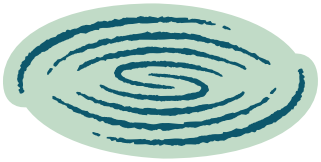

OFFICE OF THE INSPECTOR
OF CUSTODIAL SERVICES

Emergency Management Review Paper

Banksia Hill Directed Review
August 2013

Contents

1 Introduction

1.1 On the evening of Sunday 20 January 2013, an extremely serious incident of mass disorder occurred at Banksia Hill Juvenile Detention Centre ('Banksia Hill'), a facility managed by the Department of Corrective Services ('the Department'). This was by far the most serious incident of this type in Western Australia since what is generally known as the 'Casuarina Prison riot' of Christmas Day 1998. Although the incident had some very specific dynamics and features which set it apart from previous prison 'riots' in Western Australia (for example, staff and detainees were not targeted with violence), the term 'riot' is an apt description of the incident.

1.2 Banksia Hill is the state's only juvenile detention centre and at the time, housed 185 males and 21 females. The incident began just before 6.00 pm when three male detainees absconded from one of the units and then used some loose pavers and debris to break another detainee out of his cell. After the first assisted break out, the situation escalated and with more and more detainees being assisted to break out of their cells.

1.3 In total, sixty one detainees escaped from their cells and a significant number of detainees caused damage to their cells. Due to the nature of the incident and the extent of the damage, it has not been possible to put a precise figure on the number of detainees involved in the incident. Department-supplied figures put the number of detainees involved in the riot at around 73, all male, but it is more likely that, in total, somewhere between one-half and two-thirds of Banksia Hill's male detainees were actively involved to some degree, and also some of the females.

1.4 Extensive damage was caused to parts of the buildings at Banksia Hill, including 106 cells, as well as to some equipment and personal property. The worst of the damage resulted from windows being attacked from both the outside and the inside.

1.5 The consequences for the detainees were dramatic, with 73 of the male detainees being immediately transferred in the early hours of 21 January 2013 to a nearby adult prison, Hakea Prison ('Hakea'). Within the next three weeks the majority of the remaining male detainees at Banksia Hill were subsequently transferred to Hakea while the damage caused by the riot was repaired and security upgrades implemented. The female detainees continued to be housed at Banksia Hill along with a small number of male detainees under 15 years of age and some older male detainees who needed to be held there for specific purposes.

1.6 On 24 January the Minister for Corrective Services ('the Minister') directed the Inspector of Custodial Services ('the Inspector') under section 17(2)(b) of the

Inspector of Custodial Services Act 2003 (the Act) to carry out a full investigation into all aspects of the riot, including:

- context of the incident;
- facts of any contributing/causal factors;
- security and integrity of the cells;
- security systems and infrastructure;
- security practices and protocols for all staff;
- adequacy of crisis/emergency management planning and crisis/emergency management response;
- temporary housing of juvenile detainees at Hakea; and
- to report to Parliament on the findings at the conclusion of the review.

1.7 In addition, the Minister also asked the Inspector 'to review staffing levels at the facility and report on the management of the incident and its impact on staff'.

1.8 The terms of reference for this Directed Review of the riot at Banksia Hill ('the Inquiry') require the Inspector to carry out 'a full investigation into all aspects of the incident' including the specific areas identified. This Emergency Management Review Paper ('the Paper') is one of a suite of six Papers prepared as part of the Inquiry and in support of the Inspector's Report to Parliament.

2 Overview

Environment at Banksia Hill

2.1 Banksia Hill was built as an open campus which was intended to provide a secure and therapeutic environment for detainees. The campus style of the centre moved away from the small enclosed designs of the past. The physical size and layout required staff to be trained in defensive techniques for first response to incidents.

2.2 For this type of facility to be effective a delicate balance must be maintained between physical, process and dynamic security. Ideally this balance would be determined though a clearly documented and understood operating philosophy. However, no clear philosophy was in place at Banksia Hill at the time of the riot. For further information on this issue refer to this Inquiry's *Security Review Paper*.

2.3 A clear operating philosophy was particularly needed for Banksia Hill given the merging of staff cultures which followed the decommissioning of other juvenile centres in the period prior Banksia Hill's opening. Associated with this mix of staff from different sites with different practices, there was also a change in base qualifications for Youth Custodial Officers. Initially officers obtained qualifications in youth work, however in 2008 new staff were required to gain a Certificate IV in Correctional Practice to become a Youth Custodial Officer. The change in base qualifications, as well as the merging of cultures, resulted in conflicting views among staff on the right balance between welfare and security.

2.4 Approximately four months before the riot the Rangeview Remand Centre ('Rangeview') amalgamated with Banksia Hill, making it the sole juvenile detention centre in Western Australia. Despite a lead time of several years from the time the decision was made to amalgamate the facility to the actual amalgamation the process was poorly managed. Overall, the amalgamation was not a success.[1] The distinct cultures of Rangeview and Banksia Hill were not taken into account, and the absence of shared policies, procedures, and an underlying philosophy led to divisions among staff and confusion for detainees. These issues were compounded by a lack of leadership including five substantive changes in the position of Superintendent of Banksia Hill/Director of Youth Custodial since the start of 2009, with three of those changes occurring during the pivotal amalgamation year.

[1] For additional information refer to this Inquiry's *Management, Staffing and Amalgamation Review Paper.*

Scope of Review

2.5 This Paper explores the emergency management of the riot on 20 January 2013, including the Department's ability to prevent a riot, the level of preparation for the riot and its response and recovery.

2.6 However, regardless of improvements the Department can make in these areas it is important to note that the detainees concerned made choices to be involved in the riot. The individual actions of detainees during the night are not the focus of this review. The examination of individual actions is a matter within the jurisdiction of the Western Australia Police ('police') and the Department.[2] Identification of areas for improvement for the Department does not excuse the behaviour of the detainees involved in the riot.

2.7 The methodology involved in the preparation of this Paper (see Appendix A) included the examination of a number of relevant documents, a survey of Banksia Hill employees, focus groups and meetings of detainees and staff. The Inquiry also examined CCTV and Polair footage of the event as well as radio traffic.

[2] It is understood that police charged 35 detainees with criminal damage relating to the riot on 20 January 2013.

3 Conclusions

3.1 On the night of the riot, the work undertaken by several Department staff members was outstanding. The initial response to three of the detainees being 'out of bounds', was timely. Staff members were provided with clear instructions and paramount consideration was given to the safety of staff. However, this outcome relied heavily on good decision making by individuals rather than good preparation by the Department. In addition, the Department had done little to prevent this incident occurring even though there were clear warning signs that Banksia Hill had all the ingredients for a major incident to occur.

Prevention

3.2 The catalyst for this riot was three detainees absconding from a unit and ascending the roof, just prior to the nightly lockdown. This was not an unusual occurrence in Banksia Hill.

3.3 There are a number of common triggers that lead young people to ascend the roof in a detention centre, many of which can be alleviated by positive officer-detainee engagement.[3] However, the ability for constructive engagement between staff and detainees at Banksia Hill had been eroding for some time. Staff shortages, coupled with changes in practices such as having communal staff meal breaks, increased the number of unscheduled lockdowns for detainees.[4] These additional lockdowns disrupted the normal daily schedule for detainees, such as access to education and recreation, and in doing so limited the opportunities for staff to constructively engage with detainees.

3.4 This is not to say that all staff at Banksia Hill have poor relationships with detainees. In fact, some have worked exceptionally hard to establish positive relationships which were evident in conversations with detainees. It was also evident in the lack of intention of detainees to target staff on the evening. There was one clear example of where detainees had the opportunity to target a staff member but instead went out of their way to reassure the staff member that they meant her no harm.

3.5 Banksia Hill relies on a system of incentives and disincentives to manage young people in detention, a system which has been and is, struggling. Enhanced privileges are linked to specific accommodation with fewer privileges available in other units. Progression to units with enhanced privileges and regression to units with fewer privileges is dependent on behaviour. At the top of this system is self-care where detainees have a level of autonomy. At the bottom of this

[3] Office of the Inspector of Custodial Services (OICS), *Summary of a Report on an audit of Custodial Roof Ascents,* (November 2012).

[4] Communal meal breaks rather than rotational.

system are wings in Harding unit which have limited means of preoccupation and are connected to individual regimes that restrict the detainee's time out of cell. While temporary loss and recovery of privileges can be experienced by any detainee in any unit based on their behaviour, movement up and down the accommodation system provides the primary means for incentivising and dis-incentivising detainees within Banksia Hill.

3.6 For this system to be effective it requires the capacity for individuals to be moved around the centre. When there is limited capacity, detainees may be punished or rewarded based on available space rather than merit. In the last five years there has been significant growth in the number of detainees. Given the amalgamation of Rangeview with Banksia Hill in late 2012, these detainees are now accommodated in a single location. In 2009 the number of detainees rarely reached three figures in the two locations. Just prior to the riot the number had doubled with around 200 detainees being held at Banksia Hill.[5]

3.7 In addition, the increase in population count and decrease in units which resulted from the amalgamation, has restricted Banksia Hill's ability to disperse individuals who are known associates, or have a history of undertaking the same poor behaviour such as absconding and ascending the roof.

3.8 These issues are compounded by the impact of unscheduled lockdowns which changed the nature of the incentive and disincentive approach to managing behaviour. A disincentive can only be a deterrent if it is a possibility, not a reality. It is no longer a disincentive for a detainee to be confined to their cell as a punishment, when this is occurring on a daily basis for reasons beyond the detainee's control. Likewise, the loss of TV privileges when a daily schedule is in place, is more severe when confined to a cell.

3.9 The Inquiry found numerous examples of a lack of security awareness by both staff and centre management over a prolonged period. This included poor staff compliance with rules and instructions, poor intelligence gathering and the lack of attention to a known security risk of debris around the centre.

3.10 This lack of security culture, combined with population pressures, staffing difficulties and increasing lockdowns were contributing factors to the riot. Strategic intervention in any of these areas would have improved the Department's ability to prevent the riot that occurred.

Preparedness

3.11 The Department recognises that emergency preparedness is a crucially important topic for every correctional institution, noting that a major

[5] Figure based on data extracted daily from TOMS for the period 6 October 2012 to 20 January 2013.

institutional crisis can be overwhelming and almost interminable.[6] Given this acknowledgement it would be expected that each institution in the Department would have undertaken appropriate planning for emergency events and have undertaken extensive training. However this was not the case in Banksia Hill.

3.12 The Emergency Management Plan for Banksia Hill was last updated in May 2011. Although there is a departmental requirement for facility plans to be updated annually this had not occurred. In particular, it is a clear oversight that the Emergency Management Plan has not been updated since the amalgamation which has made Banksia Hill the only juvenile detention facility in WA. There had been no head office oversight to ensure this plan was updated, even though there is a quality assurance plan in place for Community Youth Justice and a security assessment in November 2012 indicated an examination of emergency management procedures at Banksia Hill would be undertaken. The result of this oversight is that there was no contingency plan in place if Banksia Hill needed to be evacuated.

3.13 Banksia Hill is required to undertake a minimum of six emergency management training exercises each year. At least one of these should be a live simulation rather than a desktop exercise. During 2012 only one desktop exercise and two live drills were conducted within the youth custodial estate falling well short of requirements.[7] In addition, only seven custodial staff attended the three exercises as the opportunity to participate in this training is restricted to who is available on shift.[8] Given Banksia Hill has an operational staff level of close to 200, this means that very few people have been involved in this type of training in the last year. One staff member reported he had not been involved in a simulation exercise since the late 1990s.

3.14 Less than a quarter of respondents to the staff survey for the Inquiry, felt that they had adequate training to prepare them for the riot. Staff consistently reported having little, or no, training in emergency management and little, or no, training to prepare them for the riot.

Response

3.15 The initial response to the three detainees being 'out of bounds' on the night of the riot was both timely and appropriate. Clear direction was provided by the Shift Manager and priority was given to ensuring the safety of staff.

3.16 As the situation escalated, more of the Department became involved in the response. Communication at a command and control level was not always good

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[6] Department of Corrective Services, Corrective Service Training Academy, Entry Level Training Program Manual – *Emergency Procedures YCS,* Module Version 3 (December 2008).
[7] Advice received from the Department 18 February 2013 - *Training Banksia Hill Staff 2012*
[8] Ibid.

and role confusion occurred. Although this did not appear to result in any negative outcomes on the night, there is substantial room for improvement in clearly defining roles, responsibilities and lines of communication during a critical incident. In particular, there is a need for having a single, identifiable incident controller assuming control of the incident, planning and guiding staff actions, and providing effective liaison. This did not occur with the Emergency Support Group (ESG) Superintendent assuming some of this role and the Director of Youth Custodial assuming other parts of this role.

3.17 The difficulties in command and control resulted in poor communication, a lack of planning to establish welfare checks for detainees still in their cells and a lack of understanding of the origin of key decisions (such as the obtaining police assistance inside the centre).

3.18 During the riot, detainees were left uncontrolled for over an hour and half causing considerable damage to the centre. Understandable reasons were provided for this delay, however, overall the response was not timely. This is not a criticism of individual actions and decision but rather a comment on the resources at Banksia Hill's disposal to deal with the riot on a Sunday night.

4 Synopsis of the Riot

4.1 On 20 January 2013 Banksia Hill was operating with an almost full complement of staff for the day shift. This followed considerable periods of staff shortages which had resulted in unscheduled lockdowns. The result was that a full and busy day had been offered to the detainees. In the words of one senior staff member, it had been a 'fantastic day'.

4.2 The normal lockdown time is 6.00 pm but around 5.45 pm, staff around Lenard Unit noted some unusual detainee interactions and signals. They contacted the Shift Manager who advised staff in Lenard Unit to commence the evening lockdown early. As soon as the process of lockdown started three male detainees absconded from the unit.

4.3 The detainees ran to the girls unit (Yeeda), scaled a management fence topped with barbed wire and climbed onto the roof. Emergency lockdown procedures were implemented whereby staff secured remaining detainees in their cells. At the instruction of the Shift Manager, one staff member remained in each unit while other staff joined the Recovery Team to form a cordon around the girls unit. By this time, the detainees had 'armed' themselves with rocks – of which there was an abundant supply - and a metal aerial. In accordance with accepted practice, staff then retreated to a safe distance and continued monitoring the actions of the detainees. The detainees remained on the roof for several minutes.

4.4 The three detainees then descended from the roof and ran past two officers who were making their way to the cordon. They reassured the officers as they passed that they had no intention of hurting them.

4.5 They then went towards the gatehouse where they encountered two Youth Custodial Officers who were escorting visitors from the facility. As the detainees approached the gatehouse one of the officers verbally challenged the detainees, instructing them to get on the ground. This deterred the detainees who responded by changing direction and heading over to the administration area where they climbed onto the roof of the education building. The visitors were escorted safely from the facility.

4.6 The detainees moved across the roof of the education building. They were armed with rocks and one detainee threw a rock at a staff member with whom he had a previous altercation earlier that day. The rock missed the staff member.

4.7 The Shift Manger controlling the incident reminded staff to stay at a safe distance from the detainees. He instructed staff who had remained in the units to lock themselves in the unit offices. He also began notifying senior departmental officers of the incident and requested assistance from the Department's Emergency Support Group (ESG).

4.8 While these events were occurring, the Primary Response Team (PRT) made up of Banksia Hill staff, was being assembled at Harding Unit. Within 15 minutes of the detainees absconding, the first team members had managed to congregate and were in the process of donning their protective gear. However, by this time the detainees had made their way across to Harding Unit where they proceeded to use loose pavers and debris to break a detainee out of his cell. The cell was breached in approximately 90 seconds, moments before the PRT entered the cell.

4.9 Two minutes later a fifth detainee was assisted to break out of his cell from a different unit. A sixth was assisted to break out of another unit eight minutes later. Some of the detainees headed towards the gatehouse where a rock was thrown against the gatehouse door. This raised concerns that detainees may attempt to escape. The Shift Manager therefore instructed the gatehouse to call the police to assist in securing the centre's perimeter.

4.10 In response to the detainees breaching their cells, the Shift Manager instructed staff to assemble at the Staff Amenities building for their safety and to ensure the security of keys that are carried by staff members. Where needed, the PRT assisted staff members to evacuate from the units. Once all staff members were accounted for the PRT formed a cordon around the Staff Amenities building.

4.11 The situation the escalated rapidly, with more and more detainees being assisted to break out of their cells. For the next hour and a half, detainees ran unimpeded around the centre causing considerable damage, especially to the living units. They formed and split groups fluidly, while assisting more and more detainees to get out of their cells. A number of detainees broke out of their cells without assistance, sometimes making their way through the A4 sized observation windows on the inside of the unit. Detainees did not attempt to injure staff nor each other.

4.12 Approximately an hour after the three detainees first absconded, centre management and the ESG arrived at the centre. An incident control facility was activated above the gatehouse and assistance from the police helicopter was requested.

4.13 The ESG Superintendent took control of resolving the incident. He planned a response utilising all available resources, including the police and the canine (K9) unit. Extensive planning was undertaken on how to contain the detainees, prior to entering the facility.

