Executive Summary to Inspection Report Cleveland Youth Detention Centre March quarter 2015

The statutory inspection of the Cleveland Youth Detention Centre (CYDC) occurred from 9-13 March 2015. The primary inspection focus areas were:

- The transition of some female young people from the Brisbane Youth Detention Centre (BYDC) to CYDC.
- Suicide risk prevention and the reporting of harm.
- At the request of the Assistant Director-General, Youth Justice Services, Inspectors also reviewed two incidents in which a young person demonstrated suicidal behaviour.

Transition of female young people to CYDC

In January 2015, female young people from north and far north Queensland were transferred to CYDC from BYDC. To assist with the transition a safety management strategy was implemented by Youth Justice Services. The safety management strategy involved seconding a select team of staff from BYDC to CYDC for several weeks in a support role while the females adjusted to CYDC routines.

The majority of female young people spoken to by Inspectors were positive about the transition to CYDC, as they are closer to their families and able to have more frequent contact. This is important as it is well-documented that family contact can assist young people's rehabilitation and reintegration prospects.

The main concern raised by the female young people was the minimal amount of items they are able to purchase with their own money at CYDC, compared to the range of items available to them when in custody at BYDC. The Inspectors have recommended that the list of items be reviewed to be in line with the range available at BYDC.

Suicide risk and reporting of harm

In relation to suicide risk and reporting of harm, it was identified that from 1 January 2014 to 31 December 2014 there were 30 incidents of young people self-harming or attempting self-harm at CYDC. The Inspectors have raised concerns with Youth Justice Services in relation to occurrences of incidents, and have made recommendations that include reviewing the CYDC behaviour management system.

Review of critical incidents

The review of two critical incidents found that there were some good practices put in place by staff that prevented a serious incident becoming more serious. It was also found that additional therapeutic intervention strategies should be included in the young people's daily management plans to assist operational staff.

Inspectors have also raised concerns in relation to the use of mechanical restraints on some young people, as they have the potential to cause harm and need to be applied per policy.

Beginning on page 26, the report makes a total of 11 recommendations which will be monitored as part of the statutory inspection process in 2015-16.