EXECUTIVE SUMMARY
Cleveland Youth Detention Centre
June Quarter 2012

The inspection of Cleveland Youth Detention Centre (CYDC) required under s263(4) of the *Youth Justice Act 1992* occurred from 14–18 May 2012 and was conducted by Principal Inspector Graham Morrison and Acting Principal Inspector Ray Currier. The scheduled focus areas were: the safety and wellbeing of young people and staff (which was a follow-up of bullying and behaviour management issues discussed in the June 2011 inspection report); and pre-admission & court procedures. The scheduled monitored areas were: behaviour development plans (BDPs) and complaints. Due to issues associated with BDPs implemented by CYDC in March 2012 following two major incidents, these acquired greater focus in the on-site inspection and in this report. The remaining areas will be included in a future inspection.

Some of the findings elicited through the June 2012 inspection of CYDC have been identified by the Inspectorate during previous inspections. These were covered extensively in the June 2011 inspection report; the June 2009 inspection report that focused on the behaviour development models of both detention centres, including the effectiveness of the points and rewards system (see upcoming September 2012 report noting current significant improvements being implemented in regard to PBS); and the March 2008 inspection (which included extensive discussion of BDPs implemented in the Jabiru unit before its demolition). The Jabiru episode involved young people being locked in their rooms for up to 22 hours each day while subject to BDPs that lasted up to a fortnight. The current report discusses recent BDPs implemented at CYDC in March 2012 that involved eight young people being locked in their rooms for approximately 22 hours per day for ten days. During consultation the Director CYDC noted that the centre 'experienced significant staffing issues as a result of injuries staff sustained during the incident; high young person numbers (overcrowding) and serious risk and threats to the safety and security of the centre'.

This report makes four new recommendations to address potential accountability gaps in the development of BDPs; compliance with the Youth Justice Regulation regarding authorisation and proper recording for planned, protracted locked-door separations that occur within BDPs; and the level of detail recorded by staff in unit logbooks. The recommendations negotiated with and accepted by the Director CYDC are presented as continuous improvement opportunities.

Summary of findings in relation to Behaviour Development Plans

The Inspectorate examined eight BDPs and surrounding documentation. These BDPs ensued from an incident on 23 March 2012 in which a young person was 'ground stabilised' by two members of staff, which escalated into other young people becoming involved and assaulting staff. Staff were able to de-escalate the incident by restraining the young people, however, 11 staff and 8 young people were seen by the nurse immediately after the incident with some being treated for minor injuries

[the Director CYDC advised that this incident and one on 17 March were the most serious risk to safety and security in the history of CYDC]. Inspectors were advised by some of the young people involved that they had been particularly concerned on that occasion by the manner in which force had been used on their peer. Findings discussed further within this report include:

1. Potential breaches of legislation and policy regarding the recording of protracted locked-door separations and the authorisation for these from executive management in central office. After the 23 March incident the young people involved were placed on locked-door separation for the great majority of each day and night for the ensuing ten days. Section 23 of the *Youth Justice Regulation 2003* (the Regulation) prescribes reasons for each period of separation, prohibits separation for disciplinary reasons, and details the way in which each period must be appropriately authorised and recorded. The separations discussed in this report were not recorded as separations in accordance with legislation and policy.

2. Potential breaches of legislation and policy in relation to the basic care and treatment of young people on BDPs, who experienced a lack of stimulation from near-continuous cell confinement over ten days and removal of mattresses during each day [the Centre Director advised that bedding is often removed to minimise the risk of using sheets etc for self harm and to ensure that young people do not sleep during the day, meaning they could be awake all night being disruptive to other young people's routine & throwing their own routine out of kilter].

The Inspectorate notes that prior to and during the code black, two of the young people were assessed by the Suicide Risk Assessment Team as being at an elevated risk of suicide. In such cases policy requires staff observations to be at higher frequency than the 'base' fifteen minute observations all young people should be subject to. At the start of his BDP, one young person had been assessed at a 'low' risk of suicide, which meant observations were required every ten minutes. His risk of suicide was lowered to 'base' on 27 March 2012. The other young person had been assessed with a current 'medium' risk of suicide when his BDP commenced, which meant observations were required every five minutes. His risk level reduced to a 'low' by the end of his BDP. The Inspectorate notes further that another of the eight young people was subject to a long-term Child Protection Order with state guardianship; and another young person was 13 years old.

3. Potential breaches of four key recommendations of the *Report of the Royal Commission into Aboriginal Deaths in Custody 1991* (RCIADIC).
It is noted that all eight young people subjected to the BDPs were of Aboriginal and/or Torres Strait Islander origin. RCIADIC states that it is 'it is undesirable in the highest degree that an Aboriginal prisoner should be placed in segregation or isolated detention' (see p11 of this report).

4. Insufficient detail in relation to general recordkeeping in section logs and shift notes, and insufficient detail on BDPs documentation regarding risk assessments and the development of interventions for individual young people (through optimising the skills and knowledge of all multidisciplinary staff members required to be involved in the BDP process).

Summary of findings in relation to Safety and Wellbeing

Findings from the June 2011 inspection were followed up to ascertain whether improvements had been made by CYDC in relation to the safety and wellbeing of staff and young people at CYDC, which had given rise to a number of issues about the extent to which young people were subject to firm and consistent management before such time as a BDP might have been warranted. Due to the emergent concerns met with by Inspectors in relation to BDPs and the resources required to analyse the weight of surrounding evidence, safety and wellbeing findings are based on the Inspectorate's analysis of incidents extracted from the Detention Centre Operational Information System (DCOIS). The key trends noted were:

- CYDC continues to face challenges in addressing ongoing displays of sexualised behaviour by young people, both towards each other and female staff members.
- Incidents of violence and aggression at CYDC were found to be at disproportionately high levels in comparison with the Brisbane Youth Detention Centre (the response of the Director CYDC during consultation was that these data should be understood in the context of the high proportion of Indigenous young people at CYDC. The Director CYDC quoted research indicating that Indigenous communities are more vulnerable to family violence than other sections of Australian society).

Documentation and staff evidence gathered during this inspection identified that effective multidisciplinary teamwork in the preparation of BDPs, and the consistent application of these by operational staff, continue to present opportunities for improvement at CYDC. In consultation, the Director CYDC advised that CYDC has now 'established a review of the BDP process'; this is currently been performed by the Multidisciplinary Team (Operations, Casework and Programs Managers and their teams).