4.14 Once entering the facility, the ESG and the police executed a coordinated response that resulted in the reapprehension of the majority of detainees known to be out of their cells within 10 minutes. However, while these detainees were being apprehended, other detainees continued to break out of their cells. It took a further four to five hours to secure all the detainees.

4.15 In total it was estimated that 61 detainees – one third of the male detainee population – had broken out of their cells during the riot. In addition to the 61 detainees who had exited their cells, a significant number caused internal damage to their cells.

4.16 Detainees apprehended outside of their cells were held on a basketball court. They were joined by detainees whose cells were no longer useable due to damage caused by themselves or others during the riot. In total, 73 detainees were held on the court until arrangements could be made to transfer them to Hakea. The transfers started just after 1.00 am.

4.17 While on the basketball court medical staff provided attention to any detainees that had injured themselves during the riot. Many detainees had sustained minor cuts and grazes, however one detainee sustained a deep cut to his leg which required hospital treatment. In addition, while awaiting transport to Hakea, there was an altercation between a detainee and an ESG officer that resulted in the officer being bitten.

4.18 Welfare checks of detainees still in their cells were first resumed in the Harding Unit just after 10.00pm, four hours after the start of the incident.

5 Prevention

5.1 In emergency management, prevention refers to any activity undertaken to stop or reduce the possibility of an emergency occurring. In the context of the riot that occurred on 20 January 2013, prevention would encompass any activity undertaken to stop or reduce the trigger for the event, in this case the initial roof ascent. Preventing the roof ascent, by extension, would have prevented the riot that followed.

5.2 However, the prevention or reduction of roof ascents has been a challenge for the Department within the youth custodial estate. Previous work by the Office of the Inspector of Custodial Services (OICS) found that these incidents occurred within the juvenile estate at a rate of 1.25 per month over the past decade.[9] This is more than double the rate of incidents occurring in adult prisons.

5.3 Over the past three years, the Department has introduced minor physical modifications in an attempt to reduce the number of roof ascents. These include the installation of barrier tape, commonly known as razor wire, on some sections of roof and the erection of demarcation fences around some parts of the Banksia Hill facility to enable segregation of units.

5.4 In addition, specialised response training was developed and implemented by the youth custodial directorate in 2010. On any given shift these trained individuals can form the Primary Response Team (PRT) if required. Their role is to contain volatile situations pending the arrival of specialist support.[10]

5.5 Physical modifications and the introduction of the PRT were focused on limiting access to the roof and ending a roof ascent quickly but the Department has not sought to address the root causes of roof ascents. A report by this Office examining custodial roof ascents released in December 2012 found a number of common triggers led young people to ascending the roof.[11] It noted that many of these triggers could be alleviated by positive officer-detainee relationships and active engagement. In essence, roof ascents could be reduced or prevented by improving the daily management of the detainees.

5.6 However, daily management of detainees continued to deteriorate particularly after the facility amalgamated with Rangeview. The detainees were locked down for extended periods of time, education programs were cancelled regularly and meaningful interactions between detainees and staff were limited. By October 2012, a senior manager within the Department noted that the lockdowns and staff shortages were increasing agitation among detainees. The situation was

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[9] OICS, *Summary of a Report on an Audit of Custodial Roof Ascents* (November 2012) 1.
[10] Department of Corrective Services, *Annual Report 2011/2012* (September 2012) 35.
[11] OICS, *Summary of a Report on an Audit of Custodial Roof Ascents* (November 2012) 1.

described as being at crisis point and it was noted there was a high risk of a major incident occurring.[12]

Detainee supervision and engagement

5.7 The primary role of a Youth Custodial Officer (YCO) is to effectively supervise detainees.[13] In doing so, YCOs are able to monitor and manage detainee behaviour. Effective supervision also enables YCOs to address safety, security, and welfare concerns of detainees. [14]

5.8 To become a YCO, officers are required to successfully complete extensive entry level and probationary training. This consists of a 13 week theory based course followed by nine months of practical on-the-job training at Banksia Hill. Effective supervision is the core focus of this program and the training module states that the 'development and use of good supervision increases a person's ability to get others to change or alter their behaviour'.[15]

5.9 Effective supervision comes through useful detainee engagement and rapport building. Engaging constructively with detainees demonstrates that they can have appropriate, functional relationships with adults or others in a position of authority. The officer-detainee relationship can also encourage information disclosure[16] which may relate to the safety, security or wellbeing of the detainee or others, and may be utilised to make intelligent decisions about the best way to manage an individual detainee.[17]

5.10 There are endless opportunities for positive staff-detainee engagement including:

- participating in meal times;
- allocating cells;
- conducting population movements and counts;
- during education, programs and review meetings;
- when conducting cell, wing and unit cleans; and
- during recreation and scheduled activities.

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[12] Director Security Services, Department of Corrective Services, email (26 October 2012).
[13] Department of Corrective Services, Corrective Services Training Academy, Entry Level Training Program Manual - *Detainee Supervision* Module Version 3.0 (14 February 2013) 7.
[14] Department of Corrective Services, *Youth Custodial Officer Job Description Form* (October 2012) 1.
[15] Department of Corrective Services, Corrective Services Training Academy, Entry Level Training Program Manual - *Detainee Supervision* Module Version 3.0 (14 February 2013) 1.
[16] It was noted by staff that the relationship with detainees had deteriorated. In the past detainees were more likely to alert an officer to others misbehaviour, such as planning a roof ascent, in order to avoid lockdowns. Lock downs were so frequent and prolonged that detainees stopped informing staff.
[17] In April 2012, a ministerial briefing was provided outlining strategies to effectively manage union issues at Banksia Hill in the lead up to the amalgamation. One of these strategies suggested educating staff to 'use intelligence information about individual young people to plan for their management.'

There is also the capacity for effective engagement when counselling or providing mediation for detainees after an incident.

5.11 However, at Banksia Hill, many of these constructive activities were being cancelled or restricted in some way due to lockdowns which interrupted the daily schedule. Consequently, the detainees were often fed in cell, superficial cell cleans were conducted, the education program was cancelled or run at a reduced capacity, and recreation was limited or non-existent. The direct result of the lockdowns meant detainee engagement was less meaningful and rapport building and information sharing was limited.

5.12 Irrespective of lockdowns, some staff were not maximising their opportunities to engage with detainees when a normal daily regime was in effect. When detainees are engaged in educational or vocational pursuits staff should perform roving patrols of classrooms, workshops and the centre's kitchen facilities. The patrol provides additional intermittent supervision to that which is already being provided by the teacher or vocational staff member, therefore providing an opportunity for staff to engage with detainees. In November 2012, the Security Services Directorate provided a Security Assessment for Banksia Hill which stated that roving patrols varied in their level and diligence.[18] Where these patrols are not carried out appropriately opportunities for engagement are lost.

5.13 While there is room for improvement, it is important to note that some staff regularly, actively and constructively engaged with detainees and build rapport. This was evident in conversations with the detainees and staff as part of the Inquiry. In addition to the positive impact these relationships have for the detainees, engagement increases the safety for the officers. During the riot there was no personal violence by detainees directed towards YCS staff. In fact, in one case, detainees specifically expressed a lack of intention to target a staff member even though they had the opportunity. The detainees were running down a path with a staff member coming the other way. One detainee stated "d*on't worry Miss, we won't hurt you. Just let us go past* (sic.)."[19] This shows a positive relationship between the staff member and detainees which should be commended and encouraged.

Lockdowns

5.14 Excessive lockdowns have been an ongoing area of concern at Banksia Hill for detainees, staff, Independent Visitors and OICS, for some time. The last inspection of Banksia Hill carried out in May 2011 and reported on in January 2012, highlighted concerns regarding lockdowns and culminated in a

[18] Department of Corrective Services, Security Services Directorate *Security Assessment* BHJDC (November 2012) 16.
[19] TOMS incident id I1240049.

recommendation for the Department to reduce the number of scheduled and unscheduled lockdowns of detainees.[20] The Department responded by stating:

> There is no alternative to the practice of lock downs within existing resources to ensure the safety and security of the centre. However the Department of Corrective Services ensures that all lockdowns are kept to a minimum.[21]

5.15 Since that response was provided excessive lockdowns have not only continued at Banksia Hill but have increased. The Department failed to understand that the safety and security of the centre was compromised because of the lockdowns, instead stating the lockdowns provided safety and security.

5.16 Detainees expressed frustration to the Inquiry about the extent to which lockdowns were occurring at Banksia Hill in the time preceding the riot. Lockdowns were preventing a normal daily regime from occurring, therefore preventing detainees' access to education, programs and recreation. Many young people stated their participation in the riot was because they 'were locked down too much'. [22] In the staff survey a third of staff also cited the lockdowns as a precipitating factor to the riot.

Recording lockdowns

5.17 The daily regime for detainees at Banksia Hill is outlined in standing orders and Assistant Superintendent's Notices.[23] These documents provide a basis for a centre timetable with young people unlocked at 7.30 am and resecured in cell again for the evening at 7.15 pm. Therefore, at the very least, detainees are secured in cell for 12 hours and 15 minutes every night.

5.18 In addition to the scheduled lockdowns of 12 hours and 15 minutes, unscheduled lockdowns were also occurring. The Department has attributed the reasons for these additional lockdown hours to staff breaks, staff training, staff meetings and staff shortages.

5.19 The Department has recognised that it's records inaccurately reflect the reality of lockdowns through under reporting. Departmental monitor reports in October 2012 indicate lockdowns occurred but these were not included in the records for the month. Accordingly, the statistics provided by the Department about lockdowns can at best be considered the minimum amount of time detainees have spent in their cells.

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[20] OICS, *Report of an Announced Inspection of Banksia Hill Detention Centre,* Report No. 76 (January 2012) 61.
[21] Ibid.
[22] Comment by a detainee during a focus group of young people who were involved in the riot.
[23] Standing Order 4 and Assistant Superintendent's Notices 14/2012 and 17/2012.

5.20 In the 12 months preceding the riot, departmental records indicate that the detainees at Banksia Hill were locked down a for a collective 43,027 hours in addition to their normal evening lock up period. This figure is the total number of hours spent in unscheduled lockdown accumulated for each detainee over the year.

5.21 Of these hours, 65% were attributed to the post amalgamation period from 1 October 2012 to 31 December 2012. During these three months the average daily population at Banksia Hill was 185, therefore each detainee was locked down an additional 152 hours over the three months. This equates to 1 hour 40 minutes extra each day, leaving the detainees on average locked in their cell for close to 15 hours per day.

5.22 These statistics also show that the Department attributes 14, 883 hours to unscheduled lockdowns from 1 January 2012 to 30 September 2012, equating to 21 minutes extra lockdown per day per detainee. Given concerns had been raised about lockdowns from multiple fronts during this period, it is unlikely this number is accurate. These low numbers demonstrate the vast underreporting of lockdowns. Logically, this means that the 15 hours per day of lockdown reported from October to December is also significantly lower than what was actually experienced by the detainees.

5.23 In submissions to this Inquiry both the Aboriginal Legal Service of WA (ALSWA) and Legal Aid commented on the amount of time detainees spent locked in their cells prior to the riot. One of the organisations indicated that several of their clients had 'reported that in the months and weeks leading up to the incident, detainees were subject to frequent and excessive lockdowns of up to 23 hours per day.'

Rolling lockdowns

5.24 Rolling lockdowns occur when there are insufficient staff to have all detainees out of cell at the one time. The staffing arrangement is based on a ratio of one custodial officer to eight detainees. In a normal living unit with 24 detainees, three YCOs and a unit manager are required in order for all detainees to be out of cell. If one YCO is not on shift only 16 detainees can be unlocked at any one time. Rotations occur for the other 8 detainees to be out of cell.

Table 1
Example of a rolling lockdown at Banksia Hill

Out of Cell	In cell
A wing + B wing	C wing
A wing + C wing	B wing
C wing + B wing	A wing

5.25 Rotations occur by having 16 detainees unlocked for a set period of time. Then half of those detainees are locked down, and the other half are joined by those that are yet to be unlocked. After the same time period, the eight detainees that have been unlocked during both time periods are locked down, while the rest of the detainees are unlocked. The rolling process continues until there is sufficient staffing. It is exacerbated when more than one staff member is absent and when detainees are double bunked due to overcrowding or cell shortages. The impact of staff shortages on Banksia Hill is further explored in this Inquiry's *Management, Staffing and Amalgamation Review Paper*.

Continuation of lockdowns

5.26 Lockdowns are not only due to staff shortages. With a full complement of staff, young people are still secured in cell while staff have their meal breaks together.[24] If meal times were rotated such that only one staff member per unit went on their break, detainees would remain unlocked. The Unit Manager could relieve each officer in the unit until all staff breaks were facilitated. Instead, staff take their meals together leaving detainees spending additional time in cell.

5.27 In addition to communal staff breaks, Banksia Hill staff have advocated for a third recovery team. The additional team was trialled at Banksia Hill for a short period after an incident on 2 October 2012. The incident involved five detainees absconding from a unit whilst another four detainees damaged their cells. Management agreed to the request for a third recovery team after staff expressed concerns about their personal safety being compromised. The additional staff required to facilitate this third team were covered by transferring staff from the unit roster. Consequently, more detainees were locked down. A monitoring report submitted to the Department after the implementation of the third team stated that

> [t]he ratio of detainees on lockdown to available staff should have a calculation that includes both safety and service provision. Not only do the lockdowns impact on detainee behaviour but they also deprive detainees of education, recreation, full psychological and medical services.[25]

5.28 Further to this advice information was also forwarded to the Commissioner and Deputy Commissioners that the use of a third recovery team seemed excessive for a centre of Banksia Hill's size.[26] Comparisons were made with Hakea which

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[24] Assistant Superintendent Notice 20/2012 *PM Program Time Table*. The notice also advises that the time table is an interim measure and that centre management were working towards producing a staff break matrix.

[25] Department of Corrective Services, *Banksia Hill Monitoring Return 3 & 4 October 2012,* 6.

[26] Director Security Services, Department of Corrective Services, email (26 October 2012).

has three recovery teams for a population in excess of 900 prisoners and Casuarina Prison, which has two teams with approximately 600 prisoners. It was then suggested that the staff would 'be much better utilised towards minimum manning to allow for detainees to be unlocked.'[27] The third recovery team was abandoned in December 2012 after the opening of Urquhart unit. In retrospect, staff believed that with three recovery teams the detainees who originally absconded on 20 January 2012 would have been contained. While there is no evidence for this claim, staff continue to advocate for this third team.

Behaviour management options

5.29 Detainee management at Banksia Hill is based on a hierarchical accommodation model of progression and regression. Certain privileges are linked to where the detainee is accommodated. After orientation to the centre, a detainee enters into the middle of the hierarchy with standard privileges.

5.30 Progression to the higher echelons with enhanced privileges provides an incentive for detainees and encourages them to meet centre expectations. At the top of this model is self-care. Self-care is likened to teenage residential living where detainees cook for themselves, make phone calls outside unlock hours and have unlimited access to televisions, games machines and their own kitchen. While they are secured in the residential unit at night, they have rooms rather than cells and their supervision level is the lowest in the centre. In essence, self-care detainees have the greatest level of autonomy.

5.31 The model provides disincentives by downgrading a detainee through the various levels of the hierarchy or removing privileges depending of the severity of the infraction. The following diagram outlines the hierarchical accommodation model for males at Banksia Hill.

[27] Director Security Services, Department of Corrective Services, email (26 October 2012).

