation policy also addresses how the time spent in separation by a young person must be calculated:

4. Counting time separated

4.1 If an incident related separation is required for individual young people, the time clock will continue to count for as long as the separation is active.

4.2 The only exception to this is for overnight lockdown. The time clock for any active incident related separation will stop at 7:30pm and will restart at 7:30am.

4.3 To remove any doubt:
- separations for routine security purposes (other than overnight lockdown) that occur while an incident related separation remains active will not be subtracted from the young person’s count of time spent in separation
- any time spent external to the locked room while the separation remains active, for example, to eat meals at a table, the time clock for the separation will continue to count.

7.2.4 Assessment and management of young people in separation

Section 3.4 of the separation policy requires that any young person subject to continuous separation must have their behaviours thoroughly assessed and reviewed on an ongoing basis. This process must include regular communication between operational staff (shift supervisor, unit management) and therapeutic staff (behaviour support team, caseworkers and psychologists) to ensure that adequate justification exists to continue the separation and to ensure the young person’s continued wellbeing.

Section 3.4 of the separation policy also requires that any young person subject to continued separation must be managed in conjunction with the behaviour development

219 Department of Justice and Attorney-General, YD-3-8, Use of separation in response to an incident, p.3.
220 ibid.
framework. This includes staff engaging therapeutically with young people subject to continued separation to understand and address the underlying causes of their behaviour.\textsuperscript{221}

The behaviour development framework is outlined in detail in the behaviour development policy. Section 3.5 of the behaviour development policy states that for persistent minor misbehaviour and moderate and serious behaviour, a youth detention centre may establish a behaviour development plan (BDP).

The purpose of a BDP is to facilitate a focused, multidisciplinary approach to the management of a young person’s behaviour.\textsuperscript{222} A BDP may be implemented if a young person displays risk factors that place other people or property at risk or the behaviour indicates an escalating risk of ongoing behavioural issues.\textsuperscript{223} An individual BDP should clearly outline the following information:\textsuperscript{224}

- **Purpose** – why has a BDP been created and what is it planned to achieve?
- **Actions taken** – what actions are being taken post-incident to resolve the young person’s behaviour, including restorative action?
- **Risk** – what are the risk factors for the young person, including relevant risk management strategies and changes to section routine as a result of the risk factors?

The manual states that separation instigated in response to an incident can only be actioned under an approved BDP.\textsuperscript{225}

### 7.2.5 Recordkeeping requirements

The manual requires that all records pursuant to s.22 of the YJ Regulation relating to the use of separation are recorded on DCOIS.\textsuperscript{226} In particular, evidence of approval of separation timeframes must be attached to the relevant incident report on DCOIS.\textsuperscript{227}

### 7.3 Use of separation following the BYDC riot

Following the conclusion of the BYDC riot, each of the seven young people involved were escorted to a unit that was separate from the other accommodation units at the centre and placed in separation for a period of 10 days.

DCOIS records and other departmental documents provide a chronology of key events over this 10 day period:

- The section log records each of the seven young people entering the unit between 4.35pm on 30 January 2017 and 3.14am on 31 January 2017.
- DCOIS separation records document the separation period for all seven young people as commencing at 7.30am on 1 February 2017. There are no separation records for the seven young people during 31 January 2017.
- At 2.53pm on 1 February 2017, the Executive Director sent an email to the Assistant Director-General seeking approval for the separation of the seven young people for between 12 and 24 hours.
- At 5.55pm on 1 February 2017, the Executive Director recorded his approval in DCOIS for the separation of the seven young people for between two and 12 hours.
- At 4.26pm on 3 February 2017 the Assistant Director-General approved by email the separation of all seven young people for between 36 and 48 hours.

\textsuperscript{221} Department of Justice and Attorney-General, YD-3-8, Use of separation in response to an incident, p.3.
\textsuperscript{222} Youth Detention Centre Operations Manual, Chapter 3 - Incident Management, p.28.
\textsuperscript{223} ibid.
\textsuperscript{224} Youth Detention Centre Operations Manual, Chapter 1 - Care and management of young people, p.30.
\textsuperscript{225} Youth Detention Centre Operations Manual, Chapter 3 - Incident Management, p.39.
\textsuperscript{226} ibid., p.38.
\textsuperscript{227} ibid., p.39.
• At 8.03pm on 4 February 2017 the Assistant Director-General approved by email the separation of all seven young people for between 48 and 72 hours. In his email approving the separation, the Assistant Director-General stated that the young people were to remain in separation until there was some improvement in their behaviour.\textsuperscript{228}

• One of the young people was released from BYDC on 6 February 2017.

• At 7.13am on 7 February 2017 the Assistant Director-General provided approval by email for the separation of seven young people (despite a young person’s release from BYDC and only six young people remaining in separation) to continue for between 72 and 96 hours and between 96 and 120 hours. This is the last record of an approval from the Assistant Director-General.

• DCOIS separation records state that the seven young people were released from separation at 9.06am on 10 February 2017.

7.3.1 Calculating continuous separation

In order to make findings about the lawfulness of the separation of the young people after the BYDC riot, the issue of how BYDC calculates the time a young person spends in separation must be addressed.

Notably, the separation policy discounts any time spent by a young person in separation during the overnight lockdown between 7.30pm and 7.30am as counting toward the aggregate time in separation for the purpose of approvals of separation for a prescribed purpose. This is the period when all young people at the centre are routinely secured in their rooms under s.21(1)(c) of the YJ Regulation.

The effect of the separation policy is that approval from the chief executive (or an appropriate delegate) for separations continuing beyond 24 hours may not be required until after a child has in fact been separated for a period as long as 48 hours.

This is demonstrated in the following hypothetical scenario.

\begin{quote}
**Hypothetical scenario**

Young person Sam is placed in separation under s.21(1)(d) of the YJ Regulation at 1.30pm on Monday afternoon. At 3.30pm the Executive Director of the detention centre approves Sam’s continued separation for more than two hours.

At 7.30pm all young people at the detention centre, including Sam, are separated in their rooms as part of the overnight lockdown under s.21(1)(c) of the YJ Regulation. The overnight lockdown continues for 12 hours until 7.30am on Tuesday morning. At this time, when all other young people are released from their rooms, Sam’s separation continues. He has been in separation and locked in his room since 1.30pm on Monday, a total of 18 hours. However, under the department’s separation policy, only six hours (between 1.30pm and 7.30pm on Monday) have counted toward the aggregate time in separation for the purpose of seeking approvals.

At 1.30pm on Tuesday, the Executive Director of the detention centre advises the Assistant Director-General that Sam has been in separation for 12 hours.

At 7.30pm on Tuesday all young people are again separated for the overnight lockdown. At 7.30am on Wednesday morning Sam has been in separation for 36 hours, but only 18 hours have been counted as aggregate time in separation for the purpose of seeking approvals.
\end{quote}

\textsuperscript{228} Email from the Assistant Director-General to the Executive Director, 8.03pm, 4 February 2017.
At 1.30pm on Wednesday, the Assistant Director-General approves Sam’s separation for a further 24 hours. Sam has been in separation for 48 hours, but only 24 hours have been counted as aggregate time in separation for the purpose of seeking approvals.

The Assistant Director-General is not required under the department’s separation policy to approve Sam’s separation again until 1.30pm on Friday.

The purpose of escalating approval requirements for separation is to ensure accountability and oversight of separation decisions. This recognises that separating young people for longer than 24 hours is a significant decision with the capacity to have a negative impact on a young person’s wellbeing.

I accept that the separation policy reflects a strict interpretation of the YJ Regulation in that it is arguable that while separated overnight, young people separated for a prescribed purpose (under s.21(1)(d) or (e) of the YJ Regulation) immediately before the overnight lockdown are separated for a routine purpose during that overnight period.

However, I am concerned that where those same young people are immediately separated for a prescribed purpose again at the expiration of the overnight lockdown period, the separation policy frustrates the approval regime set out in the YJ Regulation.

Given the potential for separation to have a significant, negative impact on the wellbeing of young people in youth detention, in my view the approach of calculating continuous separation periods by excluding the overnight lockdown period distorts the intent of the escalating approval requirements and oversight of the separation of young people.

**Opinion 23**

The separation policy stipulates that the 12 hour period of separation between 7.30pm and 7.30am under s.21(1)(c) of the YJ Regulation is not included in the calculation of a continuous separation period for a young person separated under ss.21(d) or (e) of the YJ Regulation.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

**Recommendation 13**

The Director-General of the department amend the separation policy to require approval from the chief executive’s delegate where a young person is separated for a continuous period of 24 hours, regardless of the reason for this separation.
In response to Proposed Recommendation 13 the Director-General of the department advised:

The department is committed to ensuring that separation in response to an incident is used in strict compliance with the requirements outlined in the section 2(1)(d) and (e) of the Youth Justice Regulation 2016. The decision to separate a young person is taken seriously [and it] should be noted that the provision of separation in response to an incident is complex.

The department will seek legal advice to ensure the current separation counting practices are in line with legislative requirements. This includes counting the centre’s normal hours of overnight confinement.

I note the Director-General’s response.

However, I am of the view that in addition to whether the current practice of counting time in separation is lawful, consideration must be given also to whether the practice is reasonable.

In particular, consideration must include the research that continuous, long-term separation can have a significant, negative impact on the wellbeing of young people. This being the case, it is essential that responsibility and accountability for any young person who is separated for longer than 24 hours lies with the chief executive or a properly delegated officer.

7.4 Approvals for the separation of the young people in the BYDC riot

I am satisfied that the separations of the seven young people after the BYDC riot were approved by the relevant decision-makers. At interview, both the Executive Director and the Assistant Director-General, as the delegated decision-makers, were able to demonstrate their knowledge and approval of the separation of the young people for the entire 10 day period.

Both the Executive Director and the Assistant Director-General stated that they were in regular telephone contact during the separation period. Despite gaps in the recording of approvals, which I will discuss further below, I accept that the Executive Director provided the Assistant Director-General with regular verbal updates about the seven young people in separation and that the Assistant Director-General was aware of, and approved the young people being separated for the entire 10 day period.

My concerns lie in the adequacy of recordkeeping and documented approvals, including when approvals were sought and the reasons for the decisions to separate the seven young people over the 10 days.

7.4.1 When did the separation of the young people commence?

The section log records each of the seven young people entering the unit between 4.35pm on 30 January 2017 and 3.14am on 31 January 2017. However, DCOIS separation records do not record the seven young people as being in separation until 1 February 2017.

229 Interview with the Executive Director, 30 October 2017, transcript p.64; Interview with the Assistant Director-General, 22 November 2017, transcript p.56.
230 Interview with the Assistant Director-General, 15 November 2017, transcript pp.51-52.
The Executive Director stated that the reason the separation did not commence until 1 February 2017 was because the entire centre was locked down on 31 January 2017.\(^{231}\)

The young people threw a considerable amount of debris from the roof of the section, significant damage was done to external windows in the section. All the debris, including some very small items of metal was required to be cleared from the centre grounds. Building and Asset services was required to bring trades people on site to secure the section. These tasks were critical to be fully completed before any young people were allowed out of sections and access to these areas.

Work was also required to evaluate the on-going risk on centre both from any further copycat or follow up destructive behaviour and to ensure the safety of staff and young people. This evaluation had to be conducted carefully, given the seriousness of the incident.

Staff involved in the incident, some of whom were back on duty on the 31 January 2017, required debriefing and these meetings were conducted during the day. The welfare of staff involved in the initial violent incident in [a] section required access to counselling and support from the Employee Assistance Service.

The damage to [a] section made it unable to be used, and all young people from this location were required to be accommodated elsewhere on centre. Assessments of suitability for some young people to share had to be completed, additional bedding identified and decisions made about how all young people could be safely accommodated.

These activities took all of the 31 January 2017 to complete. This was undertaken under Section 21(1)(e) of the Youth Justice Regulation.

While I acknowledge that all young people at BYDC may have been separated on 31 January 2017 while order was restored and damage from the BYDC riot repaired, it is not disputed that the seven young people were also separated during this time.

Accordingly, in my view the separation records should show that on 31 January 2017 the seven young people (along with all other young people at BYDC) were separated under s.21(1)(e) of the YJ Regulation. These records do not appear to exist and there is no satisfactory explanation as to why the separation records indicate that the period of separation commenced at 7.30am on 1 February 2017 and not on 31 January 2017.

As a consequence, because the entire first day of the separations was not documented or included in the calculation of how long the young people had been separated, none of the subsequent separation records comply with the approval timeframes set out in the YJ Regulation.

