Inspector's Overview

Banksia Hill Detention Centre is once again in crisis

We commenced this inspection in December 2021 because of our increasing concerns about the welfare of detainees and staff following a rise in the number of critical incidents, including detainee self-harm, suicide attempts, and staff assaults.

Because of the immediacy of our concerns we did not look at all operational areas across BHDC and instead focussed on conditions and treatment of detainees in the Intensive Support Unit (ISU). But it is important to also recognise that the rise in the number and severity of critical incidents has had a significant impact on services available to detainees across all other areas of the centre due to frequent lockdowns, infrastructure damage, and the impacts of very high staff attrition rates.

The ISU performs several different functions at BHDC, including: crisis care; discipline and consequences; and management of the most challenging male detainees. It is also a good thermometer to gauge the overall temperature of the centre because, ultimately, it is where those involved in critical incidents end up. As the name suggests, it is where intensive support is supposed to be offered to detainees with the greatest needs.

As a starting point, we focussed attention on whether BHDC was meeting the minimum time out of cell requirements that are set by the *Young Offenders Act 1994*, the *Young Offenders Regulations 1995* and the relevant departmental policies and guidelines.

The normal daily regime at BHDC involves 11 hours and 15 minutes out of cell each day, during which detainees would be engaged in activities such as: education, training, programs, welfare support, socialisation, social and official visits, and recreation.

Under the relevant Western Australian legislation, policies and guidelines, on a normal day detainees would be entitled to a minimum one hour out of cell per day. This is less than the two hour minimum time out of cell set out in the relevant international human rights instruments. At the risk of stating the obvious, it is important to bear in mind that even when the minimum limits are met, detainees would still be held in their cell for 22 or 23 hours per day. There can be no doubt that such conditions, especially if prolonged, would be damaging to the health and wellbeing of young people.

To assist our analysis, we used four case studies to examine their individual out of cell times and our report sets out the detailed findings. We found a steady deterioration in average out of cell hours during 2021. And there were several days in November 2021 when the four young people did not receive the minimum time out of cell required by either the relevant legislation and policy, or the international instruments. We concluded that their human rights were being breached on those occasions.

These findings were so concerning that on 17 December 2021 we issued the Department with a show cause notice under section 33A of the *Inspector of Custodial Services Act 2003* (the Act) requiring

a detailed response within six days. The Department's comprehensive response, received on 23 December 2021, acknowledged many of our concerns and set out the plans and strategies that were already underway, or were being put in place, to deal with the issues facing BHDC. This included additional funding for infrastructure repairs and upgrades, strategies to recruit and train additional custodial staff, and the development of a trauma informed operational model of care.

It is also fair to acknowledge that, prior to this inspection, the problems and issues facing BHDC had been the subject of many discussions and briefings between my office and the Minister, the Director General, the acting Commissioner, and other senior staff.

On 21 January 2022, following consideration of the Department's response, pursuant to section 33A of the Act I referred the matter to the Minister for Corrective Services. In this referral I supported the Department's planned actions. However, I suggested that as an immediate non-custodial circuit breaker, a welfare focussed non-custodial workforce be embedded to supplement the custodial and security efforts being pursued by the Department. The Minister's response reiterated the commitment to the improvements that were outlined in the Department's response and advised that the Department was exploring options for an immediate circuit breaker initiative.

It is not possible to overstate the importance of the reforms currently underway around youth detention and how young people are treated once they are sent to BHDC. But the problem is far greater and the solutions broader than just focussing on BHDC. There needs to be better integration of support services, properly resourced support mechanisms, and effective diversions and interventions beyond BHDC. Consideration also needs to be given to having appropriate facilities for young female detainees, remandees, and young people from regional and remote communities.

Our report is critical of the conditions at BHDC and for many it will be difficult reading. BHDC is not fit for purpose as a youth detention centre. It looks like, and in many respects runs like, an adult prison. Even to the point where there are adult prison officers stationed there to assist in maintaining order and security. More recently, due to staff shortages, these staff have been required just to keep the facility running. Recent critical incidents have also regularly resulted in the deployment of response teams from the Department's Special Operations Group.

The Department's response to this report and the earlier show cause notice highlighted the difficulties faced by BHDC in managing a small cohort of detainees with complex and challenging needs who were behind most of the critical incidents. These young people had been involved in self-harm and suicide attempts, staff assaults, fence and roof ascents, and infrastructure damage. This may well be a fair assessment, but as also acknowledged in the responses many of these young people have significant impairments, traumatic backgrounds of abuse and neglect, and diagnosed complex neurological disorders. This tells us that the management and care of these children must be trauma informed and evidence based with at the very least an equal focus on welfare needs alongside custodial needs. For this reason, we consider that the most important reform currently underway is the development of a trauma informed model of care. If successfully developed and implemented, this is the initiative that is most likely to have lasting impact and change.

All of this is detailed in our report along with two recommendations which were supported by the Department. I am encouraged that BHDC is finally getting attention and resourcing to address the

many challenges they are now facing. But reforms have started and failed before and the current initiatives must be sustained through to successful implementation. We will continue to closely monitor progress and implementation.

In conclusion, it would be remiss of me to not mention the efforts and commitment of many staff who work at the BHDC. Most of them do an incredible job in very difficult and challenging circumstances. We often see and hear from staff who have endured because of their commitment to providing services to the young people and trying to make a difference.

ACKNOWLEDGMENTS

It is important to acknowledge the support and cooperation we received throughout the inspection from the Superintendent and staff at BHDC. I also acknowledge and thank the Director General and the acting Commissioner for their personal engagement and cooperation with us during this inspection.

I also want to recognise the detainees we spoke to and thank them for their time and sharing their experiences with us.

Finally, I would like to thank the members of the inspection team for their expertise and hard work throughout the inspection. I would particularly acknowledge and thank the Commissioner for Children and Young People for allowing Laura Jackman to take part in the fieldwork for this inspection. A special mention is also required for Ryan Quinn and Cliff Holdom for their hard work in planning and coordinating this inspection and for Ryan Quinn as principal drafter of this report.

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Inspector of Custodial Services

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