Custodial Operations Practice Directive

Process Owner: Custodial Operations and Specialist Operations	Security Classification: Official/Public

Version: 09	Implementation date: 12/06/2024	Review date: 2025

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1. Human Rights

It is unlawful for corrective services officers to act or make decisions in a way that is not compatible with human rights, or in making a decision, fail to give proper consideration to a human right to the decision.

Giving proper consideration to human rights entails identifying human rights which may be relevant to a decision and considering whether the decision would be compatible with human rights.

A decision will be compatible with human rights when it does not limit a human right, or only limits a right to the extent that is reasonable and demonstrably justifiable.

Human rights which may be relevant include:

a) the right to privacy and reputation;
b) cultural rights – generally;
c) cultural rights – Aboriginal peoples and Torres Strait Islander peoples;
d) the right to humane treatment when deprived of liberty;
e) property rights; and
f) right to health services.

2. Limitation of Human Rights

In determining whether a limitation may be reasonable and demonstrably justified, the following factors are relevant to consider:

a) The nature of the human right- this involves looking at the purpose and underlying value of the human right. For example, the right to privacy and reputation provides that a person has the right not to have that person's privacy, family, home or correspondence unlawfully or arbitrarily interfered with.
b) The nature and purpose of the limitation – this involves considering the actual purpose or legitimate aim/reason for limiting the human right. This document provides for the processes that should be considered in the safe management of a prisoner who presents as being at risk of self-harm or attempted suicidal behaviour that has been determined through an assessment process with an appropriately trained staff member. The assessment process limits the prisoner's right to privacy by sharing the prisoner's personal information with relevant staff members directly involved with the management of that prisoner.
c) The relationship between the limitations and its purpose – this involves considering the connection between the limitation of the right and whether this will assist with achieving the purpose or legitimate aim. For example, does the limit to privacy, caused by the requirement to share information about the prisoner with relevant staff, assist in the management of the prisoner, with the least amount of risk to that prisoner?
d) The considerations around whether there are less restrictive or reasonable ways to achieve the purpose of safely managing the prisoner involves a 'necessity analysis'. This is where it is necessary to consider the purpose of the limitation and whether it can be achieved in any other way. For example, is there a less restrictive way to reduce the risk around managing a prisoner who is at risk of self-harm or attempted suicidal behaviour other than the development of an At Risk Management Plan that is communicated to staff that are responsible for the safe management of the prisoner?

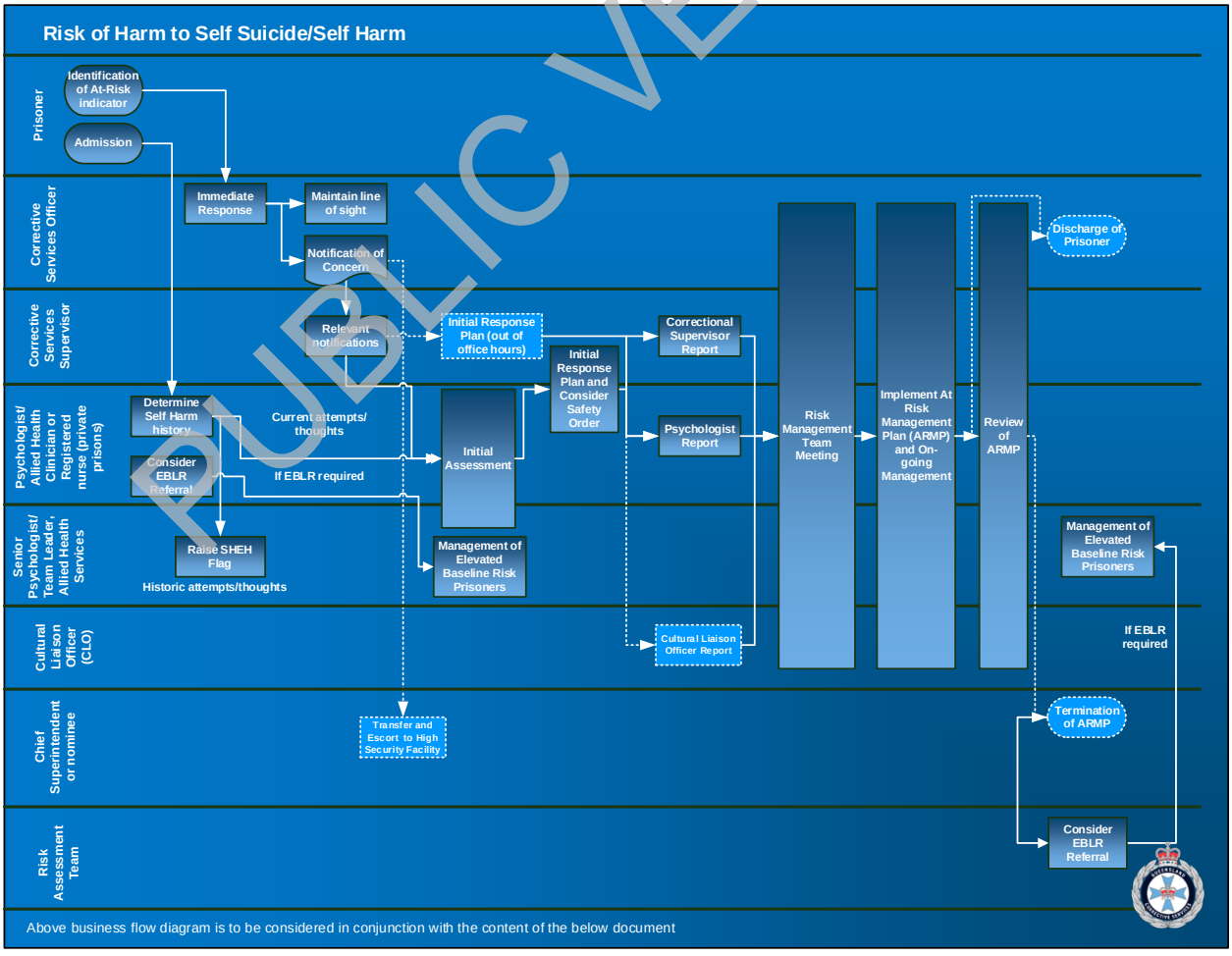
e) The importance between the purpose of the limitation and preserving the human right – this involves balancing the benefits obtained by the limitation with the harm caused to the human right. For example, does the development of an individual process that allows staff to manage the prisoner with the least amount of risk of self-harm or suicidal behaviour outweigh the impact of the limitations to privacy?

A person's human rights should only be limited to the extent that is reasonably and demonstrably justified.

QCS staff must treat all prisoners with respect. Prisoners must not be discriminated against or harassed on the grounds of their medical condition, sexual identity, gender identity, intersex status or related issues.