When this was put to the Executive Director, he stated that the individual separations of the seven young people under s.21(1)(d) of the YJ Regulation only commenced at 7.30am on 1 February 2017, and that this is the time from which all subsequent approvals should be calculated.\(^{232}\)

I do not agree that an entire day of separation can be discounted because, for administrative purposes, the seven young people were separated under different sections of the YJ Regulation on 31 January 2017 and 1 February 2017. However, in any case, both sections 21(1)(d) and (e) relate to separations for a prescribed purpose under the YJ Regulation, meaning that the approval requirements under s.21(2) and (3) still applied.

Accordingly, in my view the initial separation approvals should have been sought on 31 January 2017, and then subsequent approvals sought for every 24 hour period the young people remained separated.

231 Letter from the Executive Director to the Ombudsman, 20 August 2018.
232 Letter from the Executive Director to the Ombudsman, 20 August 2018.
7.4.2 Records for separation longer than two hours

The first record of the Executive Director approving separation for longer than two hours\footnote{Youth Justice Regulation, s.21(2)(a).} was made at 5.55pm on 1 February 2017. By this time, the young people had been in separation for at least 38 hours, depending on when their involvement in the BYDC riot ended.

While this entry was made at 5.55pm on 1 February 2017, it is likely that this is not reflective of the actual time the Executive Director approved the separation, rather it is the time the record was made in DCOIS. There is no record of the exact time the Executive Director approved the separations for longer than two hours, as this was done verbally. This point was noted by the Executive Director:\footnote{Letter from the Executive Director to the Ombudsman, 20 August 2018.}

As the DCOIS system does not automatically generate separation approval documentation and actions the Deputy Director, Unit Managers, Shift Supervisors and section staff rely on verbal communication initially to seek approval, this ensures that the Executive Director has been [advised]. The reliance on emails to exchange information about separation times is unreliable and the receiving officer cannot always have access to emails to formalise the decision. [I] always committed to respond to staff with an email approving separation [as] soon as practical and then to copy that email into the DCOIS system when time permits.

In my view, while the Executive Director explained why he approved the continued separation (the risk of further harm to people or property or the order of the youth detention centre remained), he did not provide any reasons to establish why that risk remained, or why separation of the young people was required to manage that risk.

Accordingly, while I am satisfied that a decision to separate the young people for longer than two hours was made by the Executive Director, it is not possible to determine when the decision was made or the specific reasons why the separation was necessary.

7.4.3 Records for separation longer than 12 hours

On 1 February 2017, the Assistant Director-General was informed that the young people had been in separation for longer than 12 hours, although the process for informing him was affected by error.

At 2.53pm on 1 February 2017, the Executive Director emailed the Assistant Director-General requesting the Assistant Director-General’s approval for separations between 12 and 24 hours:\footnote{Email from the Executive Director to the Assistant Director-General, 2.53pm, 1 February 2017.}

I am seeking your approval ... for 12 to 24hrs separation for the young people involved in the code black on Monday the 30th Jan-17. Please see names below ...

The Assistant Director-General subsequently approved the separations at 5.16pm on 1 February 2017, even though his approval was not necessary under the YJ Regulation. The YJ Regulation only required the Executive Director to advise the Assistant Director-General that the separations were continuing past 12 hours. The Executive Director had the delegation to approve the separations up to 24 hours.

The Executive Director advised investigators that his email to the Assistant Director-General was intended to seek approval for separation between 24 and 36 hours. The Executive Director stated that he had written the incorrect timeframe of 12 to 24 hours.\footnote{Letter from the Executive Director to the Ombudsman, 20 August 2018.}

If this is the case, there is no evidence of any specific email that informed the Assistant Director-General that the separations were continuing for longer than 12 hours. Instead,
evidence of the first contact with the Assistant Director-General is this approval request for separation between 24 and 36 hours. I note that this request was made nearly 36 hours after the last two young people were placed in separation in the early morning of 31 January 2017.

In any event, even though the formal records are not clear, as mentioned at section 7.4, I accept that the Assistant Director-General was aware that the young people were placed in separation continuously from the time they came down from the roof.

### 7.4.4 Records for separation longer than 24 hours

There are significant gaps in the recorded approvals obtained from the Assistant Director-General for separations longer than 24 hours. Approvals were not sought every 24 hours, and in some instances three or more days had elapsed between documented approvals.

Clearly, the most significant factor contributing to the gap between approvals is that BYDC did not count any of the time the young people were separated overnight, as is outlined in the separation policy.

On analysis of the DCOIS and email records obtained during the investigation:

- as outlined in section 7.4.3, an email sent by the Executive Director to the Assistant Director-General at 2.53pm on 1 February 2017 was to seek approval for separations longer than 24 hours, but mistakenly sought approval for between 12 and 24 hours. This email was sent nearly 36 hours after the last two young people were placed in separation
- the Assistant Director-General’s first clear approval for separations beyond 24 hours was by email on 3 February 2017 at 4.26pm, nearly 81 hours after the separations commenced on the morning of 31 January 2017
- the Assistant Director-General’s second approval for separations beyond 24 hours was provided nearly 28 hours later at 8.03pm on 4 February 2017
- the Assistant Director-General’s third approval for separations beyond 24 hours was provided 59 hours later at 7.13am on 7 February 2017
- there are no further records of the Assistant Director-General approving any separations for the remaining two days of separations which concluded at 9.06am on 10 February 2017.

With regard to these timeframes, the Assistant Director-General disputed that there were significant gaps between approvals, noting that under the separation policy, the 12 hour period a young person is secured in their room overnight is not counted as part of the time they are separated. The Executive Director further stated that if the time the young people spent in their rooms overnight was not counted as the separation policy allowed, then the approvals were sought and received in a timely way and within acceptable parameters.

I accept that the Assistant Director-General’s and Executive Director’s calculation of when separation approvals needed to be approved was compliant with the separation policy.

However, I have noted my disagreement with how continuous separation is calculated under the separation policy in section 7.3.1. I remain of the view that calculating continuous separation periods by excluding the overnight lockdown period distorts the intent of the escalating approval requirements and oversight of separation of young people in detention.

I also note that the Executive Director has based his assessment of when approvals needed to be sought on the separations of the seven young people not commencing until 7.30am.

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237 Letter from the Assistant Director-General to the Ombudsman, 6 September 2018.
238 Letter from the Executive Director to the Ombudsman, 20 August 2018.
on 1 February 2017. I addressed this issue at section 7.4.1 and reiterate my view that an entire day of separation cannot be discounted because, for administrative purposes, the seven young people were separated under a different section of the YJ Regulation on 31 January 2017.

Accordingly, I do not accept that the approvals for separations longer than 24 hours were sought and received in a timely way and within acceptable timeframes as required under the YJ Regulation.

Having regard to the obvious gaps in the recorded separation approvals, the following observations address some of the more specific underlying issues.

**Lack of recorded separation approvals on 2 February 2017**

Between 7.30am on 2 February 2017 and 4.26pm on 3 February 2017 the young people were apparently separated without any approval from the Assistant Director-General. As discussed above, this appears to have resulted from the email sent from the Executive Director, where he mistakenly requested approval for separation between 12 and 24 hours, rather than between 24 and 36 hours.

The Assistant Director-General approved this request, but the error was compounded when the Executive Director forwarded the email and approval to a number of senior BYDC officers at 7.27pm on 1 February 2017 stating:

> Separation approved by Assistant Director General for beyond 24 hours.

Please note that should separation be required beyond 48 hours a new request and approval will need to be obtained from the ADG [Assistant Director-General].

This was not accurate. The approval from the Assistant Director-General was for separation between 12 and 24 hours, not beyond 24 hours. This appears to have mistakenly led staff to believe that the separations had been approved for 2 February 2017.

The Executive Director admitted that this was an unintentional error; however, he also noted:

> ... [the] ADG [Assistant Director-General] approved the separation. The ADG has responsibility for approval separation beyond 24 hours and it would appear that the ADG also believed that he was [approving] separation for the period beyond 24 hours.

**Lack of recorded separation approvals after 7 February 2017**

It appears that no separation approvals were sought or received from the Assistant Director-General after 7 February 2017. This means that young people were separated for the final two days after the last approval expired without documented approval. During interview, the Executive Director stated that the reason there were no approvals for this period was that the young people were not formally separated during the final days.

We didn’t consider that they were in separation, you know, formal separation for the full 10 days, because after a period of time they were allowed to have contact and they were brought out of their rooms, so they weren’t any longer in formal separation. So that’s why you won’t find emails for 10 days’ worth … at the 10 day point they were moved [back into the general population]. And so that clearly indicates at that point in time their behaviour had started to change and they were becoming much more compliant and therefore they weren’t needing to be separated and kept at arm’s length, because of the threats they were making to staff. And so they weren’t considered to be formally in separation at that point.

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239 Email from the Executive Director to BYDC senior staff, 7.27pm, 1 February 2017.
240 Letter from the Executive Director to the Ombudsman, 20 August 2018.
241 This excludes the young person who was released from BYDC on 6 February 2017.
242 Interview with the Executive Director, 30 October 2017, transcript pp.68-69.
However, I note that the separation records document the young people as being separated until 9.06am on 10 February 2017. DCOIS records documenting the in- and out-of-room times also confirm that the young people were confined in their rooms on 8 and 9 February 2017.

In response, the Executive Director stated:  

The interview with the investigator regarding this matter occurred on the 26 October 2017. This was more than 10 months since the incident and during the interview I did not have access to records and was relying on memory. It is understandable that my recollection of events may not be entirely accurate. The records clearly indicate that separation continued until the 10 February 2017 and approvals were sought for the period.

I accept the Executive Director’s statement and I agree that the separation records indicate that the young people were separated until 10 February 2017.

However, I do not agree that approvals were sought for the entire period following 7 February 2017. The final approval was received from the Assistant Director-General at 7.13am on 7 February 2017. This means that there were no approvals for the separations between 7.13am on 8 February 2017 and the time the young people were released from separation at 9.06am on 10 February 2017.

**Opinion 24**

The decision to approve the separation of young people at BYDC between 8 and 10 February 2017 was not adequately documented.

This is administrative action that is contrary to law for the purposes of s.49(1)(a) of the Ombudsman Act.

### Seeking approval for separation for a 48 hour period

In his final approval request on 6 February 2017, the Executive Director requested that the Assistant Director-General approve the continued separation of the young people for a period of 48 hours:

I am requesting approval for the seven young people below for separation to continue from 72 to 96 hours and 96 hours to 120 hours.

This request was approved by the Assistant Director-General the following morning.

Section 21(3) of the YJ Regulation states that separate approvals must be sought for each 24 hour period a young person remains in separation:

(3) Also, if the separation for a prescribed purpose is for more than 24 hours, additional approval from the chief executive must be obtained for each 24 hour period of separation after the first 24 hours of separation.

The Executive Director stated that he was aware of the requirement under the YJ Regulation to seek approval for each 24 hour period of separation. With regard to his request to the Assistant Director-General for a separation period of 48 hours, the Executive Director stated:

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243 Letter from the Executive Director to the Ombudsman, 20 August 2018.
244 Email from the Executive Director to the Assistant Director-General, 9.49pm, 6 February 2017.
245 Email from the Assistant Director-General to the Executive Director, 7.13am, 7 February 2017.
246 Letter from the Executive Director to the Ombudsman, 20 August 2018.
247 Letter from the Executive Director to the Ombudsman, 20 August 2018.
This email meets the requirements of the policy and regulation by seeking approval for each 24 hour period of separation. The policy does not require the approval for two different 24 hour periods to be put into two separate emails or to request the approval every 24 hours. The email laid out the need for approval for each of the 24 hour periods. The intent of the regulation and policy is to avoid the blanket approval of hours of separation without end.

The email seeking this approval allows the ADG to consider each of the periods of separation the approval was sought for and either approve or not either both periods or the first period only. The ADG has the capacity to only approve the first period and to request a further email seeking approval for the second period. On this occasion he approved both.

Emails were exchanged with the ADG and phone calls made keeping him up to date with the young people’s progress while in separation. By the time he received this email the ADG would have been well aware of the circumstances at BYDC and was in a position with relevant information to make an informed decision regarding separation approval.