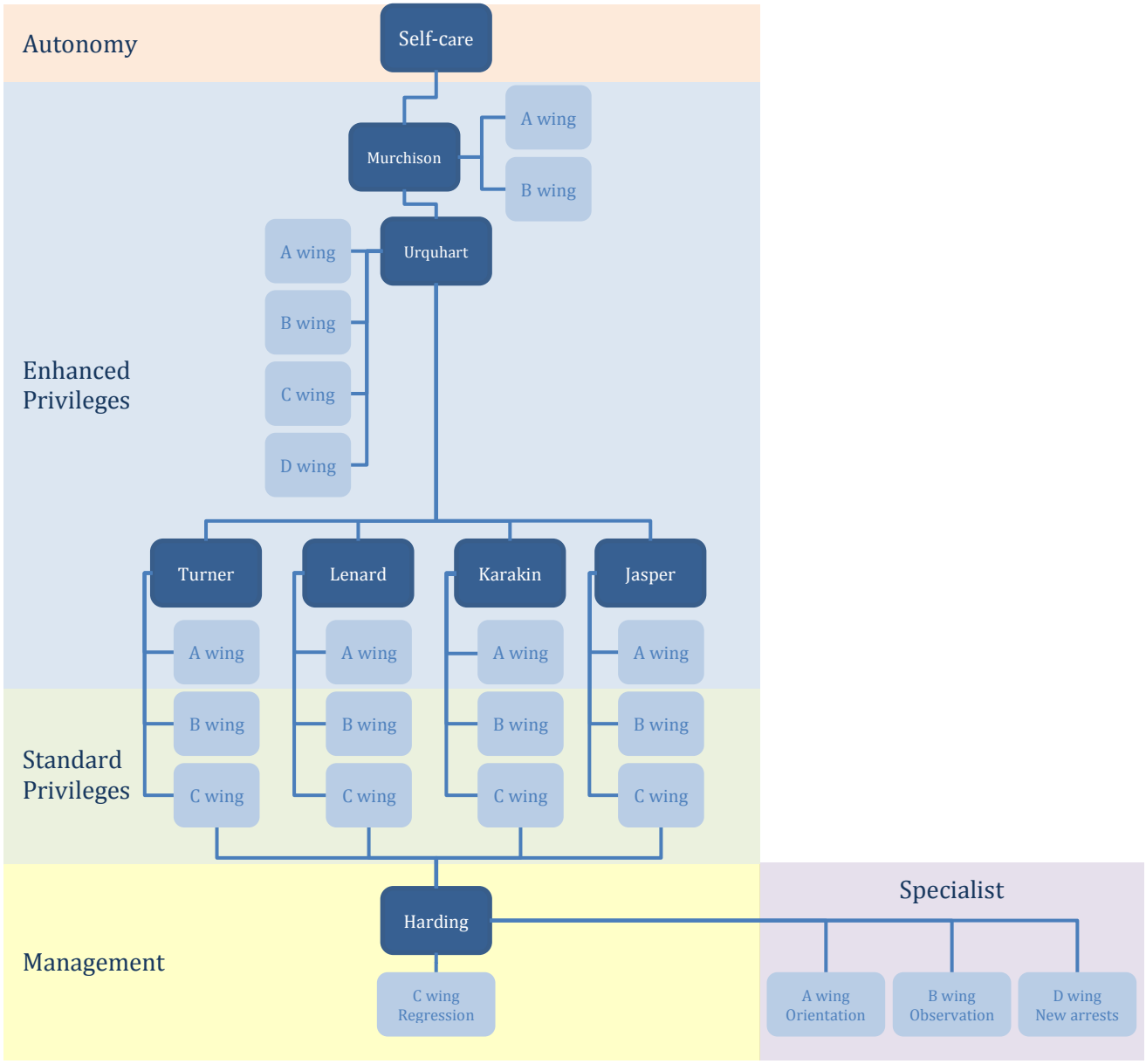

Figure 1
Hierarchical accommodation model for males at Banksia Hill

Incentives and disincentives

5.32 International literature suggests that young people have a heightened sensitivity to immediate incentives when compared with adults.[28] Within Banksia Hill incentives are intended to positively reinforce desirable behaviours. This is based on the assumption that detainees will respond to a systematic and fair

[28] Bonnie RJ, Chemers, BM & Schuck, J (editors), *Reforming Juvenile Justice: A Developmental Approach* (November 2012) Chapter 4, 2.

incentive system where the quality of time spent in detention is determined by their own behaviour.[29]

5.33 The ability to achieve self-care is the top incentive at Banksia Hill. Prior to the amalgamation, Banksia Hill was designed to house 16 detainees in self-care for a population of less than 120. However, to allow for the expansion, three of the four self-care cottages were reassigned. This left Banksia Hill with four self-care positions for a post-amalgamation population of more than 160 males. An A+ status was created to mitigate the loss that forfeiting these positions caused. However, A+ detainees do not have the added freedoms of residential living as they remain within a unit with enhanced privileges and are secured in cell of an evening. It is clear that without sufficient placements, self-care cannot be the incentive that it was designed to be.

5.34 In addition to progression through the hierarchy there are other incentives available to detainees. Privileges are 'any concession or luxury extended to a detainee in addition to any rights provided by statutory or common law'.[30] They include but are not limited to:

- ability to make social phone calls (to more than the detainee's primary caregiver);
- access to recreational or sporting equipment;
- ability to make purchases from the centre canteen;
- access to approved items of personal property;
- use of television, radio and CD players in the detainee's cell; and
- access to computer games.

5.35 Despite these incentives, the system at Banksia Hill has a strong emphasis on punitive control. Young people are expected to maintain a certain level of behaviour during their time in detention. Failure to do so results in consequences including:

- obtaining a caution;
- counselling;
- loss of privileges (such as social visits);
- loss of gratuities;
- additional domestic work or other duties;
- cell confinement within the young person' living unit;
- regression from a privileges accommodation level to a normal unit;

[29] Department of Corrective Services, Corrective Services Training Academy, *Detainee Privileges* Module, Version 1.0 (14 February 2013) 6.
[30] Ibid., 1.

- placement on an 'individual unit-based regime';
- placement on an 'individual regression regime'; and
- confinement in a nominated cell.

5.36 The most common consequence is the loss of privileges. Between 1 January 2013 and 19 January 2013 there were 118 incidents at Banksia Hill. For these incidents the loss of various privileges were issued 60 times. As a result, it appears that behaviour management at Banksia Hill is built on the temporary removal and reinstating of common privileges, rather than a system aimed at having detainees strive to achieve progressive incentives. Many staff spoken to as part of the Inquiry, including senior staff, raised concerns about the lack of incentives in Banksia Hill.

Regression

5.37 The most serious consequence for poor behaviour at Banksia Hill is regression. Regression denotes any downward movement in the ranked system whereby detainees are moved from a privileged unit to a normal living unit.

5.38 In addition, regression is also the term given to the lowest stage of the hierarchical accommodation model. Detainees are placed in Harding – the facility's multipurpose unit. Within this unit an individual regime is set to address and modify behaviour. There are three stages for detainees to progress through to return to an ordinary living unit. When first placed in Harding Unit as part of regression detainees do not have access to privileges like televisions or radios and are only entitled to two 30 minute exercise periods out of cell per day. Regression to Harding is intended to provide time for the detainee to reflect on poor behaviour with limited means for preoccupation. Earned progression to stages two and three increase the detainee's access to program participation until a committee recommends the young person can return to the general population and normal units.

5.39 There are reservations regarding the efficacy of the regression regimes. In his response to an application by the Department to have a detainee transferred to adult custody, Hon. Judge Reynolds remarked that there were serious questions about the worth and negative effects of the management regimes that were imposed against the detainee.[31] He further noted that 'the oppressive conditions of both the regression management regime and the individual management regime have the real potential to exacerbate already serious existing mental health problems for many young detainees.'[32]

[31] Hon. Judge D Reynolds, *The Department of Corrective Services -v- RP* [2012] WACC 5, 24.
[32] Ibid., 24-25.

Dispersal options

5.40 Young people who come into detention have many complexities. Controlling for any of these complexities is a challenge but can be assisted through the segregation of detainees. With Rangeview and Banksia Hill, strict separation occurred between male and female detainees and some division was attempted for offenders who were newly arrested, on remand or had been sentenced. Dispersal options were also used to separate offenders and their victims, members of feuding families, co-offenders and sometimes younger and older detainees.

5.41 Since the amalgamation, Banksia Hill has become the only detention centre in Western Australia, limiting the opportunities for dispersal and increasing the risks posed by mixed detainee cohorts. All detainees are now accommodated within eight units in one centre rather than 11 units in two facilities. This is compounded by factors such as overcrowding, regression or even recreation which may not allow for the strict adherence of segregation needs. Consequently, detainee contact is inevitable for those who should have limited or no contact with each other.

5.42 Association alerts are a specific tool of dispersal. They are used by staff to limit the contact of known associates while in custody. These alerts may be applied to prevent co-offenders from residing in the same unit or participating in programs together. The alerts can also be assigned to detainees with a particular behavioural history such as scaling the roof.

5.43 It is known that juveniles are more likely to ascend a roof in small groups rather than on their own.[33] Creating association alerts for known roof ascenders can prevent mixing of these detainees within a unit or program and limit the ability for these juveniles to coordinate a roof ascent. It is acknowledged that given the rate of these events, practical application is challenging within Banksia Hill, however as outlined below there is obvious room for improvement in the selection of detainees for association alerts and how these are managed.

5.44 Information about the planning of roof ascents and other major disruptions is occasionally received by YCS staff.[34] Association alerts should be applied to detainees when this information is forwarded and assessed by security. In November 2012, information was received regarding two detainees attempting to encourage others to abscond from their units and escape Banksia Hill by throwing rocks at the perimeter. This plan was brought to the attention of

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[33] OICS, *Summary of a Report on an audit of Custodial Roof Ascents* (November 2012) 2.

[34] In discussions with staff it was noted that historically young people approached staff when other detainees were planning to scale the roof in order to avoid additional lockdowns. This has changed in recent times as the frequency of lockdowns increased and the detainees were locked down regardless. The young people stopped talking to staff.

custodial officers.[35] Allegedly, the plan was scuttled because the two detainees could not enlist enough supporters.

5.45 An investigation was conducted into this incident by Banksia Hill security and works were carried out to reduce the risk of this type of incident occurring. However, association alerts were not applied to the detainees to ensure their dispersal and prevent or limit further interactions. As a consequence, after being removed to the Harding Unit and placed on Individual Management Regimes for five days, the detainees were then transferred to separate units and eventually placed in the same unit together. On the night of 20 January 2013, these detainees were two of the three young people who instigated the riot by absconding and scaling the roof together.

5.46 Dispersal is not only an option to separate the young people among themselves but also a means to provide a break for staff from a particular detainee. While YCOs undergo extensive training in cathartic exercises and can access a range of other services like counselling and staff supporters, on occasion physical separation between a staff member and particular detainee is needed. An assault of a staff member by a detainee is an extreme example which might warrant staff/detainee separation. Staff assaults often result in vicarious trauma which may prolong the consequence issued to the young person irrespective of improvements they make. In these cases dispersal has proved advantageous for the detainee's daily management and staff healing. With the amalgamation, staff/detainee separation is no longer feasible.[36]

Individual management

5.47 Upon arrival at Banksia Hill detainees are subject to an initial assessment using medical, psychological and other assessments. The assessments are used to determine the detainee's security rating and supervision classification. The ratings can be reviewed at any time as a result of positive or negative behavioural change, if they become an increased security risk or there is a change in the young person's circumstances. These reviews are conducted at the weekly Detainee Management Review Committee (DMRC) meetings.

5.48 The DMRC is a multidisciplinary team consisting of management and custodial staff, case planning and psychological services. DMRC meetings are an essential element of the progression/regression model, providing an opportunity to assess and approve a detainee's movement through the hierarchy. It is intended that a review of each detainee's security and supervision classification occurs regularly. Reviews take place for detainees:

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[35] TOMS incident report, id I1234111.
[36] Hon. Judge D. Reynolds, *The Department of Corrective Services -v- RP* [2012] WACC 5, 16.

- regressed in Harding;
- on Individual Management Regimes (IMR);
- listed as Special Profile Offenders;
- scheduled for review/classification as per advice from Case Planning;
- seeking placement in Murchison or self-care; and
- after a change to education is requested by the detainee (eg different classes).

Therefore, while the meetings are scheduled weekly, the individuals being reviewed may change from meeting to meeting.

5.49 Maintaining DMRC meetings has become challenging. Between July 2012 and January 2013 only ten meetings were held. Staff reported that the meetings were often cancelled due to staff shortages or stakeholder absences. Minutes noted that a written explanation was sought from absent stakeholders on two consecutive occasions. When meetings are cancelled detainee reviews do not take place.

5.50 In spite of functional tools like the DMRC meetings, YCS has treated detainee behaviours without individual distinction. Until an Assistant Superintendent's Notice was issued in May 2012 (notice 8/2012), a mandatory consequence was being issued to all detainees who scaled the roof. Detainees were subject to a mandatory loss of privileges for a period not exceeding 21 days.[37] The mandatory loss of privileges was in place for over a year. This approach was inconsistent with the governing Juvenile Custodial Rule ('JCS rule') 209 in place at the time. This rule stated that consequences issued for the management of a detainee must give due regard to:

- the nature of the conduct;
- the surrounding circumstances;
- the age of the detainee; and
- the maturity and intellectual capacity of the detainee.

Why the Banksia Hill behaviour management system is struggling

5.51 The suite of behaviour management options available to staff at Banksia is primarily dependent on accommodation. Privileges are linked to accommodation and the ability to disperse individuals relies on having adequate dispersal options.

5.52 For a hierarchical accommodation model of progression and regression to be effective it requires capacity for individuals to be moved around the centre.

[37] Superintendents Notice 5/2010 *Roof Access Incidents – Detainees Loss of Privileges*.

When there is limited capacity detainees may be punished or rewarded based on available space rather than merit. For example, a detainee achieving or exceeding expectations may reside in a unit's 'A' wing. After some repeated poor behaviours a decision is made to move that detainee to 'B' or 'C' wing. If those wings are fully populated, another detainee will need to be progressed (perhaps earlier than warranted) to accommodate the regression of the A wing detainee. Movement becomes even more problematic in a unit with double bunking.

5.53 The number of detainees in detention has been steadily growing since 2009. During 2009 numbers reached three figures on relatively few occasions and on average the population was closer to 90. During 2010, numbers quite frequently exceeded 110, rarely dropped below 100 and averaged about 95. By 2011, numbers were rarely under 110 and quite frequently exceeded 120, averaging around 115.[38] Following the closure of Rangeview, this number at times has been around 200.[39]

5.54 The increasing number of detainees is placing pressure on capacity. This is not a simple equation of 'beds vs heads' as space is needed within units to enable a hierarchical accommodation to work. Nowhere is this more apparent than where detainees are aiming to achieve self-care. As stated previously, there are now only four self-care places for 160 detainees. As a result most detainees will not attain self-care. Knowing that it is unlikely that a detainee will ever achieve self-care removes this as an incentive for many detainees and in some cases even turns into a disincentive if caution is not taken in communicating the reality of achieving self-care. One detainee who instigated the riot told the Inquiry:

> I kept asking to be moved to self-care. I had been doing the right thing for 4.5 months but they kept telling me, because of my history they wouldn't move me. What was the point of keeping on doing the right thing?

5.55 In examining this person's history it is clear he had fluctuated in the preceding months between conforming and not conforming to the behaviour expected within the centre. While the conforming behaviour may have seemed like an improvement to the detainee and possibly even to some staff, it is unlikely these small improvements would have been sufficient to secure him a place in a self-care unit. However, the detainee perceived the situation as not being rewarded for his efforts and therefore used this as an excuse to return to unacceptable behaviour. In particular the detainee attributed his lack of ability to reach self-care to prior behaviour which is unchangeable.

5.56 While individual management is generally not linked to accommodation, management plans still rely on adequate resources. Some detainee behaviours require more intensive supervision by staff and occasionally this demands a one-

[38] OICS, *Report of Announced Inspection of Banksia Hill Juvenile Detention Centre* (January 2012) iv.
[39] Figure based on data extracted daily from TOMS for the period 6 October 2012 to 20 January 2013.

to-one ratio. If this additional staffing has not been rostered a resulting lockdown of other detainees may occur. One staff member described the difficulties in balancing the rights and needs of one individual detainee against those of the group, particularly when the individual is being managed at the lower end of the hierarchical model. The staff member noted "we have the tactics to manage the detainee but not the resources." For Banksia Hill to effectively manage detainees in this model, sufficient staffing and physical space must be allocated.

5.57 Finally, the impact of unscheduled lockdowns can change the nature of the incentive and disincentive approach to managing behaviour. Whereas previously the loss of privileges was proportional punishment for poor behaviour, the loss of a TV and therefore a means to alleviate boredom during increased confinement to a cell could be seen as a double punishment and no longer proportional.

5.58 Similarly, it is hardly a disincentive to a detainee to be confined to their cell within a living unit as a punishment when this is occurring on a daily basis for reasons beyond the detainee's control. By its nature, a disincentive should serve as a deterrent. However, it can only serve this purpose when the consequence is a possibility not a reality.

5.59 One of the reasons Harding Unit, which is located at the base of the accommodation model, is undesirable is because of the confinement associated with being in this unit. However, when detainees are confined in whatever accommodation they are in, unintended consequences surface. For example, Harding is the only unit with air conditioning. During the Inquiry, one detainee advised that he would ascend the roof to gain a sense of freedom. He noted that it was cooler on the roof and in Harding because of the air-conditioning. Consequently, removal to Harding was not a consequence to avoid. The detainee noted that boys who get punished get better air-conditioning in addition to quicker access to 'the boss' which doesn't happen when you are being good.[40]

Security culture and awareness

5.60 In a maximum security facility such as Banksia Hill, it would be expected that a culture of security awareness would feature prominently in the ongoing management of the centre, staff and detainees. However, numerous examples were uncovered during the Inquiry which indicate a lack of security awareness by both staff and centre management over a prolonged period. These include poor staff compliance and intelligence gathering and the lack of attention to a known security risk of debris around the centre.

[40] Discussion with one of the detainees who instigated the riot by scaling the roof.

Poor Staff Compliance

5.61 There are a number of practices by YCS staff which reflect a lack of security awareness. Poor discipline by many staff including shift and unit managers was cited by departmental monitors. The monitors reported that staff failed to adhere to standing orders and instructions and that staff needed to recognise the difference between using initiative and not following rules.[41]

5.62 The requirement for YCS staff to wear uniforms is clearly outlined in standing orders and operational procedures.[42] However, there was poor adherence to these instructions despite Superintendents Notices in 2011 and 2012 to staff at both Rangeview and Banksia Hill which served as a reminder.[43] The notice to Banksia Hill staff was followed up nine months later with an Assistant Superintendents Notice.[44] However, despite prompting, in the days after this notice a number of monitoring reports identified non-standard issue dress and the absence of ID badges.[45]

5.63 The security assessment provided after the second escape from Banksia Hill also noted that not all staff were utilising key chains or lanyard despite a requirement to do so. The failure to comply with this procedure meant that the security assessment team found keys left on a desk in an empty room.