Considerations relevant to the Lesbian, Gay, Bisexual, Trans/transgender, Intersex, Queer/questioning and Asexual (LGBTIQA+) cohort of prisoners (where this is known) must be taken into account during any decision making. Decisions are to be made on a case by case basis following an individualised assessment of relevant factors, including relevant human rights and the reasonableness of the actions being considered.

3. At-Risk Management Process Map



4. Risk of Harm to Self

QCS has a duty of care to provide a safe environment for prisoners managed within QCS facilities and is committed to minimising the risk of prisoners self-harming and completing suicide.

Suicide is one of the world's leading causes of death and until recently was the main cause of death in custody. Prisoners are characteristically three to five times more likely to complete suicide than the general population, indicating admission into any type of custody is a risk factor. This is thought to be due to a lack of protective factors, such as a limited access to social supports, limited control over their environments and an unknown future.

There are some groups of prisoners that are found to have higher rates of suicide than others and should be monitored in accordance with their risk (see below for full list). This includes but is not limited to youthful prisoners, Aboriginal and Torres Strait Islander prisoners, those who identify as LGBTIQA+, those on remand, prisoners with chronic physical pain or physical illness and those in custody for the first time.

There are also certain periods throughout a custodial sentence that are considered higher risk than others and prisoners should be monitored in accordance with their risk during these periods (refer to the Appendix AR2 Periods of Critical Risk).

Best practice suicide prevention approaches in correctional settings are set out by the World Health Organisation's paper on suicide prevention in custodial facilities (refer to Preventing Suicide: A Resource for Prison Officers).

In order to prevent and manage any at risk behaviours, QCS employs comprehensive suicide prevention activities which include:

a) staff trained in identifying and responding to suicide and self-harm risk factors, triggers and warning signs;
b) robust procedures to manage acute risk;
c) working knowledge of vulnerable prisoner groups;
d) screening prisoners upon admission for suicide and self-harm and elevated baseline risk or suicide and/or self-harm;
e) reduction of access to lethal means via infrastructure and environmental controls, such as safer cells;
f) engagement of specialised mental health supports or services where prisoner needs are complex;
g) resilience and wellbeing programs that strengthen protective factors and support prisoners in crisis; and
h) targeted monitoring of vulnerable prisoners who demonstrate a chronic risk or elevated baseline risk of suicide and/or self-harm.

All staff involved in the management of prisoners have responsibilities and professional accountabilities in minimising harm and prevention of loss of life by:

a) completing relevant training about suicide prevention (including cultural awareness training);
    i. For example, staff must have an understanding of Aboriginal and Torres Strait Islander culture and history and how these factors influence the risk of self-harm or suicide for Aboriginal and Torres Strait Islander prisoners in custody;
b) being thoroughly familiar with the process of identification and management of "at-risk" prisoners within the corrections environment;
c) being alert to behaviours that may indicate that a prisoner is at-risk (refer to the Appendix AR1 Indicators of At Risk Behaviour);

d) being aware that particular events in a prisoner's life may elicit self-harm, suicide and attempted suicide and should address any perceived anxiety a prisoner may have in relation to the at-risk management process (refer to the Appendix AR2 Periods of Critical Risk);
e) being aware of individuals and groups who are more vulnerable to at-risk behaviour (refer to the Appendix AR3 Predisposing Risk Factors);
f) having a knowledge and understanding of the responsibilities of officers responding to emergency incidents;
g) utilising the least intrusive measures possible without compromising the prisoner's wellbeing so as to make it more likely that they will self-report feelings of self-harm and/or suicide;
h) addressing any perception by the relevant prisoner that the measures taken are punitive rather than therapeutic; and
i) being aware of prisoners that are considered to be an elevated baseline risk of self-harm and/or suicide and taking prompt action if imminent risk factors are present (refer to the Custodial Operations Practice Directive (COPD) At Risk Management: Elevated Baseline Risk).

4.1 Centre responsibilities

Centre responsibilities include:

a) considering the human rights of the prisoner and, if making a decision that would limit these rights, ensuring that the limit is reasonable and proportionate in the circumstances treating any action taken by a person to self-harm or end their life as an attempt to complete suicide;
b) ensuring safer design sheets, gowns, pillows, doonas and physical restraints are available at all secure facilities for issue to and use in the management of prisoners identified as being at risk of self-harm or suicide following consideration of the prisoner's individual circumstances and the assessed risk level;
c) ensuring safer design items (including sheets, gowns, pillows, doonas, etc.) are not used as a substitute for appropriate physical observations of the at risk prisoner;
d) ensuring all actions taken to preserve a person's life must continue until the person has been declared life extinct by a registered nurse, ambulance officer or doctor;
e) ensuring staff do not place themselves in a position where there is risk to their own personal safety when responding to an emergent incident; and
f) ensure that any special needs of the prisoner are properly considered including cultural and linguistic needs, religious, medical or dietary requirements.

Relevant managers must ensure:

a) protocols, contingency plans and staff training are implemented to manage at risk and self-harming behaviour by prisoners within the workplace, in particular, the critical period from the commencement of the emergency;
b) the assessment and/or observations of at risk prisoners are prioritised; and
c) appropriate emergency telephone contacts for an "at-risk behaviour" situation are clearly identified and displayed in prominent positions within the workplace.

Should any situation arise where any staff member is of the view that a medical situation should be escalated outside the standard practice, the process in the Appendix AR8 Response to Urgent Medical Concerns may be implemented by the Chief Superintendent of the centre.

4.2 Allied health clinicians

Psychologists, Occupational Therapists and/or Social Workers appointed to the following positions are approved to conduct (or are responsible for) mental health at-risk assessments:

a) Allied Health Clinician;
b) Senior Allied Health Clinician;
c) Team Leader, Allied Health Services; and
d) Manager, Allied Health.

All allied health professionals listed above must hold relevant qualifications, registration and/or accreditation with the relevant national board/professional association to practice.

4.3 Identification of at-risk indicator

A self-harm/suicide risk assessment must be undertaken:

a) if officers are alerted to behaviours that may indicate that a prisoner is at risk of self-harm or suicide (refer to the Appendix AR1 Indicators of At Risk Behaviour);
b) if officers are aware of particular events in a prisoner's life that may elicit self-harm or suicide (refer to the Appendix AR2 Periods of Critical Risk);
c) following transfer of a prisoner if a prisoner applies for protection status;
d) if a prisoner demonstrates self-harming/suicidal behaviour;
e) if a prisoner expresses an intent to self-harm or commit suicide (refer to the Hunger Strikes section of this COPD); or
f) if other events arise for a prisoner that may be potentially distressing (e.g. outcome from a court/board proceeding, pending discharge from custody to the community)(refer to the Appendix AR2 Periods of Critical Risk).