During interview, the Assistant Director-General stated he was aware approvals had to be sought for each 24 hour period of separation, but was unable to explain why he approved the 48 hour period on 7 February 2017.248

I do not accept the Executive Director’s view that two separate 24 hour periods of separation can be requested and approved at the same time. The YJ Regulation clearly specifies that an additional approval from the chief executive must be obtained for each 24 hour period of separation after the first 24 hours of separation. This means that a request may only be made under the YJ Regulation for a separation period of 24 hours and the chief executive or their delegated officer may only approve 24 hours of separation. After this 24 hour period has expired, a new request and approval must be sought and received.

Additionally, in my view, it is the intent of the YJ Regulation that an ongoing daily assessment about whether a young person should remain in separation should support any approval for a further 24 hour period. Such an assessment cannot be conducted if approvals for separations are made for a period longer than 24 hours.

Accordingly, I am of the view that the Assistant Director-General’s approval of separation for 48 hours was not lawful under the YJ Regulation. Again this supports a finding that proper approval was not obtained for the young people to remain in separation between 8 and 10 February 2017.

**Opinion 25**

The approval granted by the Assistant Director-General on 7 February 2017 for the separation of the young people to continue for a 48 hour period does not comply with the requirement in s.21(3) of the YJ Regulation.

This is administrative action that is contrary to law for the purposes of s.49(1)(a) of the Ombudsman Act.

### 7.4.5 Recording separation approvals

During the investigation, the Executive Director noted the difficulties with using DCOIS to monitor separation lengths and ensuring that proper approvals were sought in time.249

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248 Interview with the Assistant Director-General, 15 November 2017, transcript p.52.
249 Letter from the Executive Director to the Ombudsman, 20 August 2018.
DCOIS does not provide sufficient ease of use, notifications, visibility of events or recording of decisions for such an important matter as separations. The system fails to provide adequate administrative support for ensuring that officers are provided with timely and relevant information required to understand when decisions should be made and when appropriate approvals should be received.

The separation area of the DCOIS system displays a single instance of separation across nine screens of information. The user is required to use multiple tabs to view a range of information and data. This does not assist the user readily and easily seeing the information they need to make decisions. The information on times in and times out for separation can be confusing and unclear. The system does not provide an active notification system to advise delegates when approvals are required or if approvals are overdue. The DCOIS system is confusing, making it difficult to adequately determine when approvals are required. The system also does not support accurate interpretation or implementation of the regulation, policy and procedure.

The Executive Director stated that these functionality issues meant that the length of time a young person had been in separation needed to be calculated manually.

When dealing with a high number of young people in separation at the same time, it is likely that errors may arise in the calculations. While there may be scope for improvements in DCOIS functionality regarding calculating separation times, it is ultimately the responsibility of detention centre staff to make comprehensive and accurate records which clearly establish that proper approvals were sought for a young person in separation.

Staff must also ensure that their records are of sufficient quality to allow any subsequent audit or review to clearly establish that the period of separation was approved in accordance with the prescribed requirements of the YJ Regulation.

7.5 Did decision-makers take into account relevant factors in deciding that continued separation was justified?

Each of the seven young people involved in the BYDC riot was separated under s.21(1)(d) of the YJ Regulation, namely for the child's protection or the protection of other persons or property. The overall reason provided for the use of separation was ‘to ensure the safety of staff and to evaluate their [young people’s] intention of continuing behaviour’.

Accordingly, for the separation to have been lawful under s.21(1)(d) of the YJ Regulation, it was necessary for BYDC to establish that for each individual young person their continued separation over the 10 day period was justified because there was a risk of further harm to people or property. This process required an ongoing assessment about each young person’s behaviour while in separation and a decision about whether they could safely be reintegrated into the centre routine.

No specific reasons or assessments are provided about why separation was necessary for any of the young people on 31 January 2017 because, as discussed at section 7.4.1, staff at BYDC did not record the young people as being in separation on that day.

On 1 February 2017, the following reasons were recorded by the Executive Director while exercising his authority under s.21(2)(a) to approve separation for longer than two hours:

This approval is given for separation in response to an incident as people and or property require protection. Despite the use of interventions from the Youth Detention Protective

250 Interview with the Executive Director, 30 October 2017, transcript p.76.
251 Reason provided on the DCOIS separation record for each young person involved in the BYDC riot.
252 Department of Justice and Attorney-General, YD-3-8, Use of separation in response to an incident, p.2.
Actions Continuum to resolve an incident, the risk of further harm to people or property or the order of the youth detention centre remains. In deciding to approve separation I have given consideration to the circumstances leading to the need for separation. This separation is being used to protect a person or property and is not being used as discipline or punitively.

The [seven young people] is suitable to be separated for the time approved given their age, mental health, safety and wellbeing. The [seven young people] would continue to place themselves and others at risk of harm and injury if the separation did not occur. The level of risk that would exist to property and persons would have been high and immediate level if [the seven young people] was not placed in separation.

All seven young people have been involved in a major incident on centre resulting in tens of thousands of dollars’ worth of damage to government property and the significant injury to a staff member. This behaviour has placed the normal operations of the centre at risk. They require separation from general population for careful assessment of their behaviours and evaluation of what future risks they pose.

They have been placed in a single unit of accommodation which will require them to be placed in a locked room for periods of time. This accumulated separation will be required for longer than 24 hours due to the seriousness of the event and the related complexity of risk assessment. The continued separation is required to allow time to plan for the safe integration of [the seven young people] back to normal routine.

When planning is complete and implemented and the high risk of harm to persons and property [is] reduced ... [the seven young people] [will be] removed from separation. The implementation of this plan will be reliant on [the seven young people] willingness to comply with the components of the plan and [the] plan will effectively keep people safe while providing the young person with opportunity to participate in section activities and programs.

While these reasons do not outline the specific risks posed by each of the seven young people in requiring separation under s.21(1)(d), the justification provided appears reasonable particularly considering the proximity of the assessment to the BYDC riot.

On 1 February 2017, the Executive Director also emailed the Assistant Director-General as part of his obligation to advise him that the separation was for longer than 12 hours. The email stated the following:253

As at 13:10hrs on the 1st Feb-17 [unit] section staff state that these young people remain defiant and every time they come in contact they are bragging about their behaviours and if allowed to mix would present an unmanageable level of risk to the staff required to manage them.

Risk assessment of their behaviour is continuing. It is expected that these young people’s reintegration into general population will occur over a period of time.

We are aware of the need to re-apply for each further 24 hour period if this becomes necessary.

On 3 February 2017, the Executive Director provided further information to the Assistant Director-General as part of his request for approval for an extension of a further 24 hours separation:254

The seven young people currently remain in ... section.

Today there have been further incident reports and intelligence reports of the young people inciting others, threatening staff, damaging rooms, abusing both young people and staff, threatening, discussing and planning future codes including code blacks.

253 Email from the Executive Director to the Assistant Director-General, 2.53pm, 1 February 2017.
254 Email from the Executive Director to the Assistant Director-General, 4.24pm, 3 February 2017.
This behaviour remains inconsistent with them being returned to their regular section, general population or programming. This then will require them to continue to remain in [the unit] where their periodic separation in a locked room is needed to manage young people numbers and safety and security dynamics.

With respect to the behaviour outlined in this email, an incident report generated by unit staff on 2 February 2017 records that three young people were overheard discussing conducting another code black (riot). Other reports from 2 February 2017 record that the same three young people were involved in yelling abusive comments towards staff and police and inciting each other to make complaints about being denied access to toilets. However, there is no evidence of any similar behaviour by the other four young people.

The next request from the Executive Director to the Assistant Director-General for a further 24 hours of separations was on 4 February 2017 and stated:256

These are the young people involved in the [BYDC riot] earlier in the week.

They currently remain in [separation]. Thee [sic] behaviour in the last 24 hours has not changed. They remain defiant, abusive to staff and threatening to harm staff. They have been yelling out their windows to other young people and inciting them to riot and cause code blacks. They have been inciting any young person processing through admissions are [sic] to assault staff and damage government property. They have continued to scratch the walls in their rooms and damage property at every opportunity.

They have not responded to positive engagement by staff, attempts to discuss with them future orientated goals or planning.

At this time these young people remain a considerable threat to the good order of the centre, to the safety of staff and young people and to government property. The risk of removing them from separation … would most likely result in at least a repeat of the events [from] earlier this week.

While this advice refers to the behaviour of all seven young people, again it appears the only report generated between 2 and 4 February 2017 relates to one young person calling out to young people in another unit to riot. There does not appear to be any other record about the behaviour of the other six young people mentioned in the email. The Assistant Director-General approved the continued separation for all seven young people and made the following comment:256

They are to remain in [separation] until there is some improvement in their behaviour. The centre is at considerable risk and I will not allow a repeat of the dangerous incident. Please continue with the supportive behaviour however if there is no change then these YPs leave us with no choice. Please keep me informed of any progress.

On 6 February 2017, the Executive Director sent an email to the Assistant Director-General requesting he approve 48 hours separation. The Executive Director’s email stated:257

Yet again these young people all day today have threatened staff. There have been a further 5 incident reports involving these young people and four intelligence reports including one where they were discussing causing a Code Black and breaking into the girls section to rape them and another where they were openly planning to attempt to escape police custody on the way to court.

These actions and threatened behaviours represent a significant and on-going risk to the safety and wellbeing of staff and young people on the centre.

This was the final separation request made to the Assistant Director-General who approved the 48 hour separation period the following morning.

255 Email from the Executive Director to the Assistant Director-General, 5.39pm, 4 February 2017.
256 Email from the Assistant Director-General to the Executive Director, 8.03pm, 4 February 2017.
257 Email from the Executive Director to the Assistant Director-General, 9.49pm, 6 February 2017.
I note that two incident reports dated 5 and 6 February 2017 outline the following behaviours:

• Three of the young people were heard making loud, offensive and inciting remarks regarding the BYDC riot and injuries received by staff. Specifically, the incident report stated that these three young people:

  ... believe they have trounced staff, coupled with a new found fame from peers on centre leaves little doubt these Yp’s will at this stage not hesitate to opportunistically engage in similar behaviour. Additionally, these Yp’s present a serious risk in emboldening other Yp’s to engage in the same behaviour to achieve ‘status’ ...

• Four of the young people were yelling abuse and threatening police officers who were collecting young people for court. One of these young people also continued to verbally abuse unit staff.

Also on 6 February 2017, an incident report recorded that one young person had scratched graffiti over the walls of the medical room with a screw which was removed from a light fitting. This young person was later released from BYDC on that day.

On 8 February 2017, notes regarding two further incidents were recorded on DCOIS by the Executive Director:

1. 7th Feb 2017 [a young person] ... became agitated when he wasn’t able to make a phone call when he demanded as other YP were utilising the common area of [the unit] at that time, YP has then set off the fire sprinkler in his room ...

2. 7th Feb 2017 Admissions holding cells. [four young people] this morning have been inciting each other in regard to further riot and codes & disruptive behaviours, gloating about their ongoing behaviours & displaying aggressive behaviours to staff.

A further incident report on 8 February 2017 records that one of the young people rushed into another young person’s room and started a physical altercation, with both young people exchanging punches.

There are no further records regarding the behaviour of the young people before their release from separation on 10 February 2017.

Despite the concerning behaviour recorded, there are a number of inaccuracies and discrepancies in the records outlined above.

Firstly, although one of the young people was released from BYDC on 6 February 2017, he was included in the separation approval request to the Assistant Director-General on 6 February 2017 and this request is included on his separation record.

Further, this young person was accommodated in the medical centre, which is separate from the other accommodation areas in the unit, for the entirety of his separation period. Given this, it is not clear how the young person could have been involved in the behaviours described, namely joining the young people in the abusive and threatening behaviour, that were used to justify his continued separation.

There is also no or limited recorded evidence about any significant behavioural problems by three of the young people while they were in separation, other than one instance where the young person accommodated in the medical area scratched graffiti on the walls of his room. With respect to one other young person, there is one negative report recorded on 6 February 2017 outlining his involvement in inciting and disruptive behaviour about conducting further riots and codes.

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258 Incident report 6017242.
259 Incident report 6020496.
Despite this, their continued separation was requested by the centre and approved by the Assistant Director-General. For each of these young people, their DCOIS separation record notes that the reason for their continued separation was that their ‘behaviour remains inconsistent with them being returned to their regular section, general population or programming’.

From the recorded evidence, it is difficult to identify specific behaviour by three of the seven young people that supported a decision that they could not return to the general population.

