Executive Summary

This is a report of a quarterly statutory inspection of the Cleveland Youth Detention Centre. The on-site inspection occurred from 18 to 22 June 2018. Statutory detention centre inspections are conducted by delegated inspectors located in 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

Good controls on night-time observations are available. However, Inspectors found a lack of clarity among staff in how to conduct and record night-time observations of at-risk young people, although the centre's own standard operating procedure clearly requires use of bed check buttons where fitted. Ongoing monthly auditing is needed to ensure that observations are being conducted in accordance with this directive. The report makes recommendations to improve usage and monitoring of existing suicide risk controls and further increase training currency and coverage of trained staff in suicide risk response across all accommodation units.

Focus Area 2 – Separations

Data obtained for this inspection shows high and increasing numbers of separations of young people in locked rooms. This is correlated with frequent and ongoing staff shortages and other factors.

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.

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. Staff widely advised inspectors that they feel they have no tools to address poor behaviour, and that 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 direct non-physical behaviour management training.

The report makes recommendations to develop and implement a behavioural model as a matter of 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 and effective 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.