Staff must ensure that appropriate notifications and referrals for assessment are conducted and the referring officer must record the event as a case note. If a Notification of Concern is not required, the assessing psychologist/allied health clinician must record the details of the assessment as a case note. [redacted]

Staff must maintain an awareness of the specific at-risk management issues pertaining to offenders with special needs including:

a) Aboriginal and Torres Strait Islander prisoners;
b) female prisoners;
c) youthful prisoners (under 25 years of age);
d) prisoners from culturally and linguistically diverse backgrounds;
e) prisoners with an intellectual disability/cognitive impairment;
f) prisoners with a psychological/psychiatric disability or disorder;
g) prisoners with a history of self-harm or attempted suicide;
h) aged prisoners; and
i) LGBTIQA+ prisoners.

5. Risk of Harm to Self: Identification, Screening and Assessment of Risk

5.1 Risk identified upon admission

Admission is a time of critical risk. When admitted to custody, a prisoner must be assessed for risk of self-harm or suicide (refer to the COPD Reception Processes: Admission and Assessments and COPD Offender Pathways).

5.2 Immediate Risk Needs Assessment (IRNA)

An IRNA is to be conducted on each prisoner upon admission by a counsellor, psychologist or allied health clinician to identify any immediate risks or needs that require attention. Refer to section 21(3) of the *Corrective Services Act 2006* (CSA). Staff undertaking IRNAs must have successfully completed the mandatory IRNA online training module, accredited suicide awareness/prevention training, and cultural awareness training before commencing this task. Risks which are screened for include: risk of harm to self, to others, or from others; institutional risks; psychiatric/psychological factors; intellectual disability; medical history; and ageing and physical infirmity.

Prisoner records, including IOMS, should be accessed to ascertain the prisoner's self-harm and suicidal behaviour history. If any suicide or self-harm items are endorsed then the prisoner must be interviewed by a psychologist/allied health clinician for a full assessment of the prisoner's at-risk-status. The prisoner will also be assessed for elevated baseline risk of self-harm and/or suicide (refer to the COPD At Risk Management: Elevated Baseline Risk)

If past, immediate or elevated baseline risk of suicide or self-harm is not identified, then the prisoner requires no further assessment or warning flags.

If prisoners are admitted to the facility and an IRNA cannot be undertaken, the prisoner must be assumed to be at-risk until an IRNA and/or an initial risk assessment by a psychologist/allied health clinician can be completed. The prisoner must remain in the line of sight of a custodial officer until a risk assessment can be completed and any required subsequent action is taken (i.e. observations commenced). Refer to Immediate response - maintain line of sight section of this COPD.

Refer to the COPD Reception Processes: Admission and Assessments and COPD Offender Pathways.

5.3 IRNA Risk Assessment

When risk factors related to suicide or self-harm are identified via the IRNA, an initial assessment of risk must be completed by a psychologist/allied health clinician as soon as practicable and prior to the prisoner being placed in an accommodation unit. A full assessment of at-risk status, similar to the initial assessment undertaken following a Notification of Concern, should consider all relevant factors in determining a prisoner's level of risk.

The assessing psychologist/allied health clinician must detail a list of both protective and risk factors for the individual being assessed and provide a summary of how they have balanced and assessed the relevant factors of the case to determine the level of risk.

The purpose of the risk assessment is to consider acute risk of suicide and/or self-harm. This interview may occur at the same time as the IRNA if the IRNA was conducted by a psychologist/allied health clinician but must be considered a separate assessment and documented as such on IOMS.

If a prisoner will not co-operate with an at-risk assessment, it must be assumed that they are at-risk until this can be determined otherwise. The prisoner must remain in the line of sight of a custodial officer until a risk assessment can be completed and any required subsequent action is taken (e.g. observations commenced). Consider the Appendix AR1 Indicators of At Risk Behaviours and Appendix AR2 Periods of Critical Risk to guide decisions around interim management of at risk prisoners.

If the prisoner has no identifiable acute suicidal or self-harm risk factors present but has a history of self-harm and/or suicide, then the prisoner is required to be placed in a safer cell. The staff member who becomes aware of this information must notify the Senior Psychologist/Team Leader, Allied Health Services and correctional supervisor. The Senior Psychologist/Team Leader, Allied Health Services is responsible for the activation of a Self-Harm Episode History (SHEH) warning flag in IOMS. As per standard daily supervision requirements, staff are to remain vigilant in identifying and recognising any warning signs, triggers and imminent risk factors. Refer to the COPD Reception Processes: Admission and Assessments, COPD Offender Pathways, COPD Sentence Management: Admission and Induction, and the Appendix SM1 Criteria for Warning Flag Indicators.

If the prisoner presents with ongoing risk factors that place them at an elevated risk of suicide or self-harm but is assessed as not currently being acutely at risk, and therefore does not require observations, the prisoner should be referred for consideration under the Elevated Baseline Risk (EBLR) process. This process requires additional monitoring and intervention beyond standard supervision processes. Refer to the COPD At-Risk Management: Elevated Baseline Risk.

If the prisoner is identified as being at risk and requires observation, then an Initial Response Plan must be completed. Refer to the Risk of Harm to Self: Management of At-Risk Prisoners (Post Initial Assessment) section of this COPD.

6. Risk Identified at Any Time During the Custodial Period

6.1 Immediate response – maintain line of sight (excluding Helana Jones Centre and Princess Alexandra Hospital Secure Unit (PAHSU))

If at any time during a prisoner's custodial episode, there is any reason to believe that a prisoner may be at risk of self-harm or suicide, the prisoner must be kept in a corrective services officer's **line of sight at all times** to minimise the risk of self-harm and suicide until a Notification of Concern is actioned, an initial assessment is conducted by a psychologist/allied health clinician and any required subsequent action is taken (e.g. observations commenced).

If an attempt to self-harm, suicide or apparent death is identified refer to the COPD Incident Management: Incident Management Process and COPD Incident Management: Death in Custody.

Medical and psychological assistance must be provided to the prisoner as soon as practicable. If necessary, a transfer without notice should be arranged to a secure facility where these services can be provided (refer to the Transfer and Escort to Secure Facility section of this COPD).

In low custody facilities where adequate assessment and ongoing observation are not possible, the Chief Superintendent or nominee of a corrective services facility should arrange for the transfer of the prisoner to an appropriate secure facility where appropriate levels of support and intervention may be received (refer to the Transfer and Escort to Secure Facility section of this COPD). Medical and psychological assistance must be provided to the prisoner as soon as practicable.

For at-risk prisoners accommodated in the Maximum Security Unit (MSU), refer to the COPD Prisoner Accommodation Management: Maximum Security Unit.