This was disputed by unit staff during interview, who stated that the behaviour of all the young people during their separation was disruptive and abusive towards staff. The Executive Director stated that while the behaviour of the young people would often improve for a time, it then deteriorated with the young people shouting out and attempting to aggravate each other:

> ... my concern was that each of the children who were down in [separation] that had been involved in the incident, continued their escalated behaviours and threatening of staff. Information I was receiving in briefings was that all of those children were doing that and they were continuing to ... rile each other up.

So what would happen, what I was being told was, that staff were working with the children, they were talking with them, trying to engage with them and they would get a couple of the boys to a point where they were settled and they were doing pretty well. And then particularly in the evening, the boys would start yelling out to each other and the kids that they’d managed to get relatively settled would start to join in to make threats and call out again and start kicking doors. And they were banging doors and they were damaging property and doing all of that as well.

The Executive Director also noted that consideration of whether the separations should continue does not just relate to the behaviour of the young people while in separation immediately following an incident:

Risk is a dynamic and continuing consideration that considers a wide range of factors including:

- The behaviour of young people in separation, including behaviour recorded in incidents, observations by staff of the young people’s attitudes, conversations and actions.
- The young people’s risk to engage other young people in dangerous, destructive or disruptive behaviour, including their likely influence on other young people.
- The behaviour, conversations, and attitudes of other young people on centre and their possible involvement in similar behaviours as involved in their initial incident.
- The overall risk on the centre and the type and nature of other incidents occurring on the centre.
- The seriousness of the initial incident and if returned to normal routine too soon if other young people will perceive a nil or minor consequence for the behaviour resulting in increasing risk of further similar incidents and copy-cat behaviour.
- The ability of staff to manage the young people’s behaviour within regular accommodation given the number of other incidents on centre and the centre’s risks.
- The ability to safely and securely accommodate the young people in regular accommodation.

All of these factors are regularly and routinely considered in the normal operations of the centre. This is a daily activity undertaken to manage the centre in a safe way. All these factors were considered in these circumstances and the risk of returning the young people to regular accommodation and general population was considered too high.

260 Interview with the Executive Director, 30 October 2017, transcript p.73.
261 Letter from the Executive Director to the Ombudsman, 20 August 2018.
The other significant factor that must be considered is the history of the young person both on the centre and in the community (seriousness of offending). These matters are known to detention centre staff and are taken into consideration in determining the risk a young person poses. Some young people have serious levels of offending in the community and can have no or few incidents on centre. However, a combination of a history of serious offending and on centre behaviour increases the risk centre staff are required to manage.

The seven young people involved in the 31 January 2017 incident all had serious community offending behaviour and considerable disruptive incident involvement on centre. This together with their involvement in the riot required their risk of being involved in further serious incidents as being highly likely.

I acknowledge that multiple factors must be considered when assessing whether there remains a risk to the safety and security of the centre by admitting a young person back into the general population and structured day activities. However, if multiple factors are relevant considerations for continuing to separate a young person under the YJ Regulation, they should be clearly recorded as reasons why the separation continued. This was not the case in this instance.

The separation policy states that to justify continued separation under s.21(1)(d) of the YJ Regulation there must be evidence that the risk of further harm to people or property or the order of the youth detention centre remains. Further, the separation policy explicitly requires that if a young person is assessed to be calm and no longer poses a threat to people, property or the security of the centre, then the separation must cease.

In this instance, because there are insufficient records about the individual behaviour of each of the young people in separation, it is difficult for BYDC to justify that the risk remained for each young person, on each day of the separation. In the absence of sufficient and detailed records, it is not possible to conclusively determine that the separation of each of the young people was justified under s.21(1)(d) of the YJ Regulation for each day of their separation.

In particular, while the available evidence suggests that the behaviour of three of the seven young people between 31 January 2017 and 7 February 2017 was often abusive and threatening, there is insufficient information about their behaviour after 7 February 2017 until their separation ended on 10 February 2017 to justify their continued separation.

I am also concerned that the record about the behaviours of the remaining four young people for the entire length of their separation is insufficient. As a consequence, it is not possible to justify the length of their separation, or determine whether the separation was necessary under s.21(1)(d) of the YJ Regulation. Based on the information available, there is no apparent justification for their continued separation after 3 February 2017, the date of the Executive Director’s second recorded assessment.

The Executive Director did not agree with these findings, stating:

Given the circumstances of the incident, the behaviour of the young people, the risk of their influence on others behaviour, the threats of further riots, the previous behaviour of the young people, their likelihood to be involved in further serious violent and/or damaging behaviour was evident. Further, it would be my opinion that any reasonable person having full knowledge of the events and behaviours would consider that separation in this situation was justified and reasonable in the circumstances.

The Assistant Director-General also disagreed, stating:

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262 Department of Justice and Attorney-General, YD-3-8, Use of separation in response to an incident, p.2.
263 ibid.
264 Letter from the Executive Director to the Ombudsman, 20 August 2018.
265 Letter from the Assistant Director-General to the Ombudsman, 6 September 2018.
The factual circumstances were such that to enable these YP to be properly managed, required their separation. I relied upon the expert advice provided to me regarding the situation at the centre and the circumstances giving rise to the need to separate particular YP for periods of time.

... 

The safety of the community of the BYDC is paramount and these decisions to separate individuals are not taken lightly. If a YP is not receptive to repeated directions, it is vital for the safety of staff and other YP at the centre that consideration be given to separation.

While I acknowledge these views, if there is evidence that a young person poses a significant safety and security risk to a detention centre that necessitates their continued separation, this must be documented and the reasons for their continued separation properly explained.

Opinion 26

There were insufficient reasons provided for each of the seven young people to justify the entire length of the separation under s.21(1)(d) of the YJ Regulation.

This is administrative action that is unreasonable for the purposes of s.49(1)(b) of the Ombudsman Act.

In response to Proposed Opinion 26 the Director-General of the department advised:

The department believes there was a clear justification for separating the seven young people for the entire length of the separation. It is however, acknowledged that this information was not adequately recorded.

I remain of the view that the available records do not provide a ‘clear justification for separating the seven young people for the entire length of the separation’. If there were legitimate reasons that all seven young people needed to be separated for the entire 10 days, these reasons should have been clearly outlined in the records. Without this evidence the length of the separation timeframe for all the young people cannot be justified.

I note that the Director-General has acknowledged that information justifying the length of the separations was not recorded.

Finally, it also appears the seven young people were assessed as a group, rather than an individualised assessment being conducted about the behaviour of each young person. In explaining the concept of separation based on ‘group behaviour’ during an interview with investigators, the Executive Director stated that the seven young people had acted as a group during the BYDC riot and he was of the view that all the young people in the group needed to be settled before any individual young person could be moved back to their section.266

I think the other concern too is that you know their behaviour in the initial incident was as a group. Quite clearly they acted and behaved as a group, and they continued to support each other during the incident as a group. And there would have been concerns about them, even if a couple of the children had been relatively settled, then them going back out on the centre acting as a group again, and the other boys involving each other in another activity.

266 Interview with the Executive Director, 30 October 2017, transcript pp.73-74.
So I think it still needed to be managed that when the kids came out of [separation], that they all came out of [separation] together. And so we were satisfied that all of the children’s behaviours had settled to a point that we had all of – so look it’s also not just about that the kids are settled and they’re ready to go. It’s about too, are the plans in place, has everybody agreed that the children are to return to section?

The Executive Director’s statement appears to acknowledge that some of the young people were kept in separation because the behaviour of other young people who had been involved in the BYDC riot had not sufficiently settled in order to transition all of them back to their sections.

I am of the view that continued separation under s.21(1)(d) of the YJ Regulation is dependent on the behaviour of a young person, and an assessment that as a result of this behaviour, separation is necessary for the protection of another person or property. A young person's behaviour as part of a group may be relevant to this individual assessment, but the essential aspect is whether the young person poses a continued risk to another person or property at the detention centre.

The Executive Director disagreed with this assessment, stating: 267

The risk presented by all the young people involved in the incident on the [30] January 2017 was considered both in terms of their individual situation and with consideration of the group behaviour that they presented during the incident. The young people’s individual risk of being involved in further violent and/or damaging incidents was high. Due to the individual young people's history of involvement in other incidents, the seriousness of the current incident and the continued behaviour of young people all was considered in determining if separation should continue.

The Assistant Director-General also disagreed, stating: 268

I strongly reject the assertion that the behaviour of each of the YP in separation was not assessed individually. If one of a group was not displaying concerning behaviours, and they had demonstrated that their allegiance to the group was no longer in place, it is likely that a different decision in relation to that YP would have been made. However it is overly simplistic to say that just because 1 YP in a group is not displaying concerning behaviours that others in the group may be displaying does not mean that further separation isn’t warranted in the circumstances. It is important to have regard to the whole of the circumstances in any given situation before making a decision, which is what I did.

Both the Executive Director and the Assistant Director-General have indicated that consideration was given both to the young people's individual behaviour and level of risk, as well as their actions while part of a group.

However, from the records available, I am of the view that there is insufficient analysis about each young person’s individual behaviour and circumstances while in separation. The separation records appear to indicate that the young people were assessed as being part of a group of seven, and decisions about whether the separations should continue taken on that basis.

As indicated, while a young person's behaviour as part of a group cannot be discounted, it is important that careful consideration is given to the individual circumstances of each young person and whether their continued separation under the requirements of the YJ Regulation is justified.

As I have discussed in this chapter, the behaviour of a number of the young people does not appear to have justified their continued separation for the entire 10 day period. This being the case, it is not clear why their separation continued, other than the fact that a decision

267 Letter from the Executive Director to the Ombudsman, 20 August 2018.
268 Letter from the Assistant Director-General to the Ombudsman, 6 September 2018.
was made that none of the young people would be transitioned back into the general population until all young people were ready to be transitioned.

**Opinion 27**

The individual behaviour of each of the young people placed in separation was not the only factor assessed by BYDC staff in determining their continuing risk under s.21(1) (d) of the YJ Regulation. Instead, the behaviour of the group of young people who had been involved in the BYDC riot was taken into account when determining when to end the separation.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

In response to Proposed Opinion 27 the Director-General of the department advised:

> The department believes the young people were assessed individually for their individual and continuing risk. It is however, acknowledged that this information was not adequately recorded.

I remain of the view that the available records do not support that ‘the young people were assessed individually for their individual and continuing risk’. The information gathered throughout the investigation suggests a decision was made that none of the young people would be transitioned back into the general population until all young people were ready to be transitioned.

### 7.6 Enhancing decision-making by staff about the lawful use of separation

The issues discussed in this chapter have illustrated obvious flaws in the decision-making by BYDC staff to separate young people for a prescribed purpose under the YJ Regulation. These problems primarily relate to poor recordkeeping and inadequate evidence or reasons for decisions.

Detention centre staff with the delegation to separate a young person for any length of time must have an intimate knowledge and practical understanding of the rules regarding separation and their specific responsibilities in administering these rules. This is not apparent from the examples discussed above.

In my view, these issues can only be remedied by substantial training of staff in the decision-making process to separate young people.
Recommendation 14

The Director-General of the department provide comprehensive training to all youth detention staff with the delegation to place a young person in separation for any period of time about:

a) the circumstances when a young person may be placed in separation for any period of time
b) when approvals for separation must be sought, including how the approval must be sought
c) the specific requirements for a separation that continues past 24 hours
d) the potential consequences for non-compliance with the requirements under s.21 of the Youth Justice Regulation
e) the staff member’s responsibility to make adequate records about the separation.

In response to Proposed Recommendation 14 the Director-General of the department advised that a response to the recommendation would be included as part of the department’s response to Proposed Recommendation 16.

7.7 Support provided to young people during separation

Despite the separation policy requiring regular communication between operational staff and therapeutic staff to ensure that adequate justification exists to continue the separation and to ensure the young person’s continued wellbeing, there is no evidence of such communication for the seven young people involved in the BYDC riot.

Although the young people were visited at times by their caseworkers and psychologists, it is not clear how the information gathered by these therapeutic staff informed the decision to continue the separation, if at all.

I note that the Executive Director did not refer to any specific assessment or review by therapeutic staff in the reasons he provided to the Assistant Director-General for the continued separation of the young people. Nor did the Assistant Director-General or the Executive Director refer to this support at interview when explaining the separation.

During interview, a BYDC Psychologist told investigators that the Behaviour Support Team is not routinely advised when a young person is in separation, and to their knowledge there are no policies or procedures regarding the role of the Behaviour Support Team in assessing or working with a young person in separation.269 The Psychologist also stated that young people in separation were not routinely visited by a psychologist unless they were already a client and a specific decision was made to visit them.270

Separating young people for a period of 10 days is a significant decision and it would be reasonable to expect that therapeutic staff would have been working with the young people daily and involved in critical decision-making about the continued separation. I note that this is what the department’s separation policy requires. There is no evidence that this occurred in relation to the separations following the BYDC riot.

