

# Executive Summary

This is a joint report of quarterly statutory inspections of both the Brisbane and Cleveland Youth Detention Centres (BYDC and CYDC). The on-site inspections occurred from 8 to 12 March 2021 at CYDC and from 22 to 24 March 2021 on-site at BYDC. The BYDC inspection was continued remotely from 29 to 31 March 2021 due to Covid-19 restrictions enacted following an outbreak in the Brisbane area. Statutory detention centre inspections are conducted by delegated inspectors, located within the office of the Deputy Director-General, Department Children, Youth Justice, and Multicultural Affairs. This is a joint report covering both inspections provided to the Director-General, which aims to contribute to improving youth detention centre operations across both centres.

The focus areas under inspection in this quarter were Suicide and Self-Harm Risk Management, Behaviour Development, Management, Incident Management. The overriding theme and a major contributor to issues identified in relation to the focus areas in this inspection relates to staff shortages which is affecting many aspects of centre operations.

The key observations, findings and recommendations in relation to the focus areas are summarised below. Other issues were raised during the inspection (Short Staffing and Body Worn Cameras) and are also summarised below. These issues were discussed with relevant centre managers at the conclusion of the inspection and with the Senior Executive Director, Youth Detention Operations and Reform during a post inspection briefing.

## Focus Area 1 – Suicide and Self-Harm Risk Management

Detention centres recognise young people in custody are highly vulnerable and susceptible to suicide and self-harm. Policy and procedures regarding suicide and self-harm is prescriptive and a range of processes are in place to prevent suicidal and self-harming behaviours. While the inspectorate found most processes are conducted by staff per policy, some gaps were identified in the following areas:

- identifying and recording suicide events;
- suicide assessment and prevention plans;
- suicide risk observations; and
- training currency in suicide response for existing staff.

To address gaps in this area, the Inspectorate has recommended enhanced monitoring and staff training as well as a review of policy in consultation with partner agencies to ensure contemporary best practice is considered.

## Focus Area 2 – Behaviour Development

The behaviour development foundations described in the policy and procedure is consistent with contemporary evidence regarding behaviour management. Good behaviour is incentivised through a structured approach, principles of positive behaviour support, trauma informed and restorative practice are incorporated and behaviour support for moderate or more serious behaviour is individualised. The intent of the behaviour development framework is to guide practice within each centre; however, each centre has their own specific behaviour development model to prescribe practice in a localised setting.

The Inspectorate found that while the foundations of behaviour development within policy are contemporary, feedback from several sources (including evidence detailed in academic publications) suggest a need to review the consequence scheme to determine effectiveness and alignment with current evidence regarding the prevalence of young people in custody with severe impairments in memory, language, attention or executive function, and subsequent limitations on their ability to link and understand consequences. In this regard, the Inspectorate has recommended that the current consequence scheme within the behaviour development policy and any centre specific consequence schemes be reviewed by qualified practitioners to determine effectiveness and remain in line with contemporary evidence.

It was also found that areas of opportunity remain in the implementation of behaviour development which is impacting on the model being operationalised as a whole of centre/s approach. Limited understanding amongst staff of centre specific behaviour development models, short staffing, conflicting views and limited coaching and professional development opportunities are all impacting on a shared and consistent approach to behaviour development. To address this, the Inspectorate recommended that specific modules be created for induction training for the centre specific behaviour development models to enhance the practical training already in place to ensure consistency of practical application by Youth Workers.

Further, youth detention philosophy acknowledges that young people in youth detention centres have a responsibility to manage their own behaviour in an appropriate manner; however, it is well documented that most young people in the youth justice system do not have the skills necessary or cognitive capacity to manage their behaviour due to a range of factors. The Communication and Psychology Teams (CPT) within both centres are pivotal in the behaviour management process, undertaking a range of functions including offering individualised therapy for young people to develop and learn techniques to manage their own behaviour.