If, after an outcome from a court/board proceeding that may be potentially distressing (i.e. refusal of bail, jury verdict of guilty, sentence of imprisonment, refusal/deferment of a prisoner's parole application, suspension/cancellation of parole order), the prisoner is brought to, remains in, is transferred or is returned to a corrective services facility, if the prisoner presents with any indicators of distress or if concerns are raised by staff, the prisoner must be seen by a psychologist/allied health clinician for a self-harm/suicide risk assessment or reassessment to be conducted.

On occasions when a psychologist/allied health clinician is not available within a reasonable time frame, a prisoner must be managed on a high or continuous level of observations until able to be assessed by a psychologist/allied health clinician. The level of observations will be dependent on the prisoner's presentation and risk factors.

All staff involved in the management of a prisoner who may be at risk must be advised of the risk level of the prisoner and of any specific management requirements.

6.2 Notification of Concern (excluding Helana Jones Centre and PAHSU)

If a prisoner is identified as being at risk of self-harm or suicide, a corrective services officer must immediately report these observations to the correctional supervisor and complete an Administrative Form 53 Notification of Concern, as soon as practicable. Refer to the Appendix AR1 Indicators of At Risk Behaviours.

6.3 Relevant notifications (excluding Helana Jones Centre and PAHSU)

Once advised that a prisoner may be at risk of self-harm or suicide, the correctional supervisor must immediately ensure the safety of the prisoner and must notify:

a) the relevant accommodation manager (or duty manager after hours); and
b) the Senior Psychologist/ Team Leader, Allied Health Services or a psychologist/allied health clinician.

If the prisoner identifies as an Aboriginal or Torres Strait Islander, the correctional supervisor must also notify the relevant Aboriginal and Torres Strait Islander staff members (e.g. cultural liaison officer, correctional counsellor, psychologist, allied health clinician, support worker and/or any other relevant corrective services officer).

The correctional supervisor may, if appropriate and in line with Queensland Government Information Privacy Principles, notify family members and/or Aboriginal and Torres Strait Islander Elders to arrange contact with the prisoner (i.e. via a visit, telephone call or video link-up). Queensland Government Information Privacy Principles are available at: http://www.rti.qld.gov.au.

6.4 Initial assessment

Following the completion of an Administrative Form 53 Notification of Concern, an initial assessment of risk must be conducted by a psychologist/allied health clinician as soon as practicable. The initial assessment is a comprehensive assessment of the prisoner's current risk factors, triggers, self-harm and or suicidal behaviour, current mental status, and the presence of any protective factors.

While acknowledging past experience of a prisoner is important when completing a risk assessment, the assessing psychologist/allied health clinician must ensure they do not undervalue a prisoner's current at-risk symptomology on the basis of such past experience.

It is not appropriate to assume that management responses adopted previously that may have been effective will necessarily be the most appropriate to address the current symptomology. For example, if a prisoner's current anxiety levels are elevated, the assessing psychologist/allied health clinician should consider the most appropriate response to address the current increase in anxiety. Refer to the Appendix AR1 Indicators of At Risk Behaviours.

If it is identified during the initial assessment or ongoing management that the at risk prisoner is presenting with symptoms of anxiety or distress, the assessing psychologist/allied health clinician should consider what risk factors or triggers may be contributing to the prisoner's presentation. Anxiety can be a reaction to certain situations or life events which may be uncertain, challenging or unfamiliar for the prisoner. Suitable strategies for addressing and managing any ongoing anxiety should be considered. This may include engagement with a correctional counsellor, psychologist, allied health clinician or corrective services officer to help the prisoner identify and manage the factors that contribute to the prisoner's anxiety within the corrective services facility. Any management strategies should consider the individual needs of the prisoners and may include the provision of information/support to address any specific concerns or referral to other services for further support or input (e.g. correctional counsellor, psychologist/allied health clinician, Cultural Liaison Officer, program officer, Re-entry Services, health services, etc.).

The at-risk assessment (initial assessment) should consider the prisoner's levels of distress and anxiety and ensure that the resulting level of observations is consistent with such factors.

The assessing psychologist/allied health clinician must detail a list of both protective and risk factors for the individual being assessed and provide a summary of how these factors are weighted in the practitioner's assessment of the prisoner's overall risk of self-harm and/or suicide.

If a prisoner will not co-operate with an at-risk assessment (initial assessment), it must be assumed that they are at-risk until this can be determined otherwise. The prisoner must remain in the line of sight of a custodial officer until a risk assessment can be completed and/or any required subsequent action is taken (e.g. observations commenced).

If following the raising of a Notification of Concern, a complete at risk assessment cannot be completed for other reasons (outlined below), the prisoner must be considered to be at risk, and managed on a high or continuous level of observations, until such time as a full risk assessment can be made. This may be due to a refusal to engage in certain parts of the assessment, or an inability to engage due to mental health factors (such as active psychotic symptoms, dementia, or altered state of consciousness). The level of observations will be dependent on the prisoner's presentation and risk factors.

6.5 After hour considerations

If a psychologist/allied health clinician is not available to do the Initial Assessment (After Hours Considerations)

Where an Initial Assessment following a Notification of Concern cannot be conducted as there are no psychologists/allied health clinicians available after business hours, the prisoner is to be placed on a high or continuous level of observations. The level of observations will be dependent on the prisoner's presentation and risk factors. Consideration should be given to the Appendix AR1 Indicators of At Risk Behaviours and Appendix AR2 Periods of Critical Risk to guide decisions around interim management of at risk prisoners.

An Administrative Form 54 Initial Response Plan and Administrative Form 57 Observation Log are to be completed by the correctional supervisor.

The correctional supervisor is to brief the duty manager and gain approval for the Administrative Form 54 Initial Response Plan. This approval is to be written onto the Initial Response Plan and entered as an IOMS case note, under the At-Risk (Suicide/Self-harm) Management category. The prisoner is to remain in a corrective services officer's line of sight at all times until the Administrative Form 54 Initial Response Plan has been approved.

A psychologist/allied health clinician is to conduct an assessment as soon as practicable on the next business day, at which time the assessing psychologist/allied health clinician, in consultation with the Senior Psychologist/Team Leader, Allied Health Services will determine whether continuing observations are required.

6.6 Outcome of initial assessment: observation not required

For prisoners assessed during the initial assessment as not being at risk by a psychologist/allied health clinician the assessing officer must ensure that the most conservative approach to the ongoing management of the prisoner has been adopted in consultation with the notifying officer and relevant correctional supervisor. The assessing officer must consult the Senior Psychologist/Team Leader, Allied Health Services before determining that an Administrative Form 54 Initial Response Plan and observations is not required.