Opinion 28

Despite the requirements of the separation policy, there is no evidence of communication between operational staff and therapeutic staff regarding the circumstances of the separation and to ensure the young people’s continued wellbeing. There is also no evidence that information and assessments from therapeutic staff (i.e. behaviour support team, caseworkers and psychologists) informed the decision to continue the separation of each young person.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

7.8 Behaviour development plans

There is no evidence that the young people were managed on a BDP during their period of separation despite the behaviour development framework, as set out in the behaviour development policy, requiring a BDP be in place for persistent minor misbehaviour and moderate and serious behaviour by a young person. It seems beyond doubt that participation in a riot would necessitate a BDP.

In fact, there is no evidence of any plan or documented strategies to end the separation and transition the young people back to their sections. There is also no evidence of any plans or documented strategies to manage and improve the young people’s behaviour, and ensure they were aware of what was expected of them in order to transition back to their section.

While there is evidence of some caseworker and psychologist visits to the young people while in separation, there is no evidence of what, if any, behavioural development strategies were implemented to manage and improve the young people’s behaviour. This is particularly concerning as the justification provided by the Executive Director for continuing the separation for 10 days was the continued poor behaviour of the young people. This being the case, it is confusing why there was not a greater emphasis placed on implementing behaviour improvement strategies for the young people while they were separated.

Opinion 29

There is no evidence that the young people in separation were managed in conjunction with the behaviour development framework as outlined in departmental policy YD-1-2 Behaviour development.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

7.9 Out-of-room time

During interview with investigators, young people were relatively consistent in their complaints about the amount of time they were allowed out of their rooms during the 10 day period of separation. Many of the young people stated that they were only allowed one hour each day out of their rooms.

See section 7.2.4 for information about the behaviour development framework as outlined in the behaviour development policy.
Young people made the following comments about time spent locked in their rooms:

… we were on 23 hour lockdown … Basically we had about an hour out … Just make a phone call, play cards … like sometimes they’d like have one out in the like normal area and then one on the veranda and there was like one other boy that was - he was just up there for other reasons and I talked to him sometimes.272

I only came out one hour a day … Going to the veranda, make a phone call to my family … Or sometimes I would split it up. I’d go out for half an hour and then go back in the room and say I still haven’t finished my hour.273

I can come out an hour a day … Had phone calls and then come straight back in the room … I think one kid missed out a whole day … Because he played up about the day before ….274

[In the rooms] the whole day except for like an hour ...275

And we was only coming out one hour a day … Sometimes if that I reckon … Like sometimes you’d come out for half an hour during the day then just before bed they would let you come out and make a five minute phone call …276

At least 20 hours … I was in the … section where the normal rooms and there’s an area where there’s a table and a sink and stuff and there’s a phone and stuff. You can make phone calls. And there’s a veranda that you go out on. It’s like a veranda … There’s a seat and a table out there that’s really it … I got to mix with some of the boys, but that was rare.277

The separation record in DCOIS requires staff to record all out-of-room time during a separation event. This includes the time a young person was either in or out of the room and the out-of-room activity that the young person was engaged in.

Unfortunately, upon review of these records, the exact time a young person was in or out of their room during the 10 day separation period is not always clear.

As previously discussed, there are no separation records for any of the young people on 31 January 2017. While phone records from this day suggest that the young people were let out of their rooms for periods, it is not possible to determine how long each young person was locked down.

For other days during the separations it is often difficult to determine from the separation records whether a young person was secured in their room or out of their room. This is because detention centre staff did not always clearly record whether a young person was in or out of their room for any given time during the day. There are also instances in the records which raise questions about accuracy such as where a young person is recorded as being secured in their room, but is also recorded as making a phone call at the same time.

During the investigation, a senior BYDC officer provided comment about the accuracy of the separation records, particularly with respect to the time the young people were in or out of their rooms. The senior BYDC officer noted that many Section Supervisors were not aware how to record separation accurately on DCOIS:

Now when you’re in [the unit] as a Section Supervisor there’s different processes in terms of documenting and not every Section Supervisor is up to speed with it … not every Section Supervisor is up to speed with DCOIS in terms of documenting separation ...

272 Interview with a young person, 3 April 2017, transcript p.15.
273 Interview with a young person, 29 March 2017, transcript p.11.
274 Interview with a young person, 29 March 2017, transcript pp.8 and 9.
276 Interview with a young person, 29 March 2017, transcript p.9.
277 Interview with a young person, 29 March 2017, transcript pp.16 and 17.
278 Interview with a BYDC officer, 15 September 2017, interview audio 46:37. The senior BYDC officer attended the interview as a support person for the BYDC officer and made the comments in this capacity.
DCOIS has been with us since 2011, but it’s 2017 now, as a [senior BYDC officer] I am still going to the units every single shift to try and make sure that’s [separation] documented properly ... it’s a struggle daily for me as a [senior BYDC officer] to try and make sure the Section Supervisors are documenting every time that [the young people are out of their rooms]. When that [DCOIS] says 12 hours they haven’t been out, I don’t think it’s accurate ...

Similar observations about the accuracy of DCOIS separation records were made during interview by the MMC. The MMC told investigators that they do not rely solely on the DCOIS separation records when investigating complaints about separation due to concerns about their accuracy. The MMC stated that as a precaution, DCOIS records are discussed with relevant operational staff to clarify the accuracy of what was recorded.

The apparent lack of knowledge and competency by some BYDC staff about the requirements of recording separation is concerning. Considering that the department is required to keep a record about the length of time a young person is separated for a prescribed purpose, the current standard of recordkeeping is not adequate.

Entries in the separation record should clearly state whether a young person was in or out of their room during any given period of the day. The quality of these records should also be such that calculating the time spent in or out of a room for a young person is a straightforward process.

All staff responsible for recording separation times, particularly Section Supervisors, should be aware of the recording requirements and how to record the information accurately.

Opinion 30

Separation records for each of the young people do not always clearly record the time each young person spent out of their rooms during their separation between 31 January 2017 and 10 February 2017.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

Irrespective of the issues with recording out-of-room time for the separated young people, it is clear the young people spent a considerable period of the 10 days they were in separation locked in their rooms. On some days the records indicate that the young people spent as little as an hour, or at times even less, out of their rooms. Three young people are recorded as spending no time at all out of their rooms on both 5 and 6 February 2017, although phone records appear to indicate that they were let out of their rooms to make phone calls on 6 February 2017.

During interview, one of the young people spoke about the effect on his mental health after spending such a long period of time locked in his room:

... sometimes I felt like killing myself because I just got a bit crazy, but I don't know. I just didn't really do nothing ... We used to sometimes just talk shit to people like we'd just talk to each other, or when say the police come we'd just talk shit to them or something because it just got that boring so ... A Psychologist come to see me a few times ... my Psychologist, [came] to see me quite often.

279 Interview with the MMC, 27 October 2017, interview audio (part 3) 50:10.
280 ibid., interview audio (part 3) 50:15.
281 Interview with a young person, 29 March 2017, transcript p.10.
There are risks of long-term negative health effects as a result of the minimal stimulation experienced during separation.\textsuperscript{282} During interview with investigators, young people complained of significant boredom while being locked in their rooms as well as a lack of activities to keep them mentally stimulated. Young people stated they were given books and magazines to read and another young person stated they played with a deck of cards. The young people stated they had access to stress balls to help manage their boredom.

Given many young people in youth detention suffer from mental health issues and also have lived experiences of trauma, abuse and neglect,\textsuperscript{283} it is my view that continuous separation over multiple days should only be used in extraordinary circumstances.

It is also unreasonable for a young person to be locked in their room for periods approaching, or longer than, 22 hours per day. I acknowledge that on some days the young people were out of their rooms for longer than two hours. However, it is also probable that on other days the young people were locked in their rooms for at least 22 hours. As previously mentioned, it also appears that a number of young people were confined to their rooms almost continuously at one stage for a 48 hour period.

This is an unacceptable and unreasonable outcome which may have posed considerable risks to the mental health and wellbeing of the young people.

\textbf{Opinion 31}

The inadequate and confusing records regarding young people’s out-of-room time during the 10 day separation period are not sufficient to ensure adequate oversight of the administration of separation, or that adequate out-of-room time is afforded to young people.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

Having regard to the risks of adverse mental health outcomes for young people in separation, it is essential they are visited and closely monitored by a registered health practitioner such as a psychologist during the separation period.

Psychologists met with each of the seven young people involved in the BYDC riot on the first day they were separated on 31 January 2017. However, a BYDC Psychologist told investigators that psychologists at BYDC did not routinely visit young people in separation unless they were a client and had an identified need to engage with a psychologist.\textsuperscript{284} The Psychologist did confirm that a psychologist would visit any young person at BYDC who requested to see them.\textsuperscript{285} The Psychologist stated that the psychologists at BYDC relied on caseworkers to be regularly visiting young people in separation and to refer to them any issues of concern.\textsuperscript{286}

I am of the view that if a young person is placed in separation for longer than 24 hours (inclusive of the standard night lock down), then they must receive a visit from a registered health practitioner, and then receive subsequent visits each day the separation continues. Such visits would help ensure the welfare of the young person and ensure that any decision to continue the separation for a further 24 hours is supported by evidence regarding the physical or mental health of the young person.


\textsuperscript{284} Interview with a BYDC Psychologist, 27 July 2017, transcript p.36.

\textsuperscript{285} Ibid.

\textsuperscript{286} Ibid.
Opinion 32

Young people placed in separation for longer than 24 hours are at risk of experiencing negative mental health outcomes, but there is currently no requirement for these young people to be visited and assessed by a registered health practitioner during the time they are in separation.

This is administrative action that is unreasonable for the purposes of s.49(2)(b) of the Ombudsman Act.

7.10 Comparison with separate confinement conditions in the Corrective Services Act 2006

In correctional centres, a prisoner may be placed in separation under the Corrective Services Act 2006 (defined in that Act as separate confinement) as a result of a safety order\(^{287}\) made by the Chief Executive\(^{288}\) or as a consequence of a breach of discipline.\(^{289}\) In both circumstances, the Corrective Services Act and Corrective Services Regulation 2017 set out a number of mandated standards and safeguards, including a right for a prisoner to seek an external review of the decision to place them in separate confinement.

This is in contrast to the separation of young people in youth detention centres, where there are no mandated standards and safeguards for the young people while they are separated, and no right to seek an external review of the separation decision.

For example, unlike young people placed in separation, prisoners placed on a safety order must be examined by a doctor or nurse as soon as practical after the order is made and then each seven days throughout the duration of the order.\(^{290}\) All safety orders must also include the following details and conditions which are mandated under the Corrective Services Regulation:\(^{291}\)

- the extent to which the prisoner is to be separated from other prisoners
- any special needs of the prisoner and how the needs must be met
- how and when the prisoner may receive visits
- the amount of property the prisoner may keep and access during the period of the safety order
- the prisoner’s access to approved activities, courses and programs
- the phone calls and electronic communications the prisoner may make.

The Corrective Services Act requires that safety orders must not be for a period of more than one month\(^{292}\) and there are constraints on extending a safety order.\(^{293}\)

In addition, if a safety order was made on the advice of a doctor or psychologist, the safety order must be reviewed by another doctor or psychologist who can make recommendations to confirm, amend or cancel the safety order.\(^{294}\)

\(^{287}\) A prisoner may be placed on a safety order by the Chief Executive either for the prisoner’s safety or safety of another person, or for the security or good order of the prison.
\(^{288}\) Corrective Services Act, s.53.
\(^{289}\) ibid., s.118(2)(c).
\(^{290}\) ibid., s.57.
\(^{291}\) Corrective Services Regulation, s.7.
\(^{292}\) Corrective Services Act, s.53(2).
\(^{293}\) ibid., s.54.
\(^{294}\) ibid., s.55.
A prisoner may also request that a safety order be referred to an Official Visitor (OV) for external review and, if requested, the OV must review the safety order. If a safety order requires confinement for more than one month, an OV must conduct monthly reviews of the safety order. The OV can make recommendations about the order, but the recommendations are not binding.\textsuperscript{295}

For Aboriginal or Torres Strait Islander prisoners placed on a safety order, the Corrective Services Regulation requires the Chief Executive to tell a cultural liaison officer, an Aboriginal or Torres Strait Islander elder and a person nominated by the prisoner as a contact person that the safety order has been made.\textsuperscript{296} The cultural liaison officer must also be asked to visit the prisoner.\textsuperscript{297}

In addition to these legislative and regulatory requirements, the Risk Management Custodial Operations Practice Directive provides further guidance and direction regarding the use of safety orders to manage an identified risk to the safety and security of a correctional centre, staff or prisoners. This is to ensure that safety orders are carefully considered and based on the individual risk and need of a prisoner and the reason for their separate confinement.