5.64 In 2009 a Juvenile Custodial Services Instruction was issued establishing the procedures for bringing personal items into a secure juvenile detention centre.[46] The instruction advised that personal belongings such as mobile phones, cigarettes, lighters, wallets, hand bags, pagers, prescribed medication and vehicle keys were not permitted within operational areas of Banksia Hill. The items were to be secured in the staff amenities area and non-compliance by staff was a breach of security protocols. Further to this, YCS staff could be disciplined under Part 8, Division 3 of the *Young Offenders Regulations 1995*.

5.65 Regardless, the security assessment provided in November 2012 identified that mobile phones were still being brought into the centre.[47] During the riot, detainees breached unit offices where staff had taken personal belongings including whole bags with wallets, mobile phones and vehicle keys. Detainees

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[41] Department of Corrective Services, *Banksia Hill Monitoring Return 3 & 4 October 2012,* 5.
[42] Standing Order 2 and Operational Procedures 30 and 31.
[43] Rangeview Superintendent's Notice 07/10 sent 21/04/2011 and Banksia Hill Superintendent's Notice 1/2012 issued 12/01/2012.
[44] Assistant Superintendent's Notice 13/2012.
[45] Department of Corrective Services, *Banksia Hill Monitoring Returns* 2012-09-10, 2012-09-17 and 2012-09-20.
[46] Juvenile Custodial Services Instruction number 02/2009.
[47] Department of Corrective Services, Security Services Directorate, *Security Assessment* BHJDC (November 2012) 20.

allegedly riffled through and stole the personal property of staff.[48] Since January 2012, no staff have been disciplined under Part 8, Division 3 of the *Young Offenders Regulations 1995*[49] and advice indicates that the Department paid an officer for belongings allegedly stolen during the riot.[50] During the Inquiry, YCS staff were asked why they brought these items into the unit offices and they said that they were told that the unit office is secure. Regardless of the direct breach in policy, this response also directly contrasts with the view also expressed by staff that they had repeatedly expressed concerns over the security of the unit offices.

5.66 The absence of disciplinary action taken by the Department in relation to ongoing breaches of security protocols by the staffing group indicates an inability on the part of the Department to manage non-compliance. Even at the local level the enforcement of procedures and ongoing identification of risks does not appear to be occurring.[51] This is greatly increasing the operational risks associated with the Banksia Hill facility.

Use of Justice Intelligence Service

5.67 Justice Intelligence Services (JIS) is a branch within the Department responsible for converting information into intelligence. Information reports come directly from staff or from the security team within a prison or detention centre. The information reports have an admiralty scale attached. This allows the author to grade the information according to its reliability and credibility. The reports are then triaged for action either by JIS or the local security team. The JIS team also creates intelligence briefs from the reports identifying emerging risks.

5.68 In 2012, JIS received 8,213 information reports from prisons and detention centres across the state. From these reports, three to four intelligence briefs were produced monthly and distributed to the relevant stakeholders. It is a system that is improving with the Department's Annual Report 2011-2012 noting a 15 per cent increase of submissions from the previous financial year.[52]

5.69 Banksia Hill is a complex site with many cohorts forming the custodial population. However, staff do not submit information reports reflective of this complexity. Between January and March 2013 only thirteen reports were submitted by YCS staff from Banksia Hill and Hakea Juvenile Security. This is in stark contrast to the recently opened Wandoo Reintegration Facility ('Wandoo'). Wandoo is a minimum security facility with a small population of approximately

[48] Information provided in TOMS incident id I1241400 and the Incident Command Facility log (entry 21/01/2013 1315hrs) notes that during the riot car keys and pain relief tablets were stolen from staff property.
[49] Advice received from the Department on 13/05/2013.
[50] Advice received from the Department on 15/05/2013.
[51] Department of Corrective Services, Security Services Directorate, *Security Assessment* BHJDC (November 2012) 20.
[52] Department of Corrective Services, *Annual Report 2011/2012* (September 2012) 33.

30 prisoners. Since the beginning of 2013, Wandoo staff have submitted 27 information reports. This is twice the number of reports submitted by YCS despite having a population that is only one sixth the size.

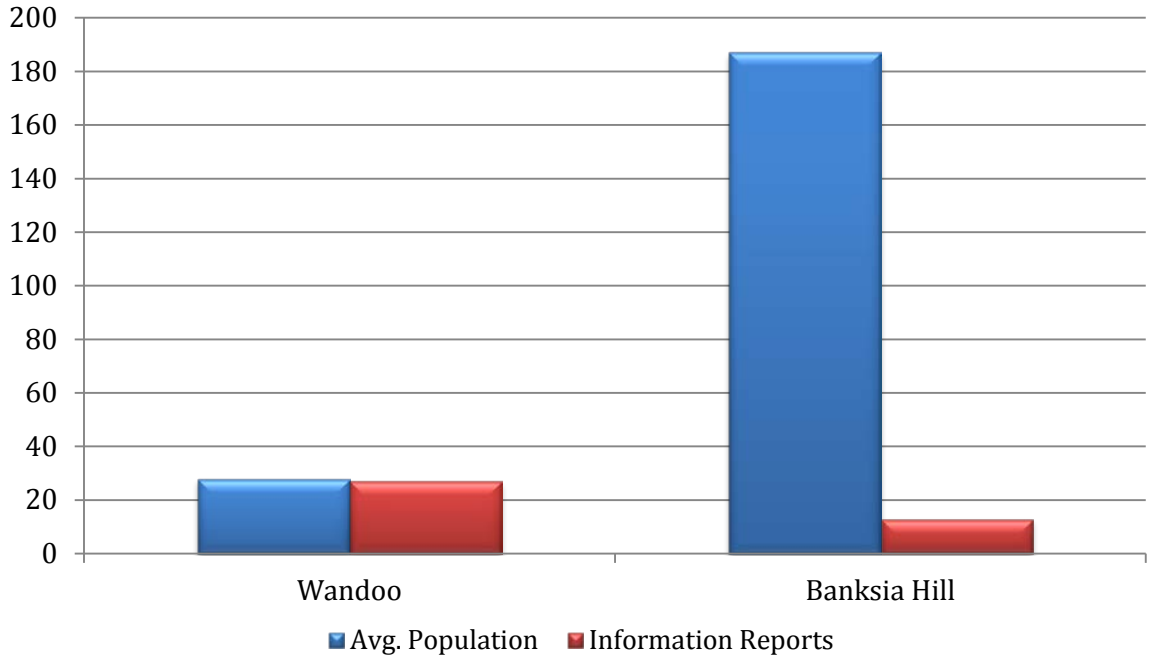

Figure 2
Custodial facility population by submitted JIS information reports beginning 2013

5.70 The low generation of intelligence reports is also demonstrated in the disproportionate number of incidents that occur in Banksia Hill in contrast to the number of intelligence reports. This may be a result of YCS staff historically submitting information through incident reports, however this information then becomes difficult to search and use for intelligence analysis either by JIS or the local security team. The table below illustrates the number of submissions to JIS per facility compared to incident reporting.

Table 2
Submission of reports by custodial facility for 2012

Facility	JIS Information reports	TOMS Incident reports
Acacia	1,010	2,788
Albany	833	889
Bandyup	1,025	1,959
Banksia Hill	70	1,419
Boronia	86	405
Broome	96	335
Bunbury	351	1,234
Casuarina	1,486	2,907

Facility	JIS Information reports	TOMS Incident reports
Eastern Goldfields	190	724
Greenough	365	1,790
Hakea	1,630	4,603
Karnet	300	662
Pardelup	97	409
Rangeview*	59	771
Roebourne	96	444
Wandoo**	0	12
West Kimberley**	17	30
Wooroloo	334	1,212
Total	**8,045**	**22,593**

* Facility decommissioned with last submissions recorded October 2012

** New facility began recording November 2012

5.71 Submitting an incident report does not preclude the submission of an information report and vice versa. However, the lack of intelligence reporting continues to occur in YCS despite JIS and the security directorate division conducting training at Banksia Hill after the second escape in August 2012.[53] There was a peak reporting period after this training with submissions in September and October 2012 recorded as 15 and 20 respectively, however this is still exceptionally low.

5.72 Regardless, this small improvement quickly tapered off with only six reports submitted in November 2012 and four in December 2012.

5.73 These low numbers of intelligence reports are not surprising given results from the Inquiry's employee survey indicate only 5 per cent of respondents felt prepared for the amalgamation with regards to intelligence gathering and information sharing. Approximately 34 per cent felt unprepared with the majority of respondents rating their level of preparedness to the amalgamation as "very unprepared" (41%).

5.74 This lack of confidence in producing intelligence was demonstrated with the riot. In the lead up to the riot there was limited information forwarded to JIS giving any indication that the riot was likely to occur.[54] However, with hindsight, staff reported unusual behaviours around the centre prior to 20 January 2013. Education staff reported odd and avoidant behaviour by one of their best

[53] Department of Corrective Services Security Services Directorate, *Security Assessment* BHJDC (November 2012) 18.

[54] Only three reports were submitted to JIS from Banksia Hill for the period 1 January 2013 until 20 January 2013. Two reports of these reports were unrelated to findings of this Inquiry. The other reflected concerns with debris.

students[55] and other staff noted detainees interacting with those they ordinarily did not mix with.[56]

5.75 Information such as unusual detainee behaviour should be submitted in a JIS information report regardless of how trivial the author believes the information to be. The admiralty scale allows staff to identify where they are not confident in information without detracting from reporting information they believe to be credible. However, some staff stated they were reluctant to use the JIS reporting system. They reasoned that young people are overly reactionary and it would be unreasonable to record everything they do. A cultural change to improve confidence in intelligence reporting including reporting when unsure of the veracity of the information will take time and resources to develop.

Debris

5.76 Even after the riot, roof ascents have continued to occur at Banksia Hill. As with many previous roof ascents, the detainees readied themselves with debris they collected around the facility. The debris included rocks, bricks and pieces of wood. These types of items are often used as projectiles to prevent staff from closely engaging with the young people. On occasion staff have been injured by these makeshift weapons.

5.77 Procedurally, when detainees become 'weaponised', staff are directed to maintain a safe distance. Staff indicated that the detainees know officers cannot take an offensive approach to roof ascents when they pick up 'weapons'.

5.78 Since 2010 there have been three major critical incidents at Banksia Hill; two escapes and the riot which is the subject of this Inquiry. Debris featured prominently on all occasions. The Department conducted security assessments after each escape and an escape review after the second escape. Each of these appraisals identified the need to remove the debris from the facility. [57]

5.79 In the time immediately after the two escape incidents security measures were tightened. Building rubble and debris were being removed daily or secured in lockable bins. This was good practice however it was not maintained. [58] The clean-up of the worksites, both during construction and after completion, was not as thorough as a maximum security facility required. Consequently, detainees

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[55] Banksia Hill site visit 27 February 2013.

[56] Department of Corrective Services, *Banksia Hill – Cold debrief of incident 20 January 2013 – Minutes*, 3.

[57] On 30 August 2010, the day after the first escape from Banksia Hill, the then Manager Statewide Security forwarded an assessment summary to the Director Juvenile Custodial Services. Two recommendations from this assessment focussed on unsecured debris and rubble. In November 2012, after the second escape, another assessment noted that procedure and practices at Banksia Hill were inadequate from a 'physical security perspective' evidenced by the debris found around the centre.

[58] The Escape Review conducted after the second escape found that 'building rubble and debris [were] utilised as weaponry by detainees in another escape event' and that 'the risk posed by building rubble was foreseeable'.

continued to access rocks, bricks and other discarded building materials which were sometimes buried, half-buried or even in plain view.

5.80 On 16 January 2013, just days prior to the riot, staff raised concerns about the amount of debris still littering the facility. There were several potentially dangerous objects such as rocks, metal pieces and two sharpened sticks reportedly lying around the ground near the Horticulture area.[59] The shift manager was contacted and a JIS security report was submitted. The officer who located the sharpened sticks was advised to submit an incident report. This was not carried out. Staff supervising within the Horticulture area were advised that all objects recovered during activities should be secured in a bin minimising the opportunity for detainees using the items as potential weapons.[60]

Photo 1
Damaged cell with visible debris/rocks (centre)

5.81 Regardless of these small attempts to tackle the debris problem, once again the use of debris was a feature of the riot. Rocks and other debris were not only used to deter staff from intervening, but specifically used to break other detainees out

[59] Department of Corrective Services Justice Intelligence Service, *Security Report JSTA2013010080* (16 January 2013) 1.
[60] Ibid.

of their cells. Immediately after the riot rubble and debris could be clearly seen around the facility.

5.82 The facility has been undergoing construction works for the past four years. For some staff recently employed at Banksia Hill, the facility has always been a construction site. Given this situation, it is concerning that long term risk management strategies were not in place to address problems with debris rather than the peaked interest which waned over time.

Security team resourcing

5.83 There was an obvious under-resourcing of security at Banksia Hill. Prior to the amalgamation there was a Security Manager's position at both Banksia Hill and Rangeview. Additionally, the building site at Banksia Hill was also resourced with a Project Security Officer. However, since the amalgamation these resources have been reduced to a single security manager overseeing the entire facility. Consequently, the security assessment in late 2012 noted, 'the security function at Banksia Hill lacks any proactive capacity and its reactive response is limited and underwhelming'.[61] The reduction in resources indicates the Department's lack of priority for security at Banksia Hill.

5.84 The assessment went on to recommend an ideal security staffing model for the new site given its size and intricacies. This model included;

- 1 x security manager;
- 2 x security officers; and
- 1 x collator[62]

5.85 No further follow up has occurred and at the time of the riot the security 'team' at Banksia Hill consisted of one person, the Security Manager. The role of Security Manager appears to be different to a security manager position in an adult facility. In particular the Security Manager is not on-call and therefore on the night of the riot was not notified by Banksia Hill staff of what was occurring. It is difficult to understand how a role dedicated to security was not integral to the response to such a large breach in security.

[61] Department of Corrective, Services Security Services Directorate, *Security Assessment* BHJDC (November 2012) 20.

[62] The recommendation was provided to the Department in November 2012 by the Security Services Directorate.

6 Preparedness

6.1 Preparedness refers to the activities that are undertaken to prepare an agency to respond to an emergency.[63] With regards to the riot on 20 January 2013, the question of preparedness refers to whether Banksia Hill was prepared to manage a roof ascent, as well as their preparedness to manage the riot that occurred.

6.2 The Entry Level Training Program for YCOs notes the importance of being prepared for an emergency.[64]

> Emergency preparedness is a crucially important topic for every State department of corrections and for every correctional institution. Large-scale detainee violence or a natural disaster can threaten the lives of both the Centre staff and detainees. In hours, a major emergency can cost a State tens of millions of dollars and result in many years of litigation. The negative publicity surrounding a major institutional crisis can also be overwhelming and almost interminable.

6.3 Preparedness for these incidents involves undertaking appropriate planning and training of staff and, in the case of Banksia Hill, an appropriate orientation to that facility for all staff amalgamating from Rangeview. As illustrated below, Banksia Hill fell well short in each of these areas of preparedness leaving it poorly prepared to deal with the riot that occurred on 20 January 2013.

Planning

6.4 As with all custodial facilities in Western Australia, Banksia Hill has an Emergency Management Plan. The current plan was created in May 2011 and outlines specific procedures staff should follow during an emergency situation. It is in line with the Department's Emergency Management Framework and is based on the Australasian Inter-Service Incident Management System.

6.5 The plan is intended as a live document that should be under constant review by the Security Manager and amended when necessary.[65] According to Youth Custodial Service Instructions the Superintendent (assumed to mean Director of Youth Custodial) is to ensure that this plan is in place. The instructions require the Plan to be reviewed annually.[66]

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[63] Department of Corrective Services, Banksia Hill Detention Centre *Emergency Management Plan,* Version 1.0 (2011) 5.
[64] Department of Corrective Services, Corrective Service Training Academy, Entry Level Training Program Manual – *Emergency Procedures YCS,* Module Version (3 December 2008) 1.
[65] Department of Corrective Services, Banksia Hill Detention Centre *Emergency Management Plan,* Version 1.0 (2011) 5.
[66] YCS Instruction 03/2011.

6.6 The Emergency Management Plan for Banksia Hill was last revised in May 2011. It is a clear oversight that the Emergency Management Plan has not been updated since the amalgamation. This is not only a failure of the local management and security team who are responsible for reviewing the plan and ensuring that an updated plan is in place, but also those responsible for preparing the centre for amalgamation. The Project Control Group Minutes for the amalgamation on 14 May 2012 note that emergency contingency management rules have been successfully reviewed.[67] Although it might be assumed that this review would encompass updating the Emergency Management Plan for the centre, this did not occur.

6.7 The failure to update the plan is compounded by the absence of Head Office oversight in ensuring that this plan was completed or appropriately updated. A Quality Assurance Plan for Community Youth Justice was developed in January 2011 which outlined an action of developing a tracking system for all prisons and detention centres to ensure that reviews of emergency management plans are conducted annually and that these plans are consistent.[68] When the Inquiry asked for copies of this tracking system, the Department advised that the 'system' was the front page of each site's emergency management plan which shows when the plan was updated. In the case of Banksia Hill, this front page of the plan clearly shows it was developed in May 2011 and has not been updated since.[69] The 'system' obviously does not have any alerts from Head Office to ensure that the plan is regularly updated.