If it is determined that continuing observations are not required, then the psychologist/allied health clinician must enter the relevant information from the Administrative Form 53 Notification of Concern and the outcome of the Initial Assessment into IOMS (NoC-IA-IRP) as a Notification of Concern only episode. Details of any other interventions required or placement/accommodation recommendations should be clearly documented.

Relevant information from the Administrative Form 53 Notification of Concern and Administrative Form 56 Initial Assessment At-Risk Prisoner must also be entered in IOMS (case note) as soon as practicable by the assessing officer and attached electronically under the attachment tab in the NoC only episode. The hard copy documents must be placed on the offender management file.

For prisoners who have had a Notification of Concern raised after hours, who are assessed by a psychologist/allied health clinician as not being at risk, the Administrative Form 54 Initial Response Plan that had been created after hours is to be terminated and ratified by the Chief Superintendent or nominee of the corrective services facility. The hard copy documents must be placed on the offender management file and attached electronically under the attachment tab in the NoC only episode.

Prisoners who are assessed as not posing an immediate/acute risk of suicide or self-harm, should be assessed to determine if they present with chronic or EBLR of suicide or self-harm. The purpose of the EBLR procedure is to ensure those with chronic or an elevated baseline risk of suicide and/or self-harm are managed in accordance with their presenting risks and needs when not under observation for acute risk. This specifically monitors prisoners who may not present as acutely at risk in a way that requires observation, but who, due to the presence of a range of risk factors, may be more likely to enter or return to an at risk state. Refer to the COPD At Risk Management: Elevated Baseline Risk.

7. Risk of Harm to Self: Management of At-Risk Prisoners (Post Initial Assessment)

7.1 Outcome of initial assessment: observations required

Regardless of whether an at-risk prisoner was identified upon admission to a centre, or through a Notification of Concern at any other point of their incarceration, once the initial assessment has been undertaken and the prisoner is considered to be at risk, the following steps should be taken.

[redacted]

7.2 Initial response plan and consider Safety Order

After the initial assessment has been completed and the prisoner is identified as being at acute risk of suicide or self-harm, the correctional supervisor and the psychologist/allied health clinician must develop an Initial Response Plan. Refer to the Administrative Form 54 Initial Response Plan.

An observation regime is a standard component of Initial Response Plans. The observation level must be set by the assessing psychologist/allied health clinician in consultation with the Senior Psychologist/Team leader, Allied Health Services. The consultation outcomes and attendees' names (i.e. assessment officer and Senior Psychologist/Team leader, Allied Health Services) must be recorded as a case note in IOMS.

The immediate management of an at-risk prisoner must ensure their physical safety from self-harm or suicide. Refer to the Appendix AR4 Risk Level/Observation Guidelines.

Observations levels are as follows:

a) a prisoner considered to be at an extreme risk of suicide or self-harm must be monitored under continuous physical observations;
b) a prisoner considered to be at a high risk of self-harm or suicide must be monitored under 15 minute or 30 minute physical observations;
c) a prisoner considered to be at a medium risk of self-harm must be monitored under 60 minute physical observations; and
d) a prisoner considered to be at a low risk of suicide or self-harm must be monitored on 120 minute physical observations.

The frequency of observations must take into account the nature of the situation, the individual needs and circumstances of the prisoner, and the level of risk. The correctional supervisor must ensure the required observations occur in a manner that ensures the continued wellbeing of the prisoner.

The assessing psychologist/allied health clinician must consult with the Senior Psychologist/Team Leader, Allied Health Services in order to determine the appropriate observation level for the prisoner.

Refer to the Administrative Form 54 Initial Response Plan.

If an Initial Response Plan is generated, the relevant information from the Administrative Form 53 Notification of Concern (NoC), Administrative Form 56 Initial Assessment and the Administrative Form 54 Initial Response Plan must be entered into IOMS (NoC-IA-IRP) as soon as practicable by the assessing officer. The hard copy documents must be placed on the offender management file and attached electronically in the relevant sections of the self-harm episode.

Other specific details of the Initial Response Plan must be filled out on an individual case by case basis and reflect the specific management requirements for that particular prisoner, in accordance with their assessed risks and needs. This will include an assessment of the prisoner's accommodation needs, use of a safety order in accordance with section 53 of the CSA and section 7 and 8 of the Corrective Services Regulation 2017, level of observations, and conditions (clothing, bedding, towels, phone calls, visits, and access to other items).

Consideration must also be given to the infrastructure within the centre, and staff should be familiar with their centre's accommodation and placement options. Staff must consider the centre's infrastructure requirements when completing the Initial Response Plan.

7.3 Shared cell accommodation considerations

Ordinarily an at-risk prisoner should be accommodated in a single cell, however the RAT panel may determine that an at-risk prisoner is suitable for shared cell accommodation.

In addition, where there are extenuating circumstances, including where the at-risk prisoner cannot be otherwise safely accommodated, the assessing psychologist/allied health clinician may assess that the at-risk prisoner is suitable for shared cell accommodation as part of the initial assessment. This decision must be made in consultation with the Senior Psychologist/Team leader, Allied Health Services and a Correctional Supervisor and documented in the Administrative Form 54 Initial Response Plan. The Chief Superintendent of the corrective services facility or nominee must also be advised.

Where a prisoner is identified as Aboriginal and/ or Torres Strait Islander consultation should also occur where practicable with a Cultural Liaison Officer.

The determination must be based on the considerations detailed in the COPD Prisoner Accommodation Management: Cell Allocation - Shared Cell Accommodation Allocation, and an assessment of risk. The suitability of the shared cell placement must then be assessed through the Risk Assessment Team (RAT) meeting as soon as practicable.

In circumstances where concerns are raised for the safety or wellbeing of either prisoner, then the shared cell arrangement must be ceased and the at-risk prisoner accommodated in a single cell until the matter can be referred to the RAT panel for further consideration.

7.4 Issuing of safer design clothing, bedding and towels

An at-risk prisoner who is assessed to be an extreme risk (requiring continuous observations) or a high risk (requiring 15 or 30 minute observations) is to be issued a safer design towel (where available) only for the time required while the prisoner is showering. The towel is to be retrieved from the prisoner after use and is not to remain in the prisoner's cell.

A corrective services officer issuing safer design clothing, bedding or towels to an at-risk prisoner is to undertake a visual inspection of each of the items prior to issue. The inspection is to ensure the items do not display signs of excessive wear, or any damage to the fabric or stitching of the items. Where there are signs of excessive wear or any damage to the item, the officer must not issue the items to the at-risk prisoner.