Prisoners placed in separate confinement as a punitive measure are also subject to legislative conditions outlining their entitlements while separated. This includes a seven day time limit to the separate confinement and a requirement that they must be examined by a health practitioner for any health concerns during the segregation.\textsuperscript{298}

These conditions for placing a prisoner in separate confinement are legislative safeguards which are not reflected in the framework for young people placed in separation. In contrast, as found in this investigation, it appears strictly lawful for a young person in youth detention to be separated in a room without a bed, bathroom facilities, running water or adequate ventilation for a period of 10 days. My views about the reasonableness of this have already been outlined.

Considering the significant body of research about the negative impacts separation has on young people, there is a strong argument for protections similar to those in the Corrective Services Act to be applied in a youth detention setting.

I have addressed this issue by way of Recommendation 16 in section 7.12.

\textbf{Opinion 33}

Unlike adult prisoners placed on a safety order or subject to separate confinement, there are no mandated conditions or external review rights for young people placed in separation under either legislation, regulation or in the policies and procedures that support the use of separation.

In response to Proposed Opinion 33 the Director-General of the department advised:

\begin{quote}
The department acknowledges the opinion of the Ombudsman, however respectfully disagrees that separation safeguards for young people in youth detention centres should be modelled on conditions designed for adult prisoners under the Corrective Services Act 2006 and Corrective Services Regulation 2018. Please refer to the response for Recommendation 16 for more information.
\end{quote}

I will address the department’s response to Proposed Opinion 33 together with the department’s response to Proposed Recommendation 16.

\begin{flushleft}
\textsuperscript{295} ibid., s.56.  
\textsuperscript{296} Corrective Services Regulation, s.8(1).  
\textsuperscript{297} ibid., s.8(2).  
\textsuperscript{298} Corrective Services Act, s.121(2) and (3).
\end{flushleft}
7.11 Enhancing decision-making by staff about the administration of separation

In my view, in light of the issues raised in this chapter, there is a need for enhanced measures regarding how separation is administered in youth detention centres, and particularly around strategies to ensure the health and wellbeing of young people placed in separation for longer than 24 hours.

In particular, there needs to be an agreed and consistent standard across both youth detention centres about how separation is administered and the responsibilities of staff involved in the separation process. Staff should be aware of this standard and take responsibility for its implementation while they are caring for young people who are separated.

**Recommendation 15**

The Director-General of the department develop and implement a procedure regarding the administration of separation, which has a particular focus on strategies to ensure the safety and wellbeing of young people while separated. Once implemented, all detention centre staff should be trained in the requirements of the procedure.

The procedure should, at minimum, address the following issues:

a) mandate a minimum period that a young person placed in continuous separation must be outside their room each 24 hour period
b) require staff to accurately and clearly record the time a young person spends out of their room for any reason during periods of separation, including for the purposes of using the bathroom, making phone calls, attending visits or exercising
c) ensure there is an adequate system to allow staff to make records of a young person’s out-of-room time and that staff are trained and demonstrate competency in its use
d) require young people placed in separation for longer than 24 hours to be visited and assessed by a registered health practitioner and a case worker, and for further visits to occur on each subsequent day the separation continues.

In response to Proposed Recommendation 15 the Director-General of the department advised that a response to the recommendation would be included in the department’s response to Proposed Recommendation 16.

7.12 Review of the legislative and regulatory framework regarding the use of separation in youth detention centres

Based on the discussion in this chapter, there are a number of concerns about how the separation of the seven young people was managed and whether the requirements of the YJ Regulation were met regarding approvals and reasons for the continued separation.

This is not to suggest that considerable risks and dangers were not present immediately following the BYDC riot, but it is questionable whether these risks were present for the entire 10 days and whether the risks from each of the young people were the same.
This chapter has identified the following issues:

- failure to seek and obtain approvals for the continuing separations within the timeframes set out in the YJ Regulation
- the lack of individualised assessments or reviews about the behaviour of each of the young people during separation to determine their genuine risks pursuant to s.21(1)(d) of the YJ Regulation
- the lack of therapeutic support or interventions provided to the young people during their separation
- the lack of communication between operational and therapeutic staff and the lack of involvement of therapeutic staff in decisions about continuing the separation
- the lack of any behavioural management or development strategies delivered to the young people during their separation to accelerate the transition back into the general population
- the lack of legislative and regulatory safeguards for the use of separation compared with the use of separate confinement in correctional centres.

Questions about the justification for the length of the separation exist because the records and evidence justifying the separation are not adequate. If young people are to be separated for extended periods, the concerns identified above must be addressed to ensure the continuing separation is appropriate and justified.

As discussed at section 7.10, when a young person is separated, there are no mandated requirements or conditions to regulate what the young person is entitled to. Instead, a young person’s entitlements appear to be at the discretion of supervising staff. This is in contrast to prisoners subject to separate confinement in a correctional centre.

Having regard to these issues, I have concerns about how separation is being used in youth detention centres and whether the current level of regulation and oversight is effective.

To address this, I am of the view that the department should conduct a review of the use of separation in youth detention centres and consider further regulatory requirements to better safeguard the health and wellbeing of young people while placed in separation.

**Recommendation 16**

The Director-General of the department review the legislative and regulatory framework regarding the use of separation in youth detention centres and determine whether they are effective and sufficient to protect the safety and rights of young people. At minimum, this should include:

- a review of the provisions of the Youth Justice Regulation and relevant departmental policies and procedures
- a comparison with the regulatory and policy requirements and safeguards for separate confinement under the Corrective Services Act and Corrective Services Regulation
- a comparison regarding how separation is regulated in other Australian jurisdictions
- a review of the adequacy of recordkeeping systems, recordkeeping requirements and the capacity of staff to efficiently and effectively use these systems
- a review of current training provided to youth detention centre staff.
In response to Proposed Recommendations 14, 15 and 16 as well as Proposed Opinion 33, the Director-General of the department advised:

The department acknowledges recommendations 14, 15 and 16 and agrees that separation is a complex issue in the current youth detention environment. This is borne out by the issues that are evidenced in The Ombudsman’s report, [the Youth Detention Review] and other recent investigations/audits of separation practices conducted internally.

It is noted that the department reviewed separation practices in 2015 and updated accompanying policies, procedures and systems to reflect the outcome of that review. Effective implementation of these changes has been challenging for a number of reasons including the changing and increasing cohort of young people and a subsequent increase in the number of large scale incidents.

In direct response to a specific recommendation made by [the Youth Detention Review], Youth Justice conducted an internal audit of separation records to ensure contemporaneous evidence is provided for continuous separations. This audit was completed in October 2018 and made a number of recommendations in relation to record keeping, professional development and the provision of therapeutic supports to young people in separation. This supports the Ombudsman’s recommendations that legislative and regulatory amendments should be considered to further safeguard young people separated in youth detention centres.

An additional internal audit of youth detention separation practices is currently underway, led by KPMG. Upon completion of this audit, Youth Justice will consider any additional actions required amongst existing recommendations and reforms in progress.

The department is committed to continual improvement and ensuring the provision of youth justice services focuses on the safety and wellbeing of young people. As a result, the current regulatory framework and supporting policies, procedures, systems, and training and communication strategies will be comprehensively reviewed. This will include the consideration of additional therapeutic and health-related safeguards for young people who are separated. The department will also ensure relevant national and international best-practice are explored.

The department, however respectfully disagrees that the separation of young people in youth detention centres should be modelled on the conditions designed for adult prisoners under the current Corrective Services Act 2006 and Corrective Services Regulation 2018.

As outlined in the Ombudsman’s report, the Corrective Services Act 2006 allows a prisoner to be placed in ‘separate confinement’ under a safety order for up to one month, with the possibility of extension. Additionally, a prisoner can be placed in ‘separate confinement’ as a punitive measure and form of punishment for up to seven days. Neither the Youth Justice Act 1992 nor the Youth Justice Regulation 2016 allow for the use of separation as a form of punishment.

The current Youth Justice Act 1992 and Youth Justice Regulation 2016 give specialised consideration to the age, maturity and inherent vulnerabilities of children who have committed offences. Similarly, the Youth Justice Principles support and advocate the rights, health, wellbeing and development of children.

The department believes that punitive approaches are neither appropriate nor ethical for children. As per current practice, unlawful separations are not tolerated by the department and any staff member suspected of approving an unjustified separation will be referred to the relevant investigative body.
I note the Director-General’s response, particularly the advice the ‘current regulatory framework [for separation] and supporting policies, procedures, systems, and training and communication strategies will be comprehensively reviewed’. I also note that an internal audit of youth detention separation practices is currently underway.

I look forward to the outcome of both reviews.

The Director-General appears to have misunderstood my intention with regard to my discussion around the separate confinement provisions in the Corrective Services Act. I acknowledge that young people cannot be placed in separation as a punishment, which is a significant difference with separate confinement under the Corrective Services Act.

However, my point is that there are significant legislative safeguards for prisoners placed in separate confinement, compared with none for young people placed in separation. This includes the right to a review of the decision that resulted in their separate confinement.

While separation may not be used as a punishment, young people can still be placed in separation for significant lengths of time as this report has demonstrated. In these instances, young people can be subject to separation conditions that are worse than experienced by prisoners who are separated as a punishment. This includes no right to an external review about the reasons for their separation, no right to see a health practitioner and no limit to the time they can be separated.

I am of the view that the department should review the protections and safeguards in the Corrective Services Act and Corrective Services Regulation and consider whether they can be enhanced and implemented in the youth justice context.
8 Use of the admission rooms to accommodate young people

This chapter examines the use of the admission rooms to accommodate young people at BYDC.

The admission rooms are located in the same unit where the young people involved in the BYDC riot were placed in separation. This chapter will focus primarily on the use of the admission rooms in response to the BYDC riot, but will also provide examples of other instances where the investigation identified that young people were accommodated in these rooms prior to the BYDC riot.

8.1 Background

On 24 January 2017, a young person contacted the Office and stated that he had been separated in a 'holding cell' (meaning an admission room) at BYDC for ‘about five days’. The young person stated the holding cell did not have a toilet and that on one occasion staff had not allowed him to leave the holding cell to use the toilet. He stated that he suffers from a mental illness and felt claustrophobic in the holding cell which was causing him some distress.

In response to the young person’s complaint, the Office contacted BYDC and sought further information about the young person’s accommodation in the admission rooms.

While the Office was assessing the complaint, the BYDC riot occurred on 30 January 2017 and the seven young people involved were placed in separation (as discussed in Chapter 7). During the separations, the admission rooms were used to accommodate up to five of the young people at different times throughout the 10 day period.

On 20 March 2017, I commenced an investigation into the use of the admission rooms for the accommodation of young people by BYDC in January and February 2017. This issue was incorporated into the ongoing BYDC investigation, particularly as the use of the admission rooms to separate young people was a significant response to the BYDC riot.

8.2 The nature and purpose of the admission rooms

The unit where the admission rooms are located consists of four single rooms and one soft room299 which contain a bed and bathroom en-suite, and five admission rooms that do not contain a bed, bathroom or running water. All five admission rooms contain a small bench seat, but no other furniture. The ordinary purpose of the admission rooms is to secure young people upon admission to BYDC for short periods until they can be transferred to an accommodation section.

Despite clearly not being for this purpose, young people accommodated in the admission rooms overnight slept on a mattress placed on the floor.

299 The soft room is a secure room with padded walls.
8.3 How the admission rooms were being used in January and February 2017

During January and February 2017 the admission rooms were being used to accommodate young people for extended periods of time.

While many staff stated that the use of the admission rooms immediately following the BYDC riot was necessary owing to the damage that had been caused to the centre, there is evidence that young people were also being accommodated in the admission rooms for considerable periods of time prior to the BYDC riot.
From BYDC accommodation records, there are a number of examples of young people being accommodated in the admission rooms during late December 2016 and January 2017. While this is not an exhaustive list, young people were accommodated in the admission rooms:

- from 23 December 2016 to 26 December 2016, a period of four days
- from 29 December 2016 to 5 January 2017, a period of seven days
- from 1 January 2017 to 8 January 2017, a period of seven days
- from 5 January 2017 to 9 January 2017, a period of four days
- from 15 January 2017 to 19 January 2017, a period of four days
- from 21 January 2017 to 25 January 2017, a period of four days
- from 21 January 2017 to 25 January 2017, a period of four days.