6.8 Additionally, a security assessment of Banksia Hill completed in November 2012 stated that among other assessments an examination would be undertaken of emergency management procedures to assess their level of adequacy.[70] However this examination did not occur.[71]

6.9 Although local development and ownership of an Emergency Management Plan is essential to ensuring its usability, effective oversight makes sure that each prison and detention centre is producing plans of sufficient quality to provide useful guidance to staff during emergency incidents. Head Office oversight is also essential to ensure that the same resources are not relied upon by different prisons and detention centres during a large event. For example if a particular issue sparked simultaneous incidents in more than one prison or detention

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[67] Department of Corrective Services, *Project Control Group CET84 - Youth Custodial Transition Project Minutes* (14 May 2012) 3.
[68] Department of Corrective Services, *Emergency Management Quality Assurance Process – Directed Review Quality Assurance Plan* (January 2011).
[69] Department of Corrective Services, Banksia Hill Detention Centre *Emergency Management Plan,* Version 1.0 (2011).
[70] Department of Corrective Services Security Services Directorate, *Security Assessment* BHJDC (November 2012).
[71] Ibid., 20.

centre over-reliance on ESG would leave some facilities unable to take action to contain the incident.

6.10 Further, an Emergency Management Plan is only useful if the right people are aware of its contents prior to an incident occurring. This can be achieved by having key personnel including the Director of Youth Custodial, Security Manager and anyone potentially acting as a designated Superintendent actively participating in the development and review of the plan. It can also be achieved through wide distribution of the plan and through training. The Shift Manager at Banksia Hill who was responsible for initial control of the riot on 20 January 2013 stated he was not aware of the Emergency Management Plan.

Evacuations

6.11 The Department had given no prior consideration of what to do in the event that Banksia Hill was rendered unusable. The current Emergency Management Plan states that in the event that an evacuation of the facility is needed, detainees will be taken to Rangeview Remand Centre. This is despite the decommissioning of Rangeview in October 2012.

6.12 The former Rangeview Remand Centre has now been transformed into the Wandoo Reintegration Facility which accommodates 18-24 year old minimum security men. At the time of the riot, the facility was no longer appropriate as a short term placement option for the detainees as several modifications were needed for cell doors, a number of units were not considered to be secure enough, and there were limited services available due to the ongoing refurbishment that was occurring. [72]

6.13 Regardless, in the event that the Banksia Hill needed to be completely evacuated, for example in a fire, Rangeview would not have had the capacity to accommodate all the detainees, as it was significantly smaller than Banksia Hill. In particular, it would not have been sufficient to accommodate the girls along with the boys. It is arguable, given Banksia Hill was always the larger facility for detainees, that Rangeview was never a realistic option for a complete evacuation of Banksia Hill.

6.14 Not having a contingency plan in place when an entire facility needs to be evacuated is not unique to Banksia Hill. The Emergency Plan for Bandyup Women's Prison outlines an evacuation strategy for prisoners to be located to the Corrective Services Academy. Although this Inquiry has not investigated the appropriateness of this strategy in depth, there are approximately 270 women some of which are rated maximum security at Bandyup. It is unlikely that the Academy is equipped to house the population at Bandyup for any length of time.

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[72] Department of Corrective Services, *Briefing Note re: Critical Incident at Banksia Hill Detention Centre on 20 January 2013 Correspondence Number: 46-01861/2,* (22 January 2013) 2.

6.15 Notably however, the Emergency Management Plan for Bandyup shows good practice with several revisions having been conducted and documented since its development.[73] The decision on where to house prisoners if a complete evacuation of this unique facility is required should be a concern for the State and as such should be considered at an Executive Level and referenced in the plan. It would not be a local decision. This is also true for Banksia Hill.

6.16 In contrast, Hakea outlines an evacuation plan that identifies dispersal of prisoners to other identified facilities based on security ratings.[74] Given there are several options where male adults prisoners can be accommodated it is reasonable for this level of planning to be imbedded into the local Emergency Management Plan. The Hakea Emergency Management Plan also shows good practice with documentation of several revisions since its development.

6.17 At the time of writing this report there remains no current Emergency Management Plan for Banksia Hill or the Hakea Juvenile Facility. Of particular concern there appears to be no consideration as to what to do with the girls if the girls unit in Banksia Hill is rendered unusable.

Policy and procedural updates

6.18 Updating the Emergency Management plan was not the only omission when preparations were made for the amalgamation of Rangeview with Banksia Hill.

6.19 There were two distinct workforces operating from Banksia Hill and Rangeview. The two sites had manifestly different practices and routines. Senior officers noted in a staff focus group that there was 'no shared understanding of policies and procedures'. In addition, Banksia Hill staff were now required to work with two new cohorts of detainee; newly arrested young people and females.

6.20 Respondents to the employee survey indicated unequivocal condemnation of the merger with no respondents considering that the preparation for the amalgamation was adequate and only three per cent reporting they felt prepared for the blending of cultures.

6.21 Youth Custodial Services Rules ('YCS rules') cover the management of detainees at Banksia Hill. The YCS rules were updated and approved on 27 August 2012, superseding the previous Juvenile Custodial Services rules ('JCS rules'). However, the new rules were not published on the Department's intranet site until 5 March 2013, after the riot. The Inquiry was advised that the updated versions required formatting prior to online publishing. This was not finalised until 22 February

[73] Department of Corrective Services, *Bandyup Prison Emergency Management Plan,* Version 2.1.1 (16 January 2012).
[74] Department of Corrective Services, *Hakea Prison Emergency Management Plan,* Version 1.3 (June 2011) 228.

2013. Therefore Banksia Hill staff were formally advised of the revisions a month after the riot.

6.22 Further, standing orders which are supported by these rules have not been updated since 2009. The standing orders still refer to the previous JCS rules and therefore no longer align with the new YCS rules. For example, Standing Order 20 – Critical Incident Including Fire, Medical, Major Disturbance and Hostage Situation Response - is to be implemented in accordance with Rules 108, 207, 208, 214 and 216. As the new rules no longer align to the previous rules, it is difficult to know which rules, JCS or YCS are supposed to support Standing Order 20.

Table 3

Differences between Youth Custodial Rules and Juvenile Custodial Rules for Standing Order 20

Number	Juvenile Custodial Rules	Youth Custodial Rules
108	Attendance of Prison Officers, Police Officers and Contractors at Juvenile Detention Centres	Attendance of Prison Officers, Police Officers and Contractors at Youth Detention Centres
207	Use of Force	Searches
208	Use of Restraints	Major Detention Centre disturbances
214	Critical incidents including fire, medical, major disturbances and hostage situations	*Does not exist*
216	Fire emergency procedures	*Does not exist*

6.23 In addition, the change in title from Superintendent Banksia Hill to Director of Youth Custodial Services which occurred in November 2012 is not reflected in the new YCS rules. Accordingly, many actions within the rules require authorisation from a role that no longer exists.

6.24 Good governance relies on having clear policies and procedures that are understood and implemented consistently by staff. It is impossible for staff to consistently apply these rules and orders when the basic documentation is in disarray. Like the Emergency Management Plan, it is a clear oversight that these rules and standing orders were not updated, linked correctly and distributed to all staff prior to the amalgamation.

Training

6.25 Less than a quarter (24%) of respondents to the staff survey felt that they had adequate training to prepare them for the riot. This sentiment was also reinforced in meetings with staff where they consistently reported to have had

little or no training in emergency management and little to no training that prepared them for the riot.

6.26 There is evidence of a poor training culture at Banksia Hill with many staff displaying a lack of understanding of the importance of training to enable them to prepare for emergencies. Some staff noted they had no specific training to quell a riot without recognising the importance of training for aspects of riotous behaviour such as responding to detainees being out of bounds. Another staff member questioned whether it was possible to have 'adequate training for this type of incident'.

6.27 While it is acknowledged that a running a scenario where detainees continually breached their cells would have been unreasonable, this does not negate the importance of being adequately trained in dealing with riotous behaviour.

Types of training at Banksia Hill

6.28 Training is undertaken at Banksia Hill, predominately through two satellite trainers but also through access to courses conducted at the Department's Training Academy (the Academy). Mandatory annual training is provided for Cardiopulmonary Resuscitation (CPR), Senior First Aid and Gatekeeper (suicide prevention) courses. Priority is also appropriately given to training in the Use of Force and Working with Female Offenders.

6.29 In 2012 the 221 operational staff at Banksia Hill during the year also completed training in another 775 courses. A sixth of these courses (123 courses) were related to emergency management.

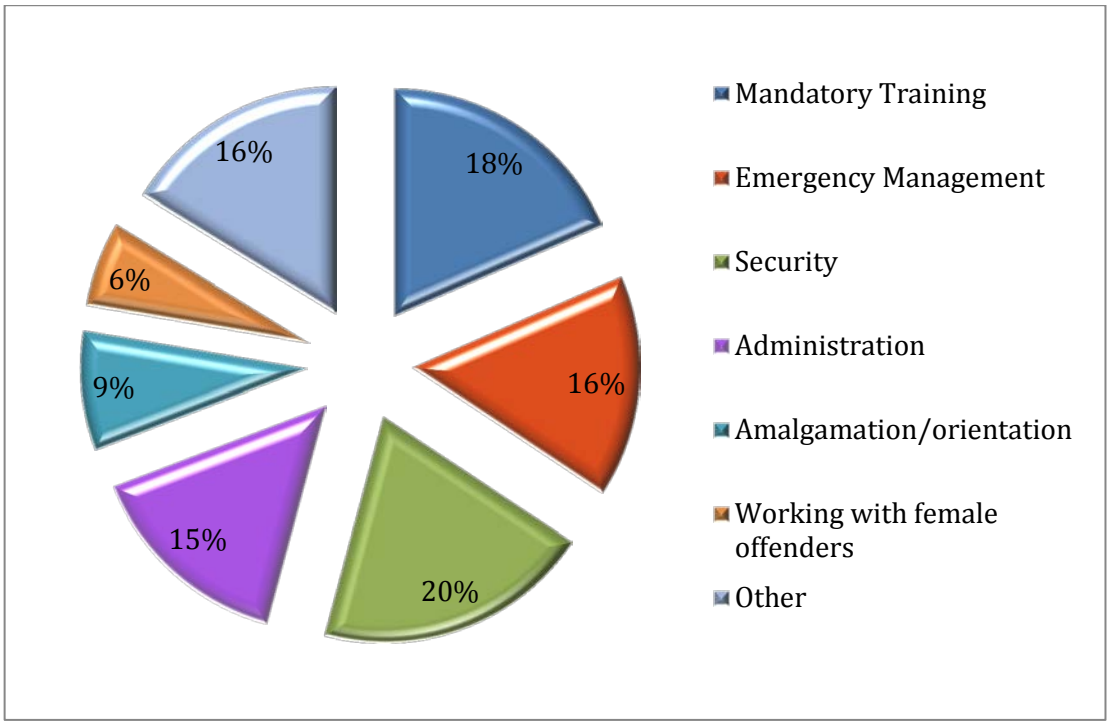

Figure 3
Types of courses undertaken at Banksia Hill in 2012

6.30 Emergency management training included courses for:

- Codes 1 and 2;
- Command Post training;
- Control Room training;
- Emergency procedures;
- Fire extinguisher training; and
- Primary Response Team training.

6.31 Speciality training for PRT, the Control Room and fire extinguisher training made up nearly three quarters of this training (72%) and the courses were often undertaken by the same staff.[75]

6.32 The Security Services Directorate and the ESG have conducted presentations at Banksia Hill about command structures during emergencies. These presentations were for the management team and senior officers and were attended by nine people.

Time and facilities for training

6.33 Training is subject to the challenges brought about by frequent staff shortages which severely limit training opportunities. To address the issue of staff shortages impacting training, a dedicated time of between 1.5 and 3 hours each Wednesday afternoon, was allocated for training. Detainees were locked down during this period so that staff could attend training. However even though the lockdown was occurring to allow staff to attend, training was not prioritised. This period was often taken up with competing priorities such as staff and union meetings. Staff estimated that as a result, training only occurred once a month.

6.34 There were also a small group of staff who only worked night shifts. Staff noted that as staff were only required to attend Banksia Hill training if they were rostered on during the Wednesday training period, nightshift workers received little or no ongoing training.

6.35 There are no dedicated training facilities at Banksia Hill in spite of the recent expansion project. Consequently, training and drills occurred in plain sight of the detainees. This allowed detainees to see the tactical response options available to youth custodial staff. Where a classroom setting was required training was run in any room that could be found, with any equipment that may be available in the

[75] 50 staff participated in these 88 courses.

room or any portable equipment. This did not create an ideal training environment for the trainers to teach, or for staff to learn.

Meeting different training needs

6.36 The continued discord between a security approach versus a welfare approach to managing detainees partially stems from differences in initial training. Staff who have been in the job for longer have been trained in youth work while newer staff have been trained in a Certificate IV in Correctional Practice. Both approaches have merit, however, both leave gaps in training.

6.37 New youth custodial recruits undertake a comprehensive entry level training program prior to being rostered on shift. The course is 13 weeks and includes theory and practical exercises. There is a strong emphasis on security within this training. Staff, particularly those in senior roles who have not received this new training can have training deficits in security and emergency management. It is difficult to bridge this gap if they have not had base training in a particular skill even if they have gained experience in their role. Providing refresher training if someone has not undertaken an initial course can be counterproductive particularly if this only serves to imbed poor practice.

6.38 Although some analysis on training gaps is performed at the Academy, this is largely based on whether a person has undertaken mandatory training and does not seek to identify gaps in training that are historical. Careful analysis of the training gaps at Banksia needs to be undertaken in order to develop an effective training schedule. This may require staff to self-identify areas where they feel they need additional training, consideration from management with regards to individual personal development and developing a minimum skill set for the centre.

Emergency Incident Simulation Based Training

6.39 As per the Department's Emergency Management Framework, Banksia Hill is required to undertake a minimum of six emergency management training exercises each year. At least one of these should be a live simulation rather than a desktop exercise. [76]

6.40 The Banksia Hill emergency management plan covers 12 incident types, including perimeter breaches, fire, major disturbances and evacuations. It is intended that each incident type be the subject of an exercise within a three year period.

[76] Department of Corrective Services, *Banksia Hill Detention Centre Emergency Management Plan*, Version 1.0 (2011) 5.

6.41 It is the responsibility of the Superintendent (assumed to mean the Director of Youth Custodial) to ensure emergency management training is conducted.[77] A training schedule received from the Department indicated that three desktop exercises and six live simulations were timetabled for Banksia Hill in 2012.[78] However, the training records provided revealed that during 2012 only one desktop exercise and two live drills were conducted. The exercises focused on perimeter breaches and fire emergencies with all exercises occurring in May, prior to the amalgamation. This number of exercises conducted falls short of requirements.

6.42 The opportunity to participate in simulation based training is restricted to those who are available on shift. Only seven custodial staff attended the three exercises in 2012.[79] Given Banksia Hill has an operational staff level of close to 200, this means that very few people have been involved in this type of training in the last year. One staff member reported he had not been involved in a simulation exercise since the late 1990s.

6.43 It is also necessary to involve other agencies in training, so that both agencies can gain an understanding of how they will interact during a major event. It is unknown when the last multi-agency training exercise was conducted at Banksia Hill.

6.44 It was evident to the Inquiry that the satellite trainers take on an enormous amount of additional duties and have limited support. For example, while there is a role for a trainer in establishing multi-agency training, the satellite trainers at Banksia Hill have become responsible for doing an annual walk around of the facility with Fire and Emergency Services to ensure that fire services will not be impeded if there is an emergency incident. Clearly, this is a management or security issue as no staff member is being trained when performing this duty. Likewise, satellite trainers are responsible for basic administration functions such as finding rooms to conduct training, identifying training deficiencies in staff and promoting courses. At the very least, administration support needs to be provided to rebalance the amount of time trainers spend training, rather than performing administration tasks.

Rostering minimum skill sets

6.45 The rostering process at Banksia Hill does not identify minimum skills sets required for managing an emergency incident and therefore, there is no assurance that a minimum number of trained staff or staff experienced in

[77] Department of Corrective Services, *Banksia Hill Detention Centre Emergency Management Plan*, Version 1.0 (2011) 5.
[78] Department of Corrective Services, *Banksia Hill Detention Centre Training Calendar* (2012).
[79] Ibid.

managing emergencies are present on any given shift. This is exacerbated when staff are acting in positions.

6.46 Staff spoken to as part of the Inquiry, consistently used the word 'luck' when referring to the skills and experience of the people who were in key positions on the night of the riot. If these individuals were not rostered on that evening the response to the riot could have been very different. This is particularly true if people were in acting positions or people were new to the facility.

Orientation to Banksia Hill during the amalgamation

6.47 Good emergency management relies on the responders having a good understanding of their environment, or the ability to quickly achieve this understanding. For staff at Banksia Hill this understanding comes from having an effective orientation.