The CPTs within both CYDC and BYDC are currently operating at a limited clinical capacity due to operational constraints. The ability for young people to access therapeutic support and interventions to develop skills and resources to improve communication skills and manage their own behaviour is significantly low. A recommendation has been made to develop a strategy to increase the ability for CPT within both centres to conduct therapeutic sessions to ensure young people receive therapeutic services as intended to support behaviour management.

### **Focus Area 3 – Incident Management**

The Inspectorates' focus on incident management looked specifically at the efficiency of incident response, including the number of staff responding and how an 'audience' may affect the duration and severity of an incident and potential trauma/impacts on young people. The Inspectorate acknowledges that the majority of incidents at both detention centres are managed safely and efficiently with effective verbal de-escalation and also noted progress in relation to incident controller training. In regards to incident controller training, the Inspectorate has made a recommendation to consider the efficient use of staff and equipment when developing a new training package as well as considering opportunities to efficiently manage incidents to minimise impacts on centre operations, young people and staff safety.

### **Other Observations and Issues**

The Inspectorate raises observations and issues on-site during the inspection, directly with staff throughout the inspections, with the Executive Directors at the exit interviews and with the Senior Executive Director, Youth Detention Operations and Reform at the preliminary finding's meetings. Both issues identified in this report are known to executive management within the detention centres and the Department of Children, Youth Justice and Multicultural Affairs. Actions are already underway to address these issues at the local and strategic level. Past issues are monitored through the Issues Registers which outline the response action taken by centre management and/or Youth Detention Operations and Reform. Issues and observations during the March 2021 Inspection include:

#### **Short Staffing**

Short staffing as a result of absenteeism is affecting many aspects of centre operations, including education and programs attendance, self-harm and protest related incidents, as well as health and therapeutic services for young people. Local management actions to address absenteeism and allocate available staff to priority areas have been implemented. Further strategies at the departmental level not limited to additional recruitment are ongoing.

#### **Body Worn Cameras**

At the time of inspection, the majority of body worn cameras (BWCs) at BYDC were unusable due to suspected manufacturing issues. Investigation of this issue and review of video footage showed that damage to BWCs was not caused by regular use or intentional damage. Positively, this issue has shown that staff have come to rely on BWCs to resolve possible investigations and also identify areas of good practice for training purposes. This issue had been escalated to the departmental level and replacement BWCs were in the process of being purchased at the time of writing this report.

## List of Recommendations

### Focus Area 1 – Suicide and Self-Harm Risk Management

#### Recommendation 1

- a) Where possible, immediate actions are put in place to address the gaps in identifying and recording suicide events, suicide observations and training currency due to the critical consequences that may result.
- b) A review of the current policy in relation to suicide and self-harm risk prevention to ensure information is contemporary, in line with current evidence and feedback from partner agencies involved in the suicide prevention process within the detention centres has been considered.

### Focus Area 2 – Behaviour Development

#### Recommendation 2

The current Incentives scheme within the Positive Behaviour Support Policy, Youth Detention Centre Operational Manual and any further centre specific consequence schemes implemented within each centre be reviewed by qualified practitioners to ensure they are in line with contemporary evidence.

#### Recommendation 3

Stand-alone modules be created for induction training for the centre specific Positive Behaviour Support models to enhance the practical training already in place to ensure consistency of practical application by Youth Workers.

#### Recommendation 4

Develop a strategy to increase the ability of CPT within both centres to conduct therapeutic sessions to ensure young people receive therapeutic services as intended to support behaviour management.

### Focus Area 3 – Incident Management

#### Recommendation 5

- a) Planned Incident Controller training developed in consultation with the Queensland Police Service includes content regarding the efficient use of staff and equipment to minimise the duration and severity of incidents.

- b) Incident review, in addition to focusing on causes and preventative and measures leading up to an incident, also focuses on the management throughout the entirety of the incident to identify opportunities to efficiently manage incidents to minimise impacts on centre operations, young people and staff safety.

**Other Issues**

No recommendations made.