As opposed to the young people accommodated in the admission rooms following the BYDC riot, these young people do not appear to have been formally separated under the YJ Regulation for the entirety of the periods outlined.

Notably, in all the time periods outlined above, there appear to have been rooms available that had access to a bathroom and running water. It is not clear whether the admission rooms were being used because other rooms had been damaged and were inoperative, because of not-to-mix issues between young people, or for another reason. Even if a young person had to be accommodated in an admission room for a short period of time due to other rooms being inoperative, it is unclear why they remained in these rooms for multiple days and in some cases over a week.

Following the BYDC riot, six of the seven young people who had been involved in the incident were accommodated in the admission rooms at one point during their period of separation. Investigators were advised that the admission rooms had to be used during this period as the damage to unit where the riot occurred meant that there were no other accommodation options available within the centre.\(^300\)

Four young people were accommodated in an admission room for the full 10 days they were in separation. One young person was accommodated in an admission room for four days and another young person for two days.

### 8.4 The problems with the extended use of the admission rooms

During interview, a number of young people described their experience of being accommodated in the admission rooms:

- Disgusting, dirty, not even a bed, not even a shower or a toilet; nothing in there at all except a plastic bench.\(^301\)
- ... you're boxed in ... you know what I mean like you can’t do nothing ... All you can do is walk up and down four, five steps and you’re walking up and down. That’s it.\(^302\)
- There’s nothing in it except for a little seat and they just gave us a mattress and a sheet.\(^303\)
- It’s just a little pink room with a square window and a little shelf-looking thing that you can sit on ... They gave us a mattress and then we put the mattress on the floor and slept on there ... I don’t think they should be allowed to put kids in a box that long, for that long ... being actually there it affects you more than what you think it would.\(^304\)

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\(^300\) Interview with the Executive Director on 30 October 2017, transcript p.62.
\(^301\) Interview with a young person, 29 March 2017, transcript p.7.
\(^302\) Ibid., p.18.
\(^303\) Interview with a young person, 29 March 2017, transcript p.12.
\(^304\) Interview with a young person, 29 March 2017, transcript p.7.
The young people also made a number of other allegations relating to their treatment while in the admission rooms. These related to:

- access to toilet and bathroom facilities
- access to water
- high temperatures in the rooms.

### 8.4.1 Access to bathroom facilities

Due to the lack of toilet and bathroom facilities in the admission rooms, young people were required to ask a staff member to be let out of their room and taken to the toilet. During interview, a number of young people complained of unreasonable delays in the time it took staff to take them to the toilet:

> You yell out and you say ‘Sir, I need the bathroom.’ Yeah. And say if it was in the day they’d probably come in about five minutes, but at night sometimes it’d take up to an hour to come.\(^{305}\)

> We had to knock on the door and ask if you could go to the toilet and sometimes they wouldn’t even let us out to go to the toilets for about half an hour, wait until the night senior to come.\(^ {306}\)

> You have to call the intercom. It takes them half an hour just to come, and just go to the toilet ... Half an hour, sometimes they don’t even come. You’ve got to keep banging and banging, go off just to get their attention ... Sometimes they would be there straight away basically, but sometimes I would just wait two minutes or something, half an hour they still haven’t come.\(^ {307}\)

> You have to yell out to the staff. Sometimes they take ages like half an hour ... You just have to yell out and wait for them ... About half an hour sometimes ... You have to wait for them to get another staff member.\(^ {308}\)

> At daytime you knock and they’ll come and let you go to the toilet. They’ll take you to another room to go to the toilet, but at night time you’d knock, you’d wake up at night time, you need to go to the toilet you’d knock and it could take up to like 15 minutes, half an hour. And it depends if they want to hurry up and get the night senior or they just want to sit around and take their time.\(^ {309}\)

During interviews with investigators, unit staff stated that young people were taken to the toilet as soon as possible and that any delay was primarily at night because of the security requirement to have a second staff member present when the young person was let out of their room. Any delay was because of the time it took for a second staff member to arrive at the admission rooms to assist in escorting the young person to the toilet.

The Executive Director acknowledged that there may have been some delay in staff escorting young people to the toilet:\(^ {310}\)

> There may have been some delay while staff waiting for a second member to become available to unlock and open the door to allow the young person to attend the toilet. While extra staff were provided on both day and night shifts in admissions ... the responsibilities of these staff may mean they were not immediately available to respond to a young person’s request for [the] toilet.

The recording of young people in and out of their rooms for the purposes of using the toilet appears to be inconsistent from day to day. On some days the unit section log records young people out of their rooms and using the bathroom while on other days, bathroom breaks do not appear to be recorded.

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306 Interview with a young person, 29 March 2017, transcript p.12.
307 Interview with a young person, 29 March 2017, transcript p.10.
309 Interview with a young person, 29 March 2017, transcript p.8.
310 Letter from the Executive Director to the Ombudsman, 20 August 2018.
It is not possible to quantify specific instances of delay in staff responding to a request from a young person to use the toilet. However, the available evidence supports a finding that delays occurred, regardless of the reason for the delay.

With respect to the practice of accommodating young people in rooms without bathroom facilities, I note that in December 1990, the General Assembly of the United Nations adopted the Rules for the Protection of Juveniles Deprived of their Liberty which state that:

31. Juveniles deprived of their liberty have the right to facilities and services that meet all the requirements of health and human dignity.

34. Sanitary installations should be so located and of a sufficient standard to enable every juvenile to comply, as required, with their physical needs in privacy and in a clean and decent manner.

The department states on its website that its policies ‘reflect the obligations outlined in the Youth Justice Act 1992 and the Australasian Juvenile Justice Administrators service standards for juvenile custodial facilities’. The service standards refer to the above mentioned United Nations Rules. In my view, the practice of accommodating young people in admission rooms for extended periods does not comply with provisions 31 and 34 of those rules.

I note that the Executive Director told investigators that the requirement to accommodate young people in the admission rooms where they had no access to bathroom facilities was ‘untenable’, but necessary due to the design limitations of BYDC and the lack of any secure facilities to accommodate young people assessed as a risk to the safety and security of the centre:

312 It is my opinion that the limitation on the design and construction of the BYDC facility had placed the management and staff in a position of having to make decisions that under normal circumstances would not need to have been made. Organisational decision making regarding the type and style of buildings in BYDC resulted in a situation that was untenable but which individual management and staff could not influence, change or improve.

8.4.2 Access to water

In addition to the lack of bathroom facilities, the admission rooms have no running water. Accordingly, young people secured in these rooms need to be provided with drinking water by BYDC staff.

During interviews with investigators, many young people raised concerns about their access to drinking water while in the admission rooms:

You just ask sir to get a cup of water and they’ll bring you a cup of water ... It was in 10 minutes.312

I had a water bottle ... I had to ask for it to be filled up...I got it [the water bottle] probably about five days into my [separation] because when I asked for water, they’d just give me a cup and then I’d just drink that and ask them to fill it back up again ... And then one of the staff members ended up just giving me an empty cordial bottle ... after a bit there they ended up just giving me a normal water bottle.314

312 Letter from the Executive Director to the Ombudsman, 20 August 2018.
313 Interview with a young person, 29 March 2017, transcript p.18.
We didn’t even get a water bottle or anything. We weren’t allowed anything like that ... Had to call up and ask ... They bring a plastic cup ... they’d just give you that and close the door.\footnote{Interview with a young person, 29 March 2017, transcript p.13.}

Water, you got to ask for that too ... There’s no bubblers in the room ... They ended up giving us water bottles on the second last day of being in there ... We were in there with no water ... we had to ask for it when we wanted it.\footnote{Interview with a young person, 29 March 2017, transcript p.11.}

Sometimes you’d get a water bottle but they didn’t allow it ... Or they just bring you a cup of water ... But they just take a while.\footnote{Interview with a young person, 29 March 2017, transcript p.15.}

If we asked for a cup of water we’d get a cup of water ... Because some staff don’t really like us because of what we did ... They could just take a while ... after a while we got a water bottle because we made a complaint to the Community Visitors and then they said we needed water in there so we got a water bottle.\footnote{Ibid., pp.15-16.}

While the young people agreed that they received drinking water when they requested it, some noted that there were delays in receiving water and that at first they were only provided water in a small plastic cup. One young person advised that after intervention by CVs, the young people were provided with water bottles to keep in their rooms.\footnote{United Nations Rules for the Protection of Juveniles Deprived of their Liberty, Rule 37.}

I note that the United Nations Rules for the Protection of Juveniles Deprived of their Liberty state that clean drinking water should be available to every juvenile at any time.\footnote{Standard Guidelines for Corrections in Australia, revised 2012, section 2.14.}

Also, while not applying to youth detention in Queensland, the Standard Guidelines for Corrections in Australia (2012) provide useful guidance on how people who are detained should be treated, and states the following with respect to access to food and water:

Every prisoner should be provided with continuous access to clean drinking water and with nutritional food adequate for health and wellbeing, at the usual hours prepared in accordance with the relevant health standards.

BYDC staff stated during interview that young people secured in the admission rooms were provided with water immediately on request. While I accept that young people were provided with drinking water as soon as possible following their request, I am of the view that it was unreasonable to accommodate young people in a room for up to 10 days (as four of the young people were) where there is no continuous access to running water. It is also not reasonable for young people to have to rely on staff to bring them water in bottles or plastic cups.

### 8.4.3 Excessive temperatures

Many of the young people made comments to investigators about the excessive heat in the admission rooms while they were accommodated there. Young people stated that the heat and lack of adequate air-conditioning meant that they were often unable to sleep at night:

\ldots the heat would get out of control in there. There’s no aircon in there ... they’re not cells you’re meant to be housed in. They’re holding cells ... There’s a window in there but it’s not allowed to be opened.\footnote{Interview with a young person, 29 March 2017, transcript p.18.}

\ldots because it was so hot, I was staying up until probably like 12 or 1 [am], sometimes maybe 2 [am].\footnote{Interview with a young person, 3 April 2017, transcript p.21.}
... it got really really hot ... it was even hot at night.

You’d have to like put the mattress right near the door so you can like breathe in the air con ... They’re [staff] like, ‘Well that’s what happens’ ... Plastic window you can’t even open, so there’s no air coming in ... Some of us would be up until 3 in the morning, trying to sleep.

During interviews with investigators, BYDC staff stated that the unit common area is air-conditioned but could not provide a definitive answer about whether there was air-conditioning in the admission rooms. Irrespective of whether there is air-conditioning in the admission rooms, the experiences of the young people outlined above suggest that the heat level in the rooms during the summer months can become excessive. This suggests an issue with ventilation levels in the admission rooms.

Excessive temperature levels that result in young people being unable to sleep, or having to lie next to the door in order to feel cool air from outside the room is unreasonable. This, when combined with the lack of free access to running water, is extremely concerning with regard to the wellbeing of young people accommodated in the admission rooms.

The lack of appropriate temperature control and ventilation is another factor which suggests that the admission rooms were unsuitable for long-term accommodation.

8.4.4 Concerns raised by the Youth Detention Inspectorate

Concerns about the use of the admission rooms to accommodate young people have previously been raised with the department by the Youth Detention Inspectorate. In its June 2015 report, the Inspectorate recommended that BYDC develop a procedure for the operation of the unit where the admission rooms are located. This was in response to a finding by the Youth Detention Inspectorate that this unit was being used to accommodate young people separately from other young people at the centre. It was also found that young people accommodated in this unit were not always formally separated under the YJ Regulation.

The recommendation was not implemented and so in its December 2016 report the Youth Detention Inspectorate again recommended a procedure for the use of the unit be developed, including the admission rooms:

... additionally, that the use of admission holding cells ... are included in the procedure (as these cells are also used to accommodate young people on restrictive measures). Consideration should be given to the maximum length of time a child or young person is allowed to be isolated in a holding cell as these cells do not have any running water or toilet facilities.

It was not until its December 2017 BYDC report that the Youth Detention Inspectorate confirmed that the recommendation had been implemented, noting that:

An accommodation model has been developed for the ... Unit, and the A/ED’s [Acting Executive Director] vision is that this unit become an ever more therapeutic space for the more chronically high-needs/challenging young people ...