6.48 At some point during the amalgamation there was an intention for staff from each facility to work at the alternative facility in order to gain familiarisation with Banksia Hill and the differences in policies and procedures between the two centres. The satellite trainers were tasked to coordinate these exchanges on top of their other training duties, however, in August 2012 this approach was abandoned in favour of an 'orientation passport' approach. As a result very few people took part in this shift swapping exercise.

6.49 The 'orientation passport' required staff to tour the facility, with suitably trained staff providing short information sessions and a walk through of each respective area. The 'passport' is then signed by the staff member conducting the tour of each area to verify the person had completed their orientation.

Table 4

Example of an orientation passport

Banksia Hill Induction Passport		
Name *Joe Bloggs*	**Employee Number** *123456*	**Role** *Youth Custodial Officer*
Administration Name; Signed;	**Case Planning** Name; Signed;	**Yeeda Unit (Female Precinct)** Name; Signed;
Psychology Name; Signed;	**Education** Name; Signed;	**Health Services** Name; Signed;
Reception & Harding Units Name; Signed;	**Urquhart Unit** Name; Signed;	**Normal Living Units** Name; Signed;
Passports can only be signed by suitably trained staff – list provided on the back of this document.		

6.50 At the time the 'orientation passport' concept was introduced it was acknowledged that an orientation was needed to ensure all staff at Banksia Hill were equipped to:[80]

- safely carry out their duties as required;
- safely negotiate through the new buildings and infrastructure;
- respond appropriately to emergencies and incidents; and
- provide a quality structured day program to the young people in the centres care.

6.51 Orientation was to provide an understanding of the layout of every building and the primary function of each business area. It was noted that staff must be aware of any safety and health issues that relate to the entire site, including;

- evacuation exits;
- emergency muster points;
- fire extinguisher locations; and
- camera locations.

6.52 It is arguable that a tour of the facility provides an effective orientation. Certainly, staff who amalgamated from Rangeview consistently reported poor orientation to Banksia Hill with many reporting receiving no orientation at all. The staff survey showed that only 3 per cent of staff surveyed believed they were

[80] Department of Corrective Services, CET84-SP-15 *Banksia Hill Detention Centre Staff Orientation Plan - Operations* Version 0.1 Initial Draft (21 August 2012) 4.

prepared to work across the centres with 83 per cent feeling unprepared or very unprepared.

6.53 Of particular concern, Shift Managers stated their orientation to Banksia Hill was completed in 45 minutes.[81] Shift Managers are the designated Superintendent when the Director of Youth Custodial and Assistant Superintendent are not on site. On the night of the riot it was the Shift Manager who was in control of the incident prior to the arrival of the Director of Youth Custodial.

6.54 In addition to being able to physically navigate around the facility, the orientation should have served as a means for merging the two cultures from the two facilities. This may have been possible with the shift swapping exercise however it was not likely to occur with the 'passport' approach.

6.55 Concerns over the clash of cultures coming together were reported in a ministerial briefing in April 2012.[82] The paper noted that perceptions of staff safety and attitudes towards detainees differed between the two sites with morale and team spirit being much higher at Rangeview.[83] It was also reported that staff at Rangeview were looking forward to the amalgamation whilst Banksia Hill staff were fearful of the move and change.[84] The briefing suggested that the planned staff interchange between the two centres be accelerated to allow staff to develop an understanding of the practices of each facility. It is unclear how soon after this briefing was made that the shift swapping approach was abandoned in favour of the 'passport' approach.

[81] Shift Manager Focus Group.
[82] Department of Corrective Services, *Banksia Hill Redevelopment Communications Strategy,* Correspondence Number 39-17289 (27 April 2012) 3.
[83] Ibid.
[84] Ibid.

7 Response

7.1 The Inquiry has shown that the initial response by staff members to the three detainees being 'out of bounds' was both timely and appropriate. Clear direction was provided by the Shift Manager to instigate a lock down of other detainees and activate the PRT. The Director of Youth Custodial Services and other centre management staff were notified and assistance was requested from the ESG. At this point all staff had a good understanding of their roles and responsibilities in addressing the incident.

7.2 Approximately 15 minutes after the three detainees had absconded from their unit, the incident took on an unanticipated complexity. The detainees assisted another detainee to break out of his cell through the external glass window using debris and rocks that were available outside his cell. Five minutes later they assisted another detainee to break out of his cell using similar methods. The situation snowballed with more and more detainees breaking out of their cells.

7.3 Over the next three hours, approximately 61 detainees had been released with the assistance of other detainees, or in some cases had released themselves by kicking out glass windows or observations windows from the inside. In addition, several cells were severely damaged by detainees who did not manage to exit the cell.

7.4 After the first assisted break out, the Shift Manager assessed this increased risk and determined external assistance was required. He had already called for assistance from the ESG, but also requested assistance from the police to provide external perimeter security, in the event of an escape attempt.

7.5 For staff safety reasons, and to ensure facility keys carried by staff were not compromised, the Shift Manager decided to withdraw staff from the units to the staff amenities building. This was carried out efficiently, with some staff evacuating themselves and others being assisted by the PRT. Once all staff had gathered in the staff amenities building and were accounted for, the PRT formed a cordon around the building.

7.6 The detainees were apprehended by teams of ESG officers and police personnel. Banksia Hill staff, including the PRT assisted in securing apprehended detainees onto a basketball court. In the early hours of the following morning 73 detainees were moved to Hakea. The administration of the detainees transfer to Hakea was managed at Banksia Hill by Banksia Hill staff.

7.7 Only one staff member was injured during the riot, in an altercation with a detainee who had been apprehended and was awaiting transport to Hakea. The low number of injuries to staff can be attributed to the heavy emphasis on

ensuring staff safety, as well as a lack of intent on the part of the detainees to harm staff members.

7.8 Although many detainees suffered minor cuts and bruises throughout the night only one detainee was seriously injured, requiring medical attention in hospital. He was released from hospital and transferred to Hakea several hours later.

Damage sustained

7.9 During the riot 106 cells were damaged to the point where they were unusable.[85] This is over half of the cells in the detention centre. In addition the day rooms and unit offices of Lenard, Turner, Jasper and Yeeda units were damaged with the former two becoming non-operational.[86]

Table 5

Number of cells in each Banksia Hill unit damaged during the riot

Unit	No of cells in Unit	No of cells damaged	Percentage of cells damaged
Harding	24	7	29.2
Jasper	24	18	75.0
Karakin	24	10	41.7
Lenard	24	16	66.7
Turner	24	22	91.7
Murchison	24	5	20.8
Urquhart	32	19	59.8
Yeeda	24	9	37.5
TOTAL	200	106	53.0

7.10 There was substantial damage to windows, viewing panels, doors and cell furniture including fans and TVs. The Department has estimated it will cost approximately $401,000 to repair the damage.[87]

Detainee intentions

7.11 Of the 206 detainees at Banksia Hill on the night concerned, it is not known exactly how many were involved in the riot although it is likely that somewhere between one-half and two-thirds of the detainees participated in the riot to some degree.[88] Approximately 61 male detainees escaped from their cells and a significant number, including some of the female detainees, damaged their cells internally without being able to get out.

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[85] Information provided by the Department on 28 March 2013 – List of damaged cells.
[86] Information provided by the Department on 28 March 2013 – Damage matrix – BH Disturbance.
[87] Information provided by the Department on 28 March 2013 – Banksia Hill Incident, 20 January 2013, Remediation Infrastructure Costs Estimates.
[88] The Department was not able to advise the total number of detainees who participated in the riot. However, the Inquiry was informed that police had interviewed 116 'persons of interest' and subsequently 35 detainees were charged with criminal or unlawful damage offences.

7.12 The three detainees who initially absconded from their unit may have had a prior agreement to engage in a roof ascent. However, there is no evidence that any of the detainees planned to instigate an event on the scale that occurred. From detainee reactions to the riot, it appears that the outcome of the evening was unplanned. As evidenced in the CCTV footage, detainees showed little coordination of their actions, with no clear leadership. Detainees split from groups and merged with others in a fluid manner throughout the evening. One youth noted detainees 'just kept on rolling' during the riot. Another noted 'after a while we realised boys were getting out on their own, we couldn't stop it'.

7.13 Early in the evening, when only the initial three detainees had absconded from the unit, a rock was thrown at a staff member which could have caused injury. In addition, a detainee who was being held on the basketball court injured an ESG staff member while being moved. These were the only two recorded incidents of altercations between staff and detainees. Other than these incidents there was no evidence of any intention by detainees to target staff. Nor was there any intention to injure other detainees.

7.14 Further, while a rock was thrown against a window in the gatehouse there was no concerted effort to break out of the centre. Staff reported that one individual from a group threw the rock against the gatehouse, but the rest the of the group were not supportive of this action and they quickly dispersed from the area.

7.15 Detainees did not damage the education, medical, gym and psychological services buildings.

Command and control of the incident

7.16 Both staff at a senior level on site and senior personnel at the Head Office incident control facility have been frank in informing the Inquiry that communication at a command and control level during the riot was not always good and that role confusion did occur.

7.17 Although this did not appear to result in any negative outcomes on the night, there is substantial room for improvement in clearly defining roles, responsibilities and lines of communication during a critical incident.

Australasian Inter-Service Incident Management System

7.18 The Department uses the Australasian Inter-Service Incident Management System (AIIMS) for managing critical incidents within prisons and detention centres. AIIMS has been designed to be applied in an all hazards–all agencies environment.

7.19 The system is based on three key principles; management by objectives, utilising functional management structures and maintaining a manageable span of

control. Management by objectives ensures that everyone involved in containing an incident is working towards a common objective. A functional management structure provides a clearly defined management structure based on function, such as control of an incident, planning or providing logistics. Functional management dictates that there can only be one Incident Controller managing an incident at any one time and there is a single reporting line for all those involved.[89]

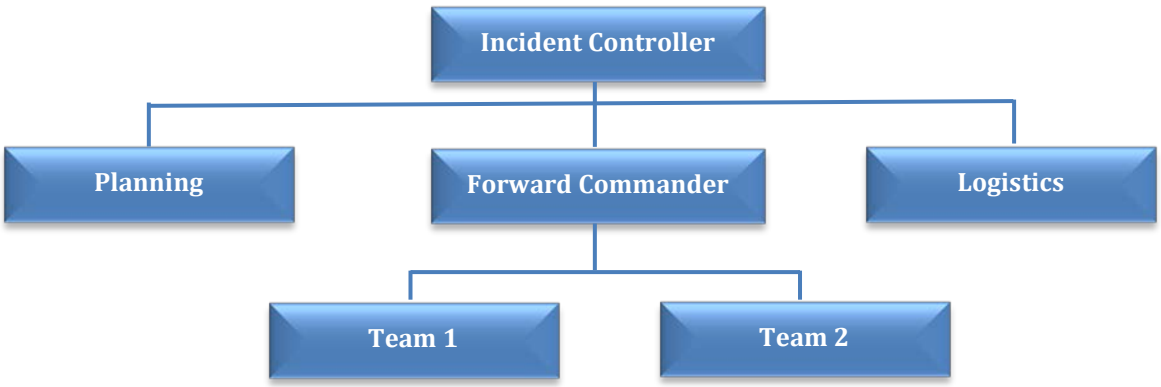

Figure 4
Common organisational structure using AIIMS

7.20 Span of control refers to the number of groups or individuals that can be successfully supervised by one person at any one time. Where span of control is exceeded, the supervising officer delegates responsibility to others. Conversely, where the span of control is lower or the tasks are fewer, the supervisor may reassume responsibility to contract the structure to fit the tasks required. In this way the system becomes scalable for any event.[90]

7.21 An organisation structure for a serious incident should include an Incident Controller, Operations Officer/Forward Commander and a person or people responsible for planning and logistics. The Incident Controller assumes control of the incident by managing the incident, establishing effective liaison with others involved in the incident and establishing and approving plans and strategies to resolve the incident.[91] This is a critical role and the person undertaking this role should be clearly identified.

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[89] Australasian Fire Authority Council, *The Australasian Inter-service Incident Management System: A Management System for any Emergency*, Third Edition, Version 1 (3 April 2004).
[90] Ibid.
[91] Department of Corrective Services, *Emergency Management Framework* version 1.0, updated January 2012.

Initial stages of the incident

7.22 At the onset of the incident the Shift Manager was the Incident Controller and all staff were aware he was undertaking this role. Communication and control during the early stages of the incident was commendable. A staff survey showed that 75% of staff who worked on the night of the riot felt they had clear instructions during the incident.

7.23 The Shift Manager prioritised the safety of the staff, which resulted in the removal of staff from the units when the situation escalated. He alerted senior management to the situation as well as instigated obtaining assistance from ESG and the police. The Shift Manager was in control of the incident for almost an hour.

Centre management arrival

7.24 The Assistant Commissioner of Youth Services, the Director of Youth Custodial Services and the Assistant Superintendent of Banksia Hill arrived on site approximately one hour into the incident. Each had been in communication with the Shift Manager prior to arrival to obtain updates. These three individuals made up the new management team who had been in place in Banksia Hill since November 2012 (for further information on this management team refer to this Inquiry's *Management, Staffing and Amalgamation Review Paper*). When this team started at Banksia Hill they made arrangements to be present for any roof ascent or other critical incident. Accordingly, it was standard practice for all three individuals to attend the scene.

7.25 On arrival, the Assistant Commissioner of Youth Services and Director of Youth Custodial Services set up the Incident Control Facility (ICF) above the gatehouse at Banksia Hill. In a debrief from a previous incident, held on the 11 January 2013, the then Commissioner of Corrective Services decided that 'in all instances the ICF will be established as soon as possible when the ESG are called to a facility'.[92] However, this was a new requirement and no staff member spoken to as part of the Inquiry could remember a previous occasion when the ICF had been established. No training had taken place using the ICF.

7.26 The ICF is a reasonably sized room with several whiteboards and computers, and two phones. Although a radio and staff mobile phones were used to supplement communication on the night, it was noted by several staff that communication into the ICF was difficult. This is supported by recordings of radio traffic where specific staff were asked to access land lines to communicate with Head Office.

[92] Commissioner, Department of Corrective Services, email (11 January 2013).

Photo 2
The Incident Control Facility (ICF)

7.27 Visual information on the riot was available via cameras in a control room approximately 50 metres away from the ICF. No camera footage was available in the ICF. Staff constantly moved back and forwards via a bridge over the sallyport to the control room to obtain an accurate picture of the events that were unfolding. This situation, combined with the communication difficulties, made it difficult to effectively run an incident from within the ICF. Training using the ICF would have identified the facilities limitations.

ESG arrival

7.28 The ESG arrived at almost the same time as the centre management team.

7.29 In the debrief from a previous incident on 11 January 2013, the then Commissioner of Corrective Services determined that during an incident:

> …once the ESG are activated and attend the scene, the incident scene is to be formally handed over to them and they take responsibility for the management of the incident until it is resolved and handed back. The officer in charge of the facility, will continue to manage the other parts of the facility not affected by the incident.[93]

With the exception of the timing of the hand over, this control structure is the same as adult facilities.

[93] Commissioner, Department of Corrective Services, email (11 January 2013).

7.30 Many staff, including the Director Youth Custodial Services and the Superintendent of the ESG have interpreted this instruction as meaning that the ESG was charged with apprehending the detainees who were 'out of bounds' during the riot while the Director of Youth Custodial Services was in control of 'the rest of the facility'. However, as the incident took place across all of Banksia Hill there was nowhere that was not affected.

7.31 The attempt to arbitrarily draw a line in what was considered the 'rest of the facility' resulted in gaps occurring during the night. For example, during the riot checking on the welfare of detainees who were not outside of their cells was largely believed to have been the responsibility of the Director of Youth Custodial Services. However staff under the control of the Director were no longer in position to carry out their normal duties of ensuring that the welfare of detainees was maintained. Planning for welfare checks should have been embedded into the plans and strategies to resolve the incident.

7.32 As it turned out, during the night an urgent situation arose with a detainee still in a cell needing medical attention. This occurred after the majority of the out of cell detainees had been apprehended. The Director of Youth Custodial Services provided instructions to staff to assist the detainee. As it was relatively safe to move staff at this time, the Director instructed the PRT to escort medical staff to attend to the detainee in the cell. While this was a positive outcome, this assistance was not integrated into the response for the rest of the incident. It goes against the AIIMS approach of having a single reporting line for all people involved in an incident and raises the question of what would have occurred if the detainee had needed medical assistance earlier in the evening while it was unsafe for Banksia Hill staff to move around.

7.33 One of the biggest challenges to effective emergency management of a critical incident is to resist the temptation for everyone to be at the front line. The importance of having a single, identifiable incident controller assuming control of the incident, planning and guiding staff actions and providing effective liaison cannot be understated. With the both the ESG Superintendent and the Director of Youth Custodial Services assuming parts of the role of incident controller clear definition of this role did not occur on the night. The result was poor communication, a lack of planning to establish welfare checks on those still in cell and a lack of understanding of the origin of key decisions (for example, the provision of police assistance inside the centre) throughout the evening.

Other control facilities

7.34 As part of the response to this incident, Incident Control Facilities were also established at Hakea and at Head Office.

