# Executive Summary

This is a report of a quarterly statutory inspection of the Brisbane Youth Detention Centre (BYDC). The on-site inspection occurred from 4 to 8 June 2018. Statutory detention centre inspections are conducted by delegated inspectors located within Governance, Corporate Services. A report of each inspection is provided to the Director-General.

The focus areas under inspection in this quarter were suicide and self-harm prevention, behaviour development (model and plans), and separations of young people. In gathering evidence, Inspectors visited all units over the inspection week (including on two partial night shifts) and spoke to staff and young people in each unit.

The key observations, findings and recommendations in relation to the focus areas are summarised below. Other issues were raised and discussed with relevant centre managers and the two acting Senior Executive Directors, Youth Justice Services during and immediately following the site visits.

## Focus Area 1 – Suicide Risk and Self Harm

Training currency in Suicide Response training is well below the target of 85% with just over half of the staff assessed as competent (55%). Paper-based observation logging for at-risk young people is open to error and does not provide certainty that suicide risk observations are being conducted in accordance with policy. Visibility into many rooms is near impossible due to severely scratched port holes and camera lens covers, despite the maintenance program in place to address this.

The Inspectorate recognises that an electronic ‘bed-check’ logging will be available in the new 16-bed unit (completed in July 2018), which will house young people while older units are upgraded with similar technology. The electronic system will provide greater certainty that suicide risk observations are occurring. The security upgrade is expected to be completed progressively by 2019.

The report makes recommendations to immediately devise an interim measure to provide better assurance over suicide risk observations and urgently increase suicide risk response training currency and coverage of trained staff across all accommodation units.

## Focus Area 2 – Separations

There are high numbers of separations shown in the data, which can be attributed mainly to staffing and major incidents when the whole of centre is locked down. BYDC is not currently meeting technical legislative requirements in regards to one-off separations, with a significant number of outstanding approvals for young people who were separated without legislative authority.

In general, separations were viewed by key staff as being overused. However, inspectors encountered a lack of readily-available and robust data to show the frequency and duration of locked-door separations experienced by individual young people. Therefore, the Inspectorate requested a new dataset, which indicates some upward trends in locked-door separation as a result of staff shortages and other incidents affecting the whole centre.

The report makes recommendations to build on the extensive dataset commissioned for this report to ensure that the individual experience of locked-door separation is captured in readily-accessible data and included in future regular performance reporting.

In relation to the frequent use of separation that occurs within the Oak unit for young people with the most challenging behaviours, the purpose of these separations was unclear. Further, when a young person is sent to Oak, this is often not communicated to caseworkers. Inspectors were advised that young people do not receive school work or attend programs while in Oak and that there is often no clear plan to address why they were sent there and how to reintegrate them back into normal routine.

The report makes recommendations to establish a clear therapeutic purpose and procedures for the Oak unit to coincide with the eventual rollout of the revised behaviour development model.

## Focus Area 3 – Behaviour Development (Rewards and Consequences)

A positive behaviour-based learning and incentives system to tie in with the Education Queensland model is still in development. The lack of a consistent model is resulting in each unit with differing 'systems' and challenging behaviour by young people when moving between units. Staff feel they have no tools to address poor behaviour and there are minimal goals for young people to strive towards.

The Inspectorate also notes that more time is allocated to training youth workers in physical control and restraint than is spent on understanding and managing behaviour.

The report makes recommendations to develop and implement a behavioural model as a matter urgency and increase behaviour management training for new and existing staff to improve their skills to recognise and manage behavioural triggers in young people and manage behaviour in the absence of a consistent model.

## Focus Area 4 – Behaviour Development (Support) Plans

The Inspectorate found that behavioural plans for young people are not always understood or used by front-line youth workers. Professional staff develop comprehensive plans for young people, but improved guidance for youth workers to effect the plans is required.

The report makes recommendations to increase communication and collaboration between psychologists and youth workers to ensure behavioural plans are implemented and adjusted as required.

## Other Issues

An overriding theme across this inspection was the perceived lack of managerial visibility in units generally. Staff invariably advised inspectors that they saw little of upper management, perhaps only Unit Managers occasionally, and that no managers or supervisors sit down and talk with them the way inspectors do. This perception is concerning and illustrative of the disconnection between staff and management.

The report makes recommendations for greater management presence and leadership in the units to observe and correct operational issues, and hold frank conversations to guide staff on setting clear and consistent boundaries for young people.