7.5 Further considerations

Hard copies of the Administrative Form 53 Notification of Concern, Administrative Form 56 Initial Assessment and Administrative Form 54 Initial Response Plan must be forwarded to the:

a) correctional supervisor;
b) Queensland Health Nurse Unit Manager/registered nurse;
c) Senior Psychologist/ Team Leader, Allied Health Services;
d) relevant manager;
e) observing officer; and
f) Chief Superintendent or nominee of the corrective services facility.

If it is determined that the prisoner must be separated under the at risk management process, the prisoner must be placed on a Safety Order. Refer to the COPD Prisoner Behaviour Management: Safety Orders.

In addition to observations, additional interventions, support, or management strategies may include:

a) support visits (i.e. from an Elder for Aboriginal and Torres Strait Islander prisoners, or a Chaplain), phone calls to/from family members (if deemed appropriate by the Senior Psychologist/Team Leader, Allied Health Services or RAT);
b) removal of property from a cell that may pose a risk to self-harming activity;
c) accommodation in the Health Centre at night;
d) separate accommodation area for day/night placement;
e) peer support systems as detailed in the Peer supports for prisoners at-risk of suicide or self-harm section in this COPD;
f) increasing the level of observations; and
g) if it is considered necessary and only if required:
    i. search the prisoner (which may require the removal of clothing);
    ii. placement in cell accommodation appropriate to the level of assessed risk;
    iii. use of safer design gown and bedding;
    iv. placing the prisoner on a Safety Order as per section 53 of the CSA.

Individualised assessments must be conducted when considering a prisoner's access to sanitary items (sanitary pads, tampons) and underwear, and must consider the least restrictive options available. If removing access to one or all of these items is critical to safety, a human rights impact assessment must be completed and the identified risk and assessment must be recorded in the relevant Initial Response Plan (IRP) or At Risk Management Plan (ARMP).

7.6 Future actions and ongoing management

The RAT must be convened as soon as practicable following the Initial Assessment and implementation of an Administrative Form 54 Initial Response Plan. Refer to the Risk of Harm to Self: Ongoing Management section of this COPD.

8. Observations

An observation regime is a standard component of Initial Response Plans and At Risk Management Plans (ARMP).

Observations must be expressed in terms of frequency relative to the level of risk. A prisoner considered an extreme risk of suicide or self-harm must be monitored under continuous observations. 15 minute or 30 minute physical observations are considered as being managed as a high risk of self-harm or suicide. A prisoner on 60 minute physical observations is considered as being managed as a medium risk of self-harm or suicide and a prisoner on 120 minute physical observations is considered as being managed as a low risk.

Observations may include:

a) physical observations – to physically observe the prisoner move or respond (i.e. move around freely or at least to note and observe them breathing normally); and
b) visual observations – to monitor the prisoner using CCTV.

Visual observations can be used as a supplement to, but **NEVER** a substitute for, scheduled physical observations. Visual observations must not be used to replace physical observations at any time. For example, if a prisoner requires 15 minute observations, they must be subject to a physical observation each 15 minutes. They must be physically observed every 15 minutes and may be visually observed between physical observations. The corrective services officer who undertakes the observation, must record it on the Administrative Form 57 Observation Log – At-Risk Prisoner.

If continuous observations are ordered, a corrective services officer must be assigned for the specific purpose of continuous observation. During continuous observation of a prisoner, the officer responsible must indicate that observations are continuous and record observations at 10 minute intervals in the observation logs. This information must be recorded on the appropriate form and in IOMS.

If it is determined that the most appropriate method of conducting observations of an at-risk prisoner results in the prisoner's separate confinement in a detention unit, safety unit or health centre, a Safety Order must be approved by the Chief Superintendent or nominee of the corrective services facility prior to the prisoner's separate confinement. The prisoner must be kept in a corrective services officer's line of sight at all times until observations commence in the detention unit, safety unit or health centre. Conditions imposed under section 53(3) of the CSA must be clearly defined and documented on the order prior to the prisoner commencing separate confinement (refer to section 53 of the CSA, the Approved Form 5 Safety Order, the COPD Prisoner Behaviour Management: Safety Orders and the COPD Prisoner Accommodation Management: Detention Unit).

The correctional supervisor must brief the corrective services officer responsible for the observation of the prisoner and provide an Administrative Form 57 Observation Log – At-Risk Prisoner for recording observations, including the requirement to record behavioural surveillances during the observation period.

The correctional supervisor must review and sign the Administrative Form 57 Observation Log – At-Risk Prisoner to ensure compliance with the Administrative Form 54 Initial Response Plan (if an ARMP has not yet been developed) or the Administrative Form 63 At Risk Management Plan at least once per shift, unless greater frequency is determined.

Each observing officer must:

a) sign the Administrative Form 63 At Risk Management Plan or Administrative Form 54 Initial Response Plan to acknowledge that they have received, reviewed and understood the contents of the form;
b) initial and record the time the officer undertook the particular observation on the Administrative Form 57 Observation Log – At Risk Prisoner. Wherever possible, this should be completed at the time of the observation. On occasions where this is not possible, this must be completed as a priority task and as soon as practicable after undertaking the observation; and
c) brief any other officer performing relieving duties of the observation requirements.

Observation logs must be retained as a physical document in the offender management file. Refer to the QCS Retention and Disposal Schedule.

If a prisoner's identified level of risk is reduced, the level of observations must also be reduced. For example, if a prisoner's identified level of risk is reduced from high risk to medium risk, the level of physical observations will be reduced from 30 minutes to 60 minutes.

If an observing officer believes a prisoner's risk of self-harm or suicide is escalating, these concerns must be documented on the observation log and the correctional supervisor must be notified immediately. Consideration must be given to increasing the observation level and other appropriate action/s.

If any staff member has concerns about an at-risk prisoner's escalating risk of self-harm or suicide, a new Administrative Form 53 Notification of Concern must be initiated and all relevant steps from the immediate response section onwards be followed (i.e. as though a new at-risk episode has been initiated), unless the current observation level is already at extreme, where a supervisor or manager may consider using professional discretion according to the presenting behaviour and risk factors.

Under a circumstance where a prisoner is currently being managed under an extreme risk of suicide or self-harm and is subject to continuous physical observation, professional discretion should be utilised regarding whether a new Administrative Form 53 Notification of Concern is required following further threats or actions of self-harm (or other risk indicators) where there is concern that the current management plan is not sufficient in managing the presenting risk.

During the observation period the prisoner's general behaviour, not limited to self-harm/suicide risk indicators, must also be recorded on the Administrative Form 57 Observation Log – At-Risk Prisoner.

The correctional supervisor must be notified immediately and/or a response code called for an act of deliberate physical self-harm.