7.35 The ICF at Hakea was activated at 9.50 pm and remained open for several weeks. Staff operating out of the ICF at Hakea coordinated arrangements for the detainees to be accepted into Hakea on the night of the riot. This included moving prisoners around to vacate cells and making arrangements for the detainees' arrival. The ICF remained open once detainees were at Hakea to coordinate the modifications required at Hakea to separate the adult prisoners and the detainees and to coordinate other activities necessary to keep the detainees housed (for example, ensuring there were facilities to temporarily hold a detainee at risk of self-harm).

7.36 The ICF at Head Office was set up at 8.10 pm to facilitate the provision of resources to Banksia Hill and to engage in decision making for things outside the remit of the Director of Youth Custodial services (for example, moving the detainees to Hakea and managing the legal ramifications of the move).

7.37 The ICF at Head Office received information and provided direction to the ICF's at Banksia Hill and at Hakea. There was also direct communication between the Head Office ICF and the ESG Superintendent. As evidenced from radio communications, there were difficulties in contacting people during the incident and communication flow to the ICF at Head Office was also restricted.

Police assistance

7.38 Police assistance was initially requested outside to guard against a possible escape attempt. Just after 6.30 pm one of the six detainees who was out of his cell at the time threw a rock at the gatehouse door. As a result the Gatehouse, under the direction of the Shift Manager called for police assistance via the '000' emergency number.

7.39 The police response included metropolitan district vehicles, support units such as Canine, Police Air Wing (Polair), Tactical Response Group (TRG), Traffic Enforcement Group (TEG), Police Transport Southern, local Detectives and eventually the Regional Operations Group. The first police officers arrived at 6.50 pm. Polair was on scene by 7.20 pm.

7.40 At approximately 8.00 pm, a joint force of ESG staff and police, including dog teams, commenced the task of apprehending detainees and regaining control of the site. This was done efficiently.

7.41 Throughout the incident control was maintained by ESG with Police working cooperatively with Department staff. Agencies should be commended on how well they worked together on the evening.

7.42 In 2007 the Department and the Western Australia Police established a memorandum of understanding (MOU) in relation to major prison incidents occurring in Western Australia. The MOU states that:

Should the ESG Incident Controller believe that police intervention may become necessary at the incident site or elsewhere he will consult with the Police Liaison Officer as to what police support may be required. When the ESG Incident *Controller* and the Police Liaison Officer determine that the incident required direct police involvement specialist police units may be deployed. These may include, but not be limited to:

- The Tactical Response Group
- TRG negotiators
- Technical Aid
- Canine Unit
- Air Support
- The Prison Squad
- Inquiry Officers (Detectives)[94]

7.43 This MOU indicates that the requirement for police assistance and the type of police assistance that will be used will be negotiated between the ESG Incident Controller and the Police Liaison Officer. The Inquiry has found that neither the ESG nor Banksia Hill centre management have a clear recollection of when it was decided that police assistance would be required inside the facility. Nor are there any records indicating clear decision making on what police resources would be used to assist in the reapprehension of detainees. In essence the ESG used whatever resources turned up to the centre.

7.44 It is important to note that even though formal consultation did not occur, the police assistance provided on the night was instrumental in apprehending the detainees in a timely manner. In particular the use of Polair provided valuable intelligence throughout much of the incident which offset the limitations of the cameras around Banksia Hill (discussed further in this Inquiry's *Security Review Paper*).

7.45 However, detainees have noted that the use of dogs was particularly intimidating. There is no suggestion that the dogs were ever off-lead or any danger to the detainees. Nevertheless detainees tended to perceive the presence of Tasers and presence of the dogs as equally threatening. There is a specific protocol (which includes authorisation from senior staff at Head Office), which must be followed for Tasers to be used within a detainee facility. No such protocol exists relating to the use of dogs to apprehend detainees who are 'out of bounds' within a juvenile facility. Consideration should be given to this, with particular attention given to the process for requesting assistance from the

[94] *Service Memorandum of Understanding between The Department of Corrective Services and Western Australia Police in relation to Major Prison Incidents Occurring in Western Australia*, MOU: 0001/2005, 6-7.

canine unit, the limitations of their involvement and approval for their use within a detention facility.

Timeliness

Primary Response Team (PRT)

7.46 The PRT is made up of staff members who are trained in primary response. While they are rostered on a shift to perform a set function, such as a Unit Manager, when an incident occurs they become part of a team to respond to the incident.

7.47 When the 'Code 2 – Out of bounds' call was made, PRT staff were required to lock down detainees in their allocated unit and proceed to either Harding Unit or the Gatehouse where they donned protective clothing. This process took just over 15 minutes, which is relatively timely. During these 15 minutes, staff rostered on as recovery team members were tracking the movements of the detainees. They were joined by other staff members and formed a cordon around the girls unit. If it was safe to intervene, the recovery team would have done so, however, as the detainees had 'armed' themselves with rocks and a metal aerial, the recovery team and other staff were instructed by the Shift Manager to hold back.

7.48 Once the PRT team had donned their protective gear, they assisted staff to evacuate from the units and formed a cordon around the staff amenities area awaiting the arrival of the ESG. Several suggestions have been made that the PRT were unable to intervene directly with the detainees, due to a lack of equipment such as capsicum spray, batons and Tasers. However, the staff survey showed a low percentage (6.8%) of YCOs believed the lack of defensive tools was a factor contributing to the riot. More staff attributed the lack of training, as a factor contributing to the riot, rather that the lack of defensive tools.

Emergency Support Group (ESG)

7.49 Six members of the ESG arrived on site at approximately one hour and 20 minutes after their call out. Given that this event occurred on a weekend it required staff to be called in for duty via personal pager. The time taken to arrive at the facility was therefore not unexpected. However consideration should be given to improvements in the availability or resources of ESG on weekends and evenings in order to improve response times.[95]

7.50 The six members of the ESG could have intervened for a simple roof ascent, however, this was no longer the situation. The ESG Superintendent sensibly waited for additional resources and a solid plan before deploying into the centre. This delay allowed a very swift response once resources were deployed and

[95] The Department has since advised (17/07/2013) that recent changes to the ESG roster provide for an additional two response staff on duty on weekends from 7:00 am – 7:00 pm.

avoided a situation whereby the ESG and the police would have been chasing detainees around the site. In five minutes they had re-apprehended 25 detainees and in another five minutes they re-apprehended a further 10 detainees. At that time it was believed that around 30 detainees were out of their cells.

7.51 Nonetheless approximately on and a half hours passed from the time the PRT set up its cordon around the staff amenities building to the time the ESG and the police deployed into the facility. This means detainees had a free run of the facility for an hour and a half. This delay suggests that the Department was not adequately prepared to respond to an incident of this size, on a Sunday night. The two factors contributing to this situation were the ability for the ESG to gather in significant numbers to effectively deploy and the lack of experience of many of the PRT members and therefore their ability to be proactive. The Shift Manager noted that he made a suggestion for checks on the female detainees, however, while discussing options for checks with staff it became apparent that many staff felt too unsafe to go to the girls' unit. The PRT team on the night was made up of approximately 50 per cent probationary officers. Other staff indicated to this Inquiry they were keen to check on the girls' unit, but were not authorised to do so as they had not undertaken the PRT training.

7.52 All decision makers prioritised staff safety on the night. While understandable, this caused delays in the response and therefore the response was not as timely as it should have been. This is not a criticism of individual decisions. The timeliness of the response was clearly affected by the limited resources available on the night of the riot.

Vulnerable detainees

7.53 There are several detainees at Banksia Hill who are especially vulnerable. This includes detainees who are deemed to be 'at-risk', those with mental health conditions and very young children and girls. Special attention needs to be given to the management of these detainees, particularly during an emergency incident.

7.54 Detainees are deemed to be at-risk in a detention centre if they:[96]

- are identified by Youth Custodial Psychological Services;
- normally abuse alcohol or drugs;
- have a history of self-harm behaviour;
- have a history of in-patient treatment;
- have made a previous threat of harm;
- are on a first admission or on very serious charges;

[96] Department of Corrective Services, *Youth Custodial Rule 703 – 'At-risk' detainees,* approved 27 August 2012.

- have a history of sexual or chronic physical abuse; and/or
- have been physically and or mechanically restrained.

7.55 On admission all detainees are checked for their at-risk status by undertaking an initial admission 'at-risk interview' of the detainee and checking for any previous alerts on the individual.[97]

7.56 All detainees classified as 'at-risk' should be managed through a written management plan or placement on the Observation Check list.[98] An 'at-risk' detainee, when confined in their own cell should be checked at intervals of no more than 15 minutes during waking hours, and 15 minutes during sleeping hours. When a detainee is assessed as requiring more frequent checks than 15 minutes then it may be necessary for them to be placed in an observation cell.

7.57 On the night of the riot 25 male detainees[99] and 7 female detainees[100] were deemed to be 'at risk', needing increased staff awareness and supervision. In addition, there were 24 detainees under the age of 15, and 21 girls at the centre.

7.58 Detainee checks were first conducted in Harding Unit, which has the observation cells, just after 10.00 pm. This was four hours after the incident began. There are no accurate logs of when detainee checks of other units were carried out although it is understood that these occurred after the initial checks in Harding Unit.

7.59 Only 14 of the 25 male detainees considered 'at-risk' were in Harding Unit. Three of the 'at-risk' detainees, one housed at Harding, were involved in the incident and two were discharged earlier that day. This left seven detainees identified as 'at risk' with no record of when they were checked during and after the riot.

7.60 When 'at-risk' detainees who were in Harding Unit on the night of the riot were interviewed, one noted that he felt safe because of the extra security in the Harding unit. However, he stated that if he had of been in a 'normal' unit he would have felt very unsafe during the riot, as he felt that other detainees do not like him. In a focus group of detainees not involved in the riot, some participants stated that they were not safe during the riot. It is important to note that there has been no suggestion in any of the focus groups or individual meetings with detainees, of any violent intent on the part of detainees towards other detainees.

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[97] Department of Corrective Services, *Standing Order 19 – Detainee Observation Checks, Observation Cells and 'At-Risk' Detainees*, updated 24 July 2009.

[98] Department of Corrective Services, *Youth Custodial Rule 703 – 'At Risk' detainees,* approved 27 August 2012.

[99] Department of Corrective Services, Banksia Hill Detention Centre *Observation Check List – Males Report for Sunday, 20 January 2013.*

[100] Department of Corrective Services, Banksia Hill Detention Centre *Observation Check List – Females Report for Sunday, 20 January 2013.*

However, the detainees' perception was that little could have been done if they were in danger as staff had 'left the units as soon as it happened'.

7.61 In the staff survey, half of those present on the night noted that either nothing could be done to ensure the safety of detainees or vulnerable detainees on the night, or that they could only complete checks when it was safe to do so. Two staff members noted that the detainees were 'abandoned'.

7.62 Although the reasons why the decisions were made on the night that led to the situation whereby detainees were 'abandoned', are understandable, this was not an ideal outcome. Alternatives other than physical checks should have been considered.

7.63 The Emergency Management Plan outlines that a staff member is to remain at the unit office, which enables cells to be monitored via intercom. This was part of the plan, as it was assumed these units would be secure. However, this was not the case. If no one is in the unit office to manage cell calls, the call is diverted to the control room.

7.64 It has been previously noted in a security assessment that the control room operator is responsible for monitoring cameras, alarms and radio transmissions. While this can be manageable in day to day operations, during an incident it was recognised that the operator would be placed under a great deal of stress and mistakes would likely occur.[101] On the night of the riot the control room operator did an outstanding job of monitoring each of these functions as well as providing liaison support to the police. Coordination of Polair was directed out of the control room.

7.65 Two additional staff members were assigned to assist in the control room, however, roles and responsibilities were fluid. One of the additional staff members took over listening to some of the cell calls. This was now the only means of communication between staff and detainees. Cell call traffic during the riot was high, encompassing genuine calls for assistance as well as things such as 'can you come and turn my light out'. As such, staff noted that some cell calls during the riot were ignored. While it was not anticipated that staff would leave units unmanned, for future events the importance of cell call traffic as a means of monitoring detainees should be identified. If it is ever necessary for staff to evacuate the units, a designated person could be assigned to monitoring cell call traffic and passing on information to the Incident Controller to action if detainees are in imminent risk of harm.

[101] Department of Corrective Services, Security Services Directorate *Security Assessment* BHJDC (November 2012) 9.

Navigating the facility

7.66 Banksia Hill staff, the ESG and the police all participated in the response to the riot. Within this group would have been people new to the facility or people that had very limited exposure to the centre. Accordingly, there were some difficulties experienced by officers in navigating the centre during the riot.

7.67 Difficulties were experienced by those trying to find their way around as well as those trying to provide instructions on their location, or where they were directing responders to go. Radio traffic had continual clarifications on locations as well as difficulties in describing units. For example, one responder would refer to Urquhart Unit, another to the unit in the middle on the eastern side of the centre and another responder was asking if that was the 'two storey boys unit'. These descriptions were likely to be referring to the same unit.

7.68 In particular Polair found it difficult to provide and receive locations. The police have noted that some sort of numbering or lettering on the roof of each unit would have been beneficial for Polair.[102] In addition, more prominent labelling of the units, or some other system such as colour coding the units would also help people on the ground to navigate their way around the centre in an emergency.

7.69 At a minimum, copies of a map of the centre that can be quickly provided to all responding staff would have been beneficial on the night.

Decision to transfer detainees to Hakea

7.70 Hakea is in close proximity to Banksia Hill and, by remarkable good fortune, on the night of the riot it had an unoccupied unit (Unit 5). Unit 5 was free because its occupants had recently moved to Units 11 and 12 at Hakea as part of a bed expansion for adults. Units 11 and 12 sit slightly apart from the rest of the prison, within the same perimeter but separately fenced. Unit 5 was the self-care unit at Hakea and probably the best of the older units in the prison.[103]

7.71 On the night of the riot, most detainees were placed in Unit 5, however some detainees were initially placed in Unit 12 which meant they were in the same compound as the adults in Unit 11. However, it appears that all detainees were transferred to Unit 5 the next day.

7.72 In hindsight, the decision to transfer detainees to Hakea on the night of the riot is likely to have been the least worst option for the detainees. However, this decision was not without legal issues. On the night of the riot no part of Hakea was gazetted for use as a juvenile detention centre. Units 5 and 12 at Hakea were first gazetted as a detention centre on Tuesday, 22 January by the combination of

[102] Western Australia Police, *Memorandum Review of the Police Response to the Banksia Hill Incident 20 January 2013* (8 April 2013) 61.
[103] OICS, *Report of an Announced Inspection of Hakea Prison,* Report No. 81 (November 2012).

the *Prisons (Hakea Prison) Order 2013*, the *Young Offenders (Banksia Hill Detention Centre) Order 2013* and the *Young Offenders (Detention Centre) Order 2013*. [104] The legal authority to hold detainees at Hakea prior to 22 January was challenged in a Supreme Court action taken by the legal guardian of one of the detainees. In that case, *Wilson v Joseph Michael Francis, Minister for Corrective Services for the State of Western Australia* [2013] WASC 157 ('Wilson case'), the Court held that the detention of the young persons at Hakea, for a little over 24 hours before Units 5 and 12 were declared a to be a detention centre was not unlawful. It was said to be justified given the unexpected emergency involved and the paramount need to ensure the safety and security of the detainees. (The legal issues with regard to this transfer are discussed in detail in this Inquiry's *Legal and Administrative Context Review Paper*).

7.73 In the Wilson case evidence was given on behalf of the Department that Units 11 and 12 at Hakea were designed as a contingency site in the event of an emergency of the type which occurred at Banksia Hill. However, given the large number of modifications that have been needed over several months to make the site suitable for the detainees it would appear that if it was designed as a contingency site, it was not designed to be an immediate emergency facility. It is also unusual that decisions were made in designing Unit 11 and 12 to remove a perimeter fence that would have isolated the detainees. One of the first major considerations for modifications at the Hakea Juvenile facility was the determination of ways to modify the fences so that the detainees could be isolated from the adults. This would not have been needed if the original perimeter fence had been left in place.

7.74 When queried about what considerations the Department had made for Hakea to be a contingency site for the juveniles, the Department responded that the evidence given to the Supreme Court:

> … related to the 640 bed expansion project, which provided DCS with extra bed capacity for an increasing population within Adult Custodial at the time. An additional benefit of having this increased bed capacity was that in the event of a serious incident it provided DCS with the means of dispersing and/or rehousing prisoners. It is difficult to state in the event of an emergency that Prison A will use Prison B as it is very much dependent on the nature of the incident, population pressures etc. Plans are formulated and acted upon to manage the situation at the time, as was in the case of Banksia Hill. When the extent of damage was realised, several options were considered in this process.[105]

[104] Government Gazette, Tuesday, 22 January 2013, No.9, 235-7.
[105] Coordinator, Custodial Inspections, Department of Corrective Services, email (14/05/2013)

7.75 This response suggests that Hakea was not considered a contingency site for the juveniles prior to the riot, beyond being one of the few prisons that had enough capacity to accommodate the detainees. The Department's response aligns more appropriately with the Supreme Court decision, that the night of the riot resulted in an 'unexpected relocation of detainees to a facility which was not designed for their use'.[106]

7.76 Regardless, the rationale for the decision to transfer the juveniles to Hakea on the night of the riot is very unclear. On the information provided to the Inquiry the decision to transfer the detainees was made in the ICF at Head Office after a discussion between those involved, of the available options. There is no written record of what options were considered on the night prior to the transfer taking place.

