Executive Summary to Inspection Report Cleveland Youth Detention Centre March quarter 2013

The Director-General of the Department of Justice and Attorney-General has obligations under the *Youth Justice Act 1992* which include:

- Section 268 (1) Subject to this Act, the chief executive is responsible for … the safe custody and wellbeing of children detained in detention centres; and

- Section 268 (4) The chief executive must monitor the operation of the detention centres and inspect each detention centre at least once every 3 months.

The Youth Detention Inspectorate, within the Ethical Standards Unit of the Department, is charged with the responsibilities of undertaking quarterly inspections of both the Brisbane Youth Detention Centre (BYDC) and Cleveland Youth Detention Centre (CYDC), in Townsville, and providing a report to the Director-General for his consideration.

The inspection of CYDC took place from 11 to 15 March 2013. The primary inspection focus area was Medical and Health Service Provision for Young People in Custody. Under s263(3) of the *Youth Justice Act 1992* the Chief Executive is responsible for providing services that promote the health and wellbeing of children detained at the Centre.

The monitored areas were the use of physical force and the use of mechanical restraints. The Commission for Children Young People and Child Guardian's June 2012 report, *Investigation into the Use of Force in Queensland Youth Detention Centres,* recommended that the Youth Detention Inspectorate conduct particular monitoring of these areas. The reporting of harm to children in the Detention Centre was also monitored as Inspectors have previously raised concerns in relation to inconsistency and failure to identify and report harm adequately. The requirement to report harm is a statutory obligation under s268 of the *Youth Justice Act 1992*.

The criteria for each inspection focus area were derived from the Youth Detention Expectations Document (the Expectations). The Expectations are based on compliance with the Director-General's statutory obligations, United Nations Rules, recommendations from government inquiries such as the *Commission of Inquiry into Abuse of Children in Queensland Institutions* and the *Royal Commission into Aboriginal Deaths in Custody,* as well as best practices identified through the inspection process to encourage an environment of continuous improvement.

The inspection identified that young people in detention are provided with a range of medical services that are comparable to medical services provided in the community. The services include Clinical Nurses rostered on 24 hours a day, seven days a week; a Visiting Medical Officer (VMO) who attends the Centre three days a week; a Queensland Mental Health Team situated within the Centre; and a Dentist, who visits CYDC once a week. Young people who require specialist medical services not available within the Centre are provided with escorted leave to the Townsville Public Hospital or to a specialist clinic at the discretion of the VMO and Centre Director.

Overall, there was sufficient evidence for Inspectors to determine that the criteria for medical and health service provision were met. There were no significant concerns identified by the Inspectors or any issues raised by medical staff, young people or operational staff, in relation to this focus area. The findings are recorded against each relevant Expectations criterion. There are no recommendations relating to this focus area.

In relation to the monitored focus area of reporting harm (or alleged harm) to children in youth detention centres, the Inspectorate recommended that further development of this area was required. This opinion is based on a case study of a young person (A) within this report, noting that other incidents which involved identifying harm met the Department's reporting requirements.

It was considered that particular attention should be placed on the causes and risks of emotional and psychological harm to young people in detention. The Inspectorate identified two significant incidents involving 'A' which were not formally reported to the Assistant Director-General, Youth Justice as required by the approved policy and procedures to report harm or alleged harm of a young person in detention.

One incident involved 'A' tying a tee-shirt around his neck. A staff member discovered him lying on the floor unconscious and called an emergency code for assistance. The second incident involved staff members using restricted practices such as physical force, mechanical restraints and the forced removal of the same young person's clothes. These incidents comprise the case study outlined later in this report.

The Inspectorate has made a total of five recommendations that, if implemented as intended, will assist in ensuring the Director-General's statutory obligations are met.

Subsequent to the completion of the inspection there have been steps taken within the Department, and at CYDC, towards addressing the concerns referred to in this report.

These steps are discussed in more detail in the body of the report.