The frequency of review of observations is determined on an individual needs basis in consultation with the RAT. However, the minimum requirement for a review of observations is once per week (i.e. seven days) per prisoner. In considering the frequency of review of observations, consideration should be given to ensuring there has been sufficient time for the prisoner to demonstrate a change in risk and stability in changes.

The Chief Superintendent or nominee may authorise an increase, maintenance, cessation or reduction of observation levels following the RAT meeting recommendations. If an increase in the observation level is recommended, a new Notification of Concern must be raised.

9. Risk of Harm to Self: Queensland Health Services (including PAHSU) and Low Security Facilities

9.1 Psychological and cultural support for prisoners receiving in-patient services at a hospital or other health service (excluding PAHSU)

Where an identified need arises (e.g. a prisoner expresses suicidal ideation), QCS staff are to liaise with Queensland Health to raise awareness of the issue and ensure there is a corresponding case note that this liaison has taken place.

9.2 Princess Alexandra Hospital Secure Unit (PAHSU)

Management of prisoners admitted as inpatients to the PAHSU will become the responsibility of the PAHSU Medical Director. The PAHSU Medical Director, Nursing Coordinator, correctional supervisor or custodial representative in consultation will determine the appropriate management of at-risk prisoners while admitted as inpatients.

9.3 Observations

The PAHSU Medical Director will determine observation requirements for prisoners admitted to the PAHSU. Corrective services officers situated in the outpatients ward are responsible for conducting observations of at-risk PAHSU day patients.

9.4 Low custody (including Helana Jones Centre)

If a prisoner may be at-risk of self-harm or suicide, the officer must:

a) undertake appropriate interim action (e.g. talk with the prisoner, show concern, ask questions, identify precipitators);
b) advise staff in the immediate area of the officer's concerns;
c) arrange for placement of the prisoner in an area where they can be closely monitored until any required subsequent action is taken (e.g. observations commenced);
d) ensure that the Chief Superintendent or nominee of the corrective services facility is notified as soon as practicable;
e) if services are available, notify the Queensland Health Nurse Unit Manager/registered nurse;
f) notify the Senior Psychologist/Team Leader, Allied Health Services; and
g) complete the Administrative Form 53 Notification of Concern as soon as possible and forward to the Chief Superintendent of the corrective services facility or nominee.

10. Risk of Harm to Self: Other Considerations

10.1 Peer supports for prisoners at-risk of suicide or self-harm

The relevant manager must, at a minimum:

a) coordinate the internal and external responses to manage the security and integrity of the entire facility;

b) arrange further assessment;
c) if appropriately qualified, personally determine at-risk level; or
d) where assessment and ongoing observation are not possible, arrange for the transfer of the prisoner to an appropriate secure facility where appropriate levels of support and intervention can be received (refer to the Transfer and Escort to Secure Facility section of this COPD).

If an attempted self-harm, suicide or apparent death is discovered, refer to the COPD Incident Management: Incident Management Process and COPD Incident Management: Death in Custody.

The provision of peer support by prisoners can be an additional resource to supplement the QCS at-risk management process.

Peer support can be defined as:
a) accommodation arrangement – placing a prisoner assessed as being at-risk of self-harm or suicide with another prisoner not currently considered to be at-risk to provide emotional and social support; or
b) a formal Peer Support Program – a more structured program involving prisoners actively performing roles such as risk identification, provision of support and basic counselling.

The provision of peer support is intended to augment but not replace the formal at-risk management approach.

It is not mandatory that all at-risk prisoners are provided with peer support, but RATs should consider the suitability of providing a prisoner with peer support when developing the ARMP, taking into account any cultural and additional individual needs of the prison particularly for Aboriginal and/or Torres Strait Islander prisoners.

When determining appropriate prisoners who could be selected to double-up with at-risk prisoners, the Chief Superintendent must ensure that a suitability assessment is conducted and consent for the accommodation arrangement is provided by both prisoners. Refer to the Further shared cell accommodation considerations for at-risk prisoners section of this COPD.

Chief Superintendent should implement appropriate controls to ensure peer support systems (both double-up accommodation and structured programs) are adequately oversighted.

If a Chief Superintendent elects to implement a structured Peer Support Program at their corrective services facility the scope should be determined at the local level. Prisoners in a structured Peer Support Program should be carefully selected and receive training prior to commencing in the peer support role. This training could include suicide awareness, basic counselling skills, active listening skills and how the role of peer support fits in the broader agency at-risk management approach.

By way of suggestion of what a Peer Support Program could look like, details of a successfully implemented peer Support Program are outlined in the Appendix AR5 Peer Support Worker Program.

10.2 External supports

The Senior Psychologist/Team Leader, Allied Health Services should give consideration to contacting the prisoner's next of kin/family members to seek information regarding issues of concern. If deemed appropriate, this should only be done with the informed consent of the prisoner or in accordance with the COPD Confidential Information: Disclosure of Confidential Information.

10.3 At-risk low custody

The Contingency Checklists must be completed by the relevant person. Refer to the Administrative Form 59 At Risk First Officer Response Low Custody and Administrative Form 60 At Risk Supervisor Response Low Custody.

11. Placement of a Prisoner in a Padded Cell

A padded cell should only be used as a last resort for placement, having considered all other placement options and the balance between the necessity of the placement and the prisoner's human rights.

Padded cells are to be used only after due consideration for the best management of the prisoner in line with duty of care principles. Placement of a prisoner in a padded cell should only occur if the prisoner is assessed as being at imminent risk of engaging in self-harming behaviours that places the prisoner at risk of death or serious injury.

Placement of a prisoner in a padded cell involves the prisoner being separated from the general prisoner population and therefore the requirements of a Safety Order under section 53 of the CSA must be adhered to (refer to the COPD Prisoner Behaviour Management: Safety Orders).

Placement in a padded cell should only occur for the minimum time necessary to manage the prisoner's imminent risk of engaging in self-harming behaviours.

A review of a prisoner's placement in a padded cell must occur in accordance with at risk management process within 24 hours of placement in the padded cell or next business day as coordinated by a psychologist/allied health clinician.

11.1 During business hours

The Chief Superintendent or nominee must make the decision to place a prisoner in a padded cell upon receiving advice in relation to the prisoner's placement from a psychologist/allied health clinician and a custodial supervisor. A decision to remove the prisoner from the padded cell must be made after discussion with a psychologist/allied health clinician and a custodial supervisor. The reasons for these decisions must be recorded in a case note.

11.2 Outside business hours

The duty manager must make the decision to place a prisoner in a padded cell upon receiving advice in relation to the prisoner's placement from a custodial supervisor. A decision to remove the prisoner from the padded cell must be made after discussion with a custodial supervisor. The reasons for these decisions must be recorded in a case note.