7.77 The records show that the ICF at Head Office was set up at 8:15 pm. At 8:30 pm contact was made with Hakea to prepare for the arrival of detainees. Although the making of prompt decisions during an emergency incident, is commendable, it is concerning that this decision was apparently made in 15 minutes without any documentation of the implications of the transfers and any alternatives considered. If this decision was made prior to the establishment of the ICF it becomes even more important to document who was involved in the decision making and what was considered.

7.78 The Inquiry found that neither the then Commissioner nor Centre Management of Banksia Hill was involved in making the decision to transfer the juveniles to Hakea on the night of the riot. However, each of these individuals supported the decision as it was clear to them that there were limited options available. Extensive work was done in the days after the riot to examine other options, but none provided a better alternative.

Allegations of mistreatment during the riot and transfer

7.79 Several allegations of mistreatment of detainees during their reapprehension and the transfer to Hakea were made to the Inquiry. The Inspector does not have the jurisdiction to deal with complaints concerning a particular individual and where necessary, these claims were forwarded to the appropriate agency.[107]

7.80 There was limited CCTV footage of the time when the detainees were held at Banksia Hill after they were re-apprehended. Logs were examined and several staff and detainees were interviewed as part of the Inquiry. Where appropriate, follow up interviews were held with detainees, for example where detainees stated a Taser had been used on a specific individual. The interview of the specific individual established this allegation was untrue. However, the way in

[106] Martin CJ, *Wilson –v- Joseph Michael Francis, Minister for Corrective Services for the State of Western Australia* [2013] WASC 157 (3 May 2013) 8.
[107] Section 26(2) of the *Inspector of Custodial Services Act 2003.*

which detainees were treated once at Hakea was observed directly by this Office and has been commented on in this Inquiry's *Post-Incident Management Review Paper.*

8 Recovery

8.1 Recovery from an emergency incident refers to the ability for people to return to the routine established prior to the incident and sometimes encompasses making improvements. In relation to the riot much of the recovery is still to take place, in particular returning all detainees from Hakea to Banksia Hill. However, there are some key elements to recovery that have already taken place, or should be considered in the immediate future.

Record keeping

8.2 While the riot is still fresh in so many people's minds and in the midst of the huge jump in workload that has occurred as a result of the riot, it is sometimes easy to overlook the importance of accurately documenting what took place. At the time of writing this Paper only three detainees (involved in instigating the riot) had been linked to the riot by way of an incident report, in the Total Offender Management System (TOMS). In essence, that means there is no record linking the other numerous detainees who were involved in the riot. Without accurate records the knowledge of who was identified as being involved in the riot is likely to be lost.

8.3 It is standard practice to record critical incidents in detention centres and prisons and this process was in place prior to and after the riot. Many of the incidents that have been recorded in TOMS are minor in comparison to the riot, therefore the absence of documentation on the riot is imbalanced.

8.4 Further, there are no corresponding minutes or outcomes attached to the three individuals who have been linked to the riot. This means there is no record of the consequences that were imposed on these three individuals as a result of instigating the riot.

8.5 Accurate and thorough record keeping is an ongoing issue for the Department in particular, at Banksia Hill. In the last Banksia Hill report in January 2012 it was noted that there were significant data, documentation and record keeping deficiencies in particular relating to the use of regression.[108] This Paper makes several references to poor record keeping practices including recording lockdowns and placing intelligence in incident reporting, if it is reported at all. Substantial effort needs to be made in changing record keeping practices across Banksia Hill and should start with accurate records being developed on the riot and those identified as being involved.

[108] OICS, *Report of an Announced Inspection of Banksia Hill Detention Centre,* Report No. 76 (January 2012).

Debriefs

8.6 A debrief provides an opportunity to review a situation and determine learnings from the incident. It is a means for improving a response to similar situations in the future. An effective debrief requires honest and frank discussion which can only occur in a no-blame environment. A debrief can also serve the purposes of record keeping.

8.7 Debriefing is also an important tool in fostering the wellbeing of participants in an activity. A short ('hot') debrief occurred after the riot on the morning of 21 January 2013. This debrief was cursory and was considered a welfare check for staff given many had worked for almost 24 hours.[109] It was noted that this debrief was deliberately shortened because of staff fatigue. This was understandable given it occurred at approximately 5:00 am and many staff had been there since the day shift the day before.

8.8 A cold debrief was conducted on 6 February 2013 and minutes were recorded. These minutes indicated that staff were given the opportunity to discuss the events leading up to the roof ascent, the riot and the response. A range of other comments were made regarding the physical security of the site, the upgrades being undertaken and the relocation of detainees to Hakea. The minutes do not indicate who was in attendance and advice from the Department states that the minutes were not disseminated to the wider staff group.[110]

8.9 Police were integral in the response on the night. In addition, the Department of Fire and Emergency Services and St Johns Ambulance attended Banksia Hill during the riot, although neither of these agencies was needed inside the centre. To date, an operational debrief with these stakeholders has not been conducted. This is despite that procedure being a requirement outlined in Standing Order 20, section 6 and the Banksia Hill Emergency Management Plan listing a debrief as part of the recovery process.

Reducing the psychological impact of critical incidents

8.10 There are psychological impacts associated with critical incidents. In particular, it was noted by several staff undertaking the Inquiry that some Banksia Hill staff members were experiencing strong emotional reactions to the riot. Banksia Hill staff spoke about being 'gutted' by the actions of the detainees. Others expressed frustration at the detainees and believe their actions during the riot were personal. Recovery from this position back to positive engagement with detainees and a positive approach to their roles will for some be a natural progression. However, for others, a more structured approach may be necessary.

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[109] Department of Corrective Services, Banksia Hill Detention Centre *Uniformed Staff (shift) Sign-on Sheet, 20-Jan-2013.*

[110] Coordinator, Custodial Inspections, Department of Corrective Services, email (18 April 2013).

8.11 Worklink Occupational Health and Rehabilitation Service have outlined six fundamental strategies to assist the recovery of individuals experiencing normal distress following a critical incident.[111] These are:

- Preparing workers for possible critical incidents in the workplace;
- Demobilisation;
- Defusing;
- Debriefing;
- One on one support sessions; and
- Follow up support.

8.12 Preparing workers for possible critical incidents can be achieved by doing an accurate risk assessment. In this case, this should include a risk assessment relating to the return to Banksia Hill. Staff noted that they have concerns about the safety of the Banksia Hill site, including concerns that knives may have gone missing on the night and could be hidden around the facility. It is not known whether or not knives have been buried around in the facility. However, Banksia Hill staff need to be engaged about their concerns and a plan needs to be developed to adequately address these concerns. Given that staff are already returning to Banksia Hill to supervise the girls and the younger boys, engagement with staff about these issues needs to occur as soon as possible.

8.13 Demobilisation and Defusing refers to meeting the immediate needs of staff by reviewing the event and clarifying ongoing concerns. To a certain extent this occurred during the short debrief after the riot on the morning of 21 January 2013.

8.14 Debriefing has been discussed above and while both a cold and a hot debrief have been carried out, a debrief for the purpose of staff airing their concerns and developing plans to address these concerns does not appear to have been conducted either in one session or in smaller sessions. Many staff noted that the meetings conducted during this Inquiry were the first opportunity they had been provided to talk about the incident. A support session was planned for 7 February, however this was cancelled. One on one support sessions and follow up support has been provided by the Department, with 93 per cent of respondents to the staff survey indicating they had been offered this support. However, staff have not necessarily taken up this opportunity.

8.15 Overall, the Department has made a concerted effort to support staff after this critical incident. However, the factors that staff directly attributed to causing the riot have not changed and therefore recovery will be limited. As noted in the this

[111] *Reducing the Psychological Impact of Critical Incidents.* Presentation by Work-Link Occupational Health and Rehabilitation Service; RiskCover Psychological Inquiries Seminar (17 April 2013).

Inquiry's *Management, Staffing and Amalgamation Review Paper*, until staff are united under a shared philosophy and culture (with associated performance management mechanisms in place), there will continue to be high levels of unplanned leave, low morale and an overall 'identity crisis' among staff.

Appendix A: Methodology

The preparation of this review paper involved the examination of a significant number of relevant documents, a survey of all Banksia Hill employees, focus groups and meetings of detainees and staff. The Inquiry also examined CCTV footage of the event, Polair footage of the event and radio traffic.

Meetings

A number of meetings were held with specific staff members from Banksia Hill, Hakea and Head Office. Most of these meetings were held in the two week period from 25 February to 8 March.

A number of individual meetings were held with detainees who initiated the riot as well as others relevant to specific aspects of the Inquiry.

Employee Survey

To provide an opportunity for Banksia Hill staff to confidentially provide their views on the riot and their working life, an online employee survey was emailed to all Banksia Hill staff members. The survey covered a number of areas including their perception of personal safety and the factors that contribute to safety, the quality of the preparation for the amalgamation, the contributing factors to the riot, the level of detainee access to services after the riot, and their actions on the night of the riot.

Due to a lack of computer access for staff members stationed at Hakea Prison, hard copy versions of the survey were left with locked boxes in Units 11 and 12. Staff were provided one and a half weeks to complete the survey, either online or via the hard-copy version.

There were a total of 110 respondents to the survey. Due to length of time the survey was available, it is likely that some employees were not able to complete it due to being on worker's compensation leave or annual leave. However, the response rate was over 50 per cent for those staff who were not on leave during the survey distribution period.

A brief summary of the survey results is included in the Appendices of this Inquiry's *Management, Staffing and Amalgamation Review Paper*.

Detainee focus groups

Five focus groups of detainees were held to enable a cross section of information to be gained about the detainees experiences prior to, during and after the riot. These focus groups were broken into:

- two groups of boys who were moved to Hakea on the night of the riot
- one group of boys who remained at Banksia on the night of the riot
- girls at Banksia Hill
- one group of vulnerable detainees.

Participants for the boys' focus groups of those 'involved' in the incident were randomly selected from the list of individuals who were transferred on the night, excluding those that had been released from custody. Participants were randomly assigned to either group. Each group had 10 participants.

Participants for the boys focus groups of those 'not involved' in the incident were randomly selected from the list of individuals who were not transferred on the night, excluding those that had been released from custody and those that were accommodated at Banksia when the focus group was held (25 February 2013). 10 detainees participated in the focus group.

All the girls in custody at the time the focus group was held (26 February 2013), participated in the focus group, whether they were there or not there at the time of the riot.

One focus group was intended to involve up to eight participants who were identified as being on 15/15 checks on the night of the riot. Some of these individuals were at Hakea Juvenile, however when selecting participants most were accommodated at Banksia, therefore only those at Banksia were selected. At the time the focus group was held (26 February) however, many of these individuals had been released from custody and therefore there were only two participants.

Appendix B: Chronology of event beginning 20 January 2013

Time	Events, actions and decisions
1745	Staff contacted the Shift Manager suspicious about detainees absconding the unit to ascend the roof.
1755	A population count was called for the facility.
1755	Three detainees absconded from a unit and the whole centre was alerted via radio transmission. An instruction was issued to secure all detainees in cell.
	The absconding detainees entered the female precinct and scaled the roof. They remained on the roof for few minutes, descended and ran into officers demanding the staff get out of their way. The detainees continued towards a group of visitors being escorted from the centre. They were deterred by an officer and turned around ascending another roof. Whilst on this roof, one of the detainees throws a rock at an officer but misses.
1810	A radio transmission was issued advising that the population count was correct with three detainees recorded as unsecure.
1812	The detainees, having descended the roof again, were observed outside the centre's management wing. Staff witnessed the detainees throwing rocks at a cell's external window. The cell window was breached in less than two minutes and a special profile offender was freed from this cell.
1818	The four detainees moved to another unit and freed a fifth detainee.
	A call was made to the Department's Emergency Support Group (ESG) requesting their assistance.
	The five detainees were observed moving towards another unit. The officer supervising detainees in this unit secured herself in the office bathroom.
1822	A sixth detainee was observed breaching his cell from this unit.
	The group of detainees moved to the gatehouse. One detainee was observed throwing a rock at the glass entry door. They group of detainees continued moving unchecked throughout the centre.
1834	The Shift Manager requested the assistance of Western Australia Police (WAPOL) to man the perimeter wall.
1844	The detainees entered an unfinished and unsecured unit. They were observed re-emerging from the unit with bedframes, table legs and a fire extinguisher.
1850	Eight detainees were confirmed out of cell.
	The Director of Youth Custodial Services and the Assistant Superintendent arrived onsite and assumed control of the incident
1900	All staff were accounted for in the staff amenities room after being escorted from various units throughout the centre by Banksia Hill's Primary Response Team (PRT).
1901	The detainees breached two unit offices and a detainee was overheard on the public address system encouraging other detainees to damage centre property.
1904	The ESG arrived onsite.

Time	Events, actions and decisions
1910	WAPOL begin manning the centre's external perimeter road in the event of a detainee attempting to escape.
1930	PRT & WAPOL response planning was conducted.
1936	16 detainees were confirmed out of cell.
1937	Approval was given by the Corrective Services Commissioner for the use of Tasers.
1948	Some detainees were observed accessing the centre's administration building.
	The ESG checked their weapons and WAPOL firearms were secured outside the centre.
2000	ESG and WAPOL move into the facility
2005	Approximately 25 detainees are apprehended and held on the basketball court near Turner unit.
2009	A perimeter breach was called as one detainee was observed nearing the perimeter wall.
2010	Approximately 10 detainees surrendered in the girl's precinct.
2015	The Incident Control Facility (ICF) at the Department's Head Office was opened.
2030	A second perimeter breach was called as three detainees were observed nearing the perimeter wall. The Director of Youth Custodial Services and WAPOL requested authorisation from the ICF to have the detainees removed from Banksia Hill.
	The Hakea Superintendent is contacted regarding the availability of space in Hakea for the detainees
2110	A list of the detainees was compiled and organisation for detainee transfers to Hakea began.
2125	Hakea Prison's Superintendent arrives at Hakea with Senior Youth Justice staff.
2126	The Banksia Hill Security Manager arrived onsite.
2130	The ESG Superintendent advised the ICF that 37 detainees were apprehended and plans were in place for a population count and cell integrity checks. The ESG Superintendent stated that no use of force was deployed and there were no injuries to detainees or staff. The ICF instructed the ESG Superintendent to ensure all detainees were medically assessed.
2150	The Hakea Command Post was opened.
2200	Welfare checks began in some units within the centre for detainees who remained in cell.
2220	Hakea staff were given a copy of Juvenile Custodial Rule 208 (use of restraints) and two YCOs were posted at Hakea for the night.
2222	A female detainee was identified as suffering an asthma attack.
2225	The ICF advised the prison officers' union (WAPOU) that Banksia Hill detainees would be relocated to Hakea.
2229	The detainee suffering an asthma attack was administered medication by medical staff. The detainee was then moved to another cell having caused damage to own her cell when she was allegedly attempting to gain staff attention.
2308	Another population count is called.

Time	Events, actions and decisions
2322	Banksia Hill medical staff assess the apprehended detainees. One detainee is assessed as requiring hospitalisation.
2324	The population count continues as more detainees are apprehended and secured.
2230	Hakea staff were deployed to the unit awaiting the relocated detainees. The number of detainees to be accommodated at Hakea continues to change throughout the night.
0021	The Director of Youth Custodial Services queried the population count and subsequently another count was undertaken.
0025	All apprehended detainees had their shoes removed after a detainee attempted to abscond from the basketball courts where he was being held.
	Cell integrity checks commenced throughout the centre.
0031	Another special profile offender allegedly assaulted a senior ESG officer. He was restrained with mechanical restraints on both wrists and ankles.
0038	The Director of Youth Custodial Services provided an update to the ICF noting his uncertainty regarding Taser use. A direction was issued by the ICF Incident Controller that the detainee, who allegedly assaulted the senior ESG officer, was not to be transferred to Hakea with the other detainees.
0115	The first WAPOL transport van departed Banksia Hill for Hakea Prison with 12 detainees on board.
0122	The Shift Manager calls the population count correct.
0220	The detainee involved in the alleged assault of the senior ESG officer was moved to the centre's multi-purpose unit.
	Six additional transfers were conducted by WAPOL to Hakea Prison.
0415	The Director of Youth Custodial Services provided another update to the ICF reporting that 144 male cells were assessed for cell damage. Damage was recorded in 92 cells.
0421	The transfer was completed with 73 detainees removed to Hakea Prison.
0432	A Banksia Hill staff debrief was conducted.
0509	The Director of Youth Custodial Services advises the ICF that the staff debrief was concluded and that staff were disgruntled. The Director confirmed no detainees were Tasered.
0740	The Corrective Services Commissioner declared the situation an 'emergency' and the incident a 'riot'.
0753	The Corrective Services Commissioner verbally briefed the Inspector of Custodial Services.
0828	The ICF were advised that some staff property was allegedly stolen during the riot. These belongings included medication.
0859	There were discussions held at the ICF regarding whether some detainees at Hakea were to be transferred to Casuarina Prison.

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