While this is a positive development, it is not clear what timeframe has been provided to transition the unit to a therapeutic space or what, if any, prohibitions will be placed on the use of the admission rooms to accommodate young people for extended periods of time.

324 Interview with a young person, 29 March 2017, transcript p.11.
325 Interview with a young person, 29 March 2017, transcript p.17.
8.5 The appropriateness of using the admission rooms

I am of the view that the accommodation of young people in the admission rooms for extended periods of time without free access to bathroom facilities, clean drinking water and adequate temperature levels is unreasonable.

This view was not disputed by BYDC staff interviewed as part of this investigation, although staff emphasised that the use of the admission rooms, particularly during the aftermath of the BYDC riot, was necessary due to the limited accommodation options available at the time.

The Executive Director stated that the admission rooms had to be used to accommodate young people during January and February 2017 because of the amount of damage that had been caused to the general accommodation rooms by the young people. The Executive Director stated that in his opinion, the damage young people had been able to cause to these rooms was ‘a result of the inadequate design and construction of the BYDC facility’. These flaws meant that ‘BYDC was not suitably constructed to provide a safe and secure environment’.

The Executive Director also stated that throughout December 2016 and January and February 2017 young people escalated the amount of damage across the centre through copy-cat behaviour when they realised security and safety could easily be circumvented. This resulted in an increasing number of unserviceable rooms which, following the BYDC riot, was not sufficient to accommodate all the young people at the centre.

During interview, the Executive Director agreed that the admission rooms were not an appropriate place to accommodate young people. However, he noted that due to the number of rooms that had become unserviceable, the centre had no other options:

So on that next day [after the BYDC riot] … I had 124 young people on centre and I had 100 beds at that point in time. So, overnight that first night, we had to sleep five young people on mattresses on the floor.

…

So, with the beds on floor, that meant that on the night after the incident we had 42 young people sharing out of 124 young people, and we were already needing to make decisions that were relatively high risk about sharing children that perhaps under normal circumstances you wouldn't have shared, but for the sake of making room for beds. So that's a bedding problem I guess …

The Executive Director further stated that had the admission rooms not been used to accommodate the young people involved in the BYDC riot, other young people would have had to sleep on mattresses on the floor in their sections:

... but potentially even if we'd removed them from [the admission rooms] that would have meant that placing them down in section meant that some other child needed to be placed in a separation room on a mattress. So, you know it was, the pressures were on around bed space, there's no easy solution to that unfortunately.

Finally, the Executive Director expressed the view that the safety and security of the centre would have been at risk if the young people involved in the BYDC riot had been accommodated in an alternative unit.

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326 Letter from the Executive Director to the Ombudsman, 20 August 2018.
327 Ibid.
328 Ibid.
329 Interview with the Executive Director, 30 October 2017, transcript p.74.
330 Ibid., p.62.
331 Ibid., p.74.
332 Letter from the Executive Director to the Ombudsman, 20 August 2018.
These young people had damaged a section to such an extent that all 30 rooms were unserviceable. The risk of them repeating this behaviour in a second accommodation section was too high. If that were to occur BYDC may go down by 60 rooms and the operations of the entire centre come under threat. Therefore, the risk to the centre and its continuing operations was significant and the consequences potentially catastrophic requiring all decisions post incident to be made with this consideration.

The Assistant Director-General also emphasised that BYDC management had no choice but to accommodate young people in the admission rooms following the BYDC riot:333

We were faced with a shortage of accommodation and we sought to rectify this shortage as a matter of urgency – everything was done to get the YP out of these rooms as quickly as possible.

However, the Assistant Director-General also told investigators that he had not been aware that the young people were being accommodated in the admission rooms at the time he had approved their separation following the BYDC riot:334

That wasn’t described to me in my approval processes that I’m aware of. I mean my view of being in separation is that you’re in a normal unit … not an admission cell. But having said that, if there were seven kids and there’s only four beds in [the unit], where do they put the children? Could they place them in any other unit when they were highly – and the other stuff that they were telling me at that time was that the kids were just screaming out the whole time to riot, to get A, get B, do this. So they were being pretty disruptive from what I understand. But I wasn’t aware that they were actually in admission cells. I just thought they were in [a unit].

The Assistant Director-General stated that had he been aware, he would not have approved the use of the admission rooms to accommodate young people during their separation.335 However, while the Assistant Director-General queried whether alternatives to the admission rooms could have been considered by BYDC, he also acknowledged that there were limited options available considering the scale of the damage that had been caused to the centre:336

Look there would have been issues with them all [young people involved in the BYDC riot] being in [the unit] because they wouldn’t have fit them all in. But the issues would have been their participation wasn’t all the same. So some warranted levels of separation but that could have been confined to their units. So maybe for the ones who were lesser involved, being confined to their rooms for longer in a day and when the kids went to programs they didn’t go or something, that they weren’t general population. So there are ways to do that within the units. But given that they’d basically wrecked their own unit, there was nowhere for them to go. So conceivably there was no other room, given they’d totally destroyed a place. And then you’ve basically got 16 beds out of the whole place. It would be almost impossible to find somewhere for them. But admission cells are not ideal places for any long term separation. They’re not.

In response, the Executive Director noted that in three of the four emails forwarded to the Assistant Director-General seeking approval for the continued separation of the young people, a screen shot was included that showed that a number of the young people were being accommodated in the admission rooms.337

Because of the lack of facilities, the admission rooms at BYDC are clearly unsuitable for accommodating young people for any significant period of time, particularly overnight. The rooms are intended to be used as a short-term holding area for young people upon admission to BYDC. This also appears to be the view of senior departmental officers.

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333 Letter from the Assistant Director-General to the Ombudsman, 6 September 2018.
334 Interview with the Assistant Director-General, 15 November 2017, transcript pp.47-48.
335 ibid., p.48.
336 ibid.
337 Letter from the Executive Director to the Ombudsman, 20 August 2018.
While agreeing that the use of the admission rooms to accommodate young people was not ideal, the Executive Director noted that there were limited options at BYDC to accommodate young people involved in violent and destructive behaviour:\footnote{ibid.}

BYDC lacks an accommodation unit that would provide an appropriate design for locating young people temporarily, who involve themselves in violent or destructive behaviours. It is my opinion that such a unit would be designed to provide the level of security required to allow the proper support and supervision of young people who are a potential high risk, while ensuring the safety of staff and other young people ...

In 2011, management at BYDC requested the Department consider the construction of an additional unit ... Work was undertaken to identify a location for the building, however, funding was not supported and the project did not proceed beyond the initial early scoping stage.

Such a facility was not available to management and staff at BYDC on the 31 January 2017. Instead the admissions rooms and [the] unit was the only option.

I acknowledge the accommodation pressures experienced by BYDC in the days following the BYDC riot as a result of other units being uninhabitable, as well as the current design limitations of BYDC as raised by the Executive Director. However, I remain of the view that it is unreasonable to accommodate a young person in the admission rooms for any significant period of time.

In making this point, I note that it is clear that the use of the admission rooms was not limited to the period immediately following the BYDC riot and that it appears that they have been used as an alternative accommodation area for young people for some time.

This being the case, rather than continue to use the admission rooms, the department must consider alternative options for accommodating young people at BYDC at times when they are not able to be accommodated in a general accommodation unit.

\textbf{Opinion 33}

BYDC accommodated young people in the admission rooms for extended periods of time without free access to bathroom facilities, clean drinking water and adequate temperature control and ventilation.

This is administrative action that is both unreasonable and oppressive for the purposes of s.49(2)(b) of the Ombudsman Act.

\textbf{Recommendation 17}

The Director-General of the department ensure that:

\begin{itemize}
  \item[a)] young people are not accommodated in rooms at a detention centre that do not have access to a bathroom, clean drinking water and adequate temperature control and ventilation unless in exceptional and limited circumstances
  \item[b)] a policy and procedure is developed and implemented to regulate the specific use of the admission rooms, including the adequacy of staffing while these rooms are in use
  \item[c)] staff are provided with adequate training about the requirements developed regarding the use of the admission rooms.
\end{itemize}
In response to Proposed Recommendations 17, the Director-General of the department advised:

The department is committed to protecting the safety and wellbeing of young people in youth detention. Determining the most appropriate room accommodation for a young person is a critical mechanism to ensure their safety and stability while in separation.

The existing separation policy YD-3-8 stipulates that young people must either have access to, or be capable of requesting access to water and sanitation facilities whilst separated. It is acknowledged that admission rooms that do not enable free access to sanitation facilities are not appropriate to accommodate young people who are separated for extended periods of time.

The department will consider strengthening existing policy and procedural documentation and local practices to ensure the use of admission rooms are only used in exceptional and limited circumstances. This will include staffing and training considerations as relevant.

I note the Director-General’s response.
9 Conclusion

This report has examined how the accommodation and management of three high risk young people who were transferred from CYDC critically impacted on the safety, security and normal functioning of BYDC. Less than three months after the arrival of the CYDC young people, BYDC experienced a violent and destructive riot. While a number of factors were identified as the cause of this riot, many of these factors stemmed from the presence and management of the CYDC young people at the centre.

The investigation identified that the perception that formed among young people about the CYDC young people, coupled with their mistrust of staff, ultimately culminated in the BYDC riot. As this report has identified, there were a number of missed opportunities by BYDC that may have prevented this incident occurring.

The deficiencies identified in this report are particularly concerning given the continuing growth in the population of Queensland’s two youth detention centres. The department’s projections show continuing growth in youth detention numbers in the years ahead, which will continue to offer challenges in managing young people in youth detention.

BYDC’s capacity and preparedness to successfully manage the transition of the CYDC young people gives rise to concerns about its preparedness to cope with higher numbers of young people in the future.

Finally, the accommodation and separation practices examined in this report raise concerns about the sufficiency of the facilities in the admission rooms and recordkeeping attached to the management of particularly vulnerable young people in separation. The isolation and impact of separating a young person requires the highest care and rigour in decision-making, and BYDC’s processes were found wanting in this regard.

The findings, opinions and recommendations in this report are made to assist the department to strengthen its administrative practices in managing the complex environment of youth detention.
Appendix A: Jurisdiction and procedural fairness

Ombudsman jurisdiction

The Ombudsman is an officer of the Queensland Parliament empowered to deal with complaints about the administrative actions of Queensland government departments, public authorities and local governments.

Under the Ombudsman Act, I have authority to:

- investigate the administrative actions of agencies on complaint or on my own initiative (without a specific complaint)
- make recommendations to an agency being investigated about ways of rectifying the effects of its maladministration and improving its practices and procedures
- consider the administrative practices of agencies generally and make recommendations, or provide information or other assistance to improve practices and procedures.

The Ombudsman Act outlines the matters about which the Ombudsman may form an opinion before making a recommendation to the principal officer of an agency. These include whether the administrative actions investigated are contrary to law, unreasonable, unjust or otherwise wrong.

Although the Ombudsman is not bound by the rules of evidence, the question of the sufficiency of information to support an opinion of the Ombudsman requires some assessment of weight and reliability. The standard of proof applicable in civil proceedings is proof on the balance of probabilities. This essentially means that, to prove an allegation, the evidence must establish that it is more probable than not that the allegation is true. Although the civil standard of proof does not strictly apply in administrative decision-making (including the forming of opinions by the Ombudsman), it provides useful guidance.

‘Unreasonableness’ in the context of an Ombudsman investigation

In expressing an opinion under the Ombudsman Act that an agency’s administrative actions or decisions are ‘unreasonable’, I am applying its popular, or dictionary, meaning. I am not applying the doctrine of legal unreasonableness applied by the Courts when judicially reviewing administrative action.

Procedural fairness

The terms ‘procedural fairness’ and ‘natural justice’ are often used interchangeably within the context of administrative decision-making. The rules of procedural fairness have been developed to ensure that decision-making is both fair and reasonable.

The Ombudsman must also comply with these rules when conducting an investigation. Further, the Ombudsman Act provides that, if at any time during the course of an investigation it appears to the Ombudsman that there may be grounds for making a report that may affect or concern an agency, the principal officer of that agency must be given an opportunity to comment on the subject matter of the investigation before the final report is made. A proposed report was prepared to satisfy this requirement.

Section 55(2) of the Ombudsman Act provides that I must not make adverse comment about a person in a report unless I give that person an opportunity to make submissions about the proposed adverse comment. The person’s defence must be fairly stated in the report if the Ombudsman still proposes to make the comment.