12. Transfer and Escort to Secure Facility

If an at-risk prisoner is to be transferred between corrective services facilities, the officer responsible for authorising the transfer must ensure that:

a) a sending facility staff member advises an appropriate receiving facility staff member (e.g. correctional supervisor; Senior Psychologist/Team Leader, Allied Health Services; Manager, Sentence Management Services) and transporting officer, of the prisoner's risk level as assessed prior to departure from the sending facility. The sending facility must provide this advice *prior* to the prisoner's departure from that facility. The sending facility

staff member must also confirm with the receiving facility staff member that the receiving facility has the capacity to conduct observations of the prisoner to the required level; and

b) the escorting officers are provided with all necessary documentation including a copy of the Administrative Form 54 Initial Response Plan or Administrative Form 63 At Risk Management Plan, and sufficient copies of Administrative Form 57 Observation Log – At-Risk Prisoner to record observations throughout the escort.

Upon arrival at the receiving facility, the transporting officers must provide the receiving facility with:

a) an Administrative Form 62 Transfer Summary and Approved Form 9 Order for Transfer of a Prisoner;
b) all necessary documentation including a copy of the Administrative Form 54 Initial Response Plan or Administrative Form 63 At Risk Management Plan, and completed copies of Administrative Form 57 Observation Log – At-Risk Prisoner that record observations throughout the escort; and
c) a verbal report of the prisoner's presentation during the transfer, with a particular focus on any issues that may be pertinent to the prisoner's at-risk status.

Receiving facility staff members who are given any information about the prisoner's at-risk status (including the verbal report from the transporting officer) must ensure that the correctional supervisor is advised of this information as soon as practicable, and make a case note of the information they received from the transporting officer.

An assessment of risk must be conducted by a psychologist/allied health clinician following transfer of an at-risk prisoner from another facility and must be documented in a case note in their current self-harm episode. The at-risk prisoner must be managed in accordance with the observation level set by the sending facility until a RAT meeting can be convened, unless it is determined that the prisoner's risk level has escalated and more frequent observations are required. In this instance, a new Notification of Concern is to be raised, initial assessment completed, and new Initial Response Plan created to reflect the change in risk level, observations, and associated conditions.

Prisoners will transfer to a new centre with an Administrative Form 54 Initial Response Plan or Administrative Form 63 At Risk Management Plan created by the sending facility. As centres may have differing conditions, a consideration during the assessment of risk upon transfer must consider whether the prisoner can be safely managed in accordance with the sending conditions outlined in the Initial Response Plan or ARMP. If it is assessed that the prisoner cannot be safely managed or a change in conditions is required, consideration must be given to raising a Notification of Concern and completing a new Initial Response Plan.

If more frequent observations are required, the psychologist/allied health clinician and correctional supervisor must complete a new copy of the relevant paperwork. Refer to the Administrative Form 53 Notification of Concern, Administrative Form 56 Initial Assessment At-Risk Prisoner and Administrative Form 54 Initial Response Plan.

The correctional supervisor must then take the required steps to ensure that appropriate at-risk management strategies are identified and utilised for that prisoner.

13. Risk of Harm to Self: Ongoing Management

13.1 Convening the Risk Assessment Team (RAT) – (except PAHSU)

A RAT meeting must be convened as soon as practicable following initial assessment and implementation of an initial response plan. The purpose of the meeting is to develop and document a comprehensive Administrative Form 63 At Risk Management Plan based on a range of professional assessments to ensure the safe management of each at-risk prisoner including the level of observations attributed to each case.

At a minimum, the RAT must consist of a representative from each of the following areas:

a) correctional supervisor;
b) Psychological Services/Allied Health Services; and
c) Aboriginal and Torres Strait Islander representative (if the at-risk prisoner identifies as an Aboriginal or Torres Strait Islander person).

The RAT must independently conduct a personal assessment of each prisoner as soon as practicable, but on the same day, prior to the meeting, in accordance with their professional role and area of employment. Correctional supervisors conducting this assessment should be those which are employed within the at-risk prisoner's accommodation area.

The correctional supervisor, psychologist/allied health clinician and Aboriginal and Torres Strait Islander representative (if applicable) who conducted the assessment of the prisoner should attend the RAT meeting in person. Where personal attendance is not possible, the nominee who attends in their absence should also be familiar with the prisoner being reviewed.

The Administrative Form 64A At Risk Assessment Report must be completed by the correctional supervisor and cultural liaison officer using IOMS prior to the RAT Meeting. The Administrative Form 64B At Risk Assessment Report must be completed by the psychologist/allied health clinician using IOMS prior to the RAT meeting. The signed hard copies of these reports must be placed on the offender management file after the meeting.

13.2 Correctional Supervisor report

A Correctional Supervisor report should include, but is not limited to the following information:

a) an assessment of risk;
b) a summary of information obtained from interview with the prisoner;
c) a summary of the prisoner's behaviour and interactions (including with other prisoners) within the unit compiled from the observation records since the last risk assessment meeting;
d) a summary of log book notes;
e) a summary of Prisoner Telephone System recordings (if possible, practicable and/or relevant);
f) a summary of any safety concerns/association issues and recommendation on where a prisoner should be placed including any recommendations to address any environmental risks (e.g. removal of hanging points);

g) an assessment of the prisoner's suitability for shared cell accommodation and recommendation; and
h) whether a temporary Safety Order/Safety Order is in existence or should be made/extended.

Refer to the Administrative Form 64A At Risk Assessment Report.

13.3 Clinical report

A clinical report should include, but is not limited to the following information:

a) an assessment of risk;
b) a report on the psychological status of the prisoner;
c) recommendations for ongoing support;
d) recommendations for specialist intervention or management strategies (if required);
e) any behavioural problems;
f) an assessment of the prisoner's social, relationship, family matters (stressors);
g) an assessment of the prisoner's accommodation needs relating to their assessed risk factors;
h) recommendations on where a prisoner should be placed and any recommendations to address any environmental risks (e.g. removal of hanging points);
i) an assessment on the prisoner's suitability for shared cell accommodation and recommendation;
j) any welfare/personal issues such as religious needs, visits and phone calls; and
k) any information that may assist in the effective management of the prisoner.

13.4 Cultural Liaison Officer (or Aboriginal and Torres Strait Islander Representative) report

A Cultural Liaison Officer (or Aboriginal and Torres Strait Islander representative) report should include, but is not limited to the following information:

a) an assessment of risk;
b) an overview of any welfare needs or cultural issues being experienced by the prisoner;
c) an assessment of the prisoner's accommodation needs relating to culturally specific factors;
d) recommendations on where a prisoner should be placed including any recommendations to address any environmental risks (e.g. removal of hanging points);
e) an assessment of the prisoner's suitability for shared cell accommodation and recommendation; and
f) a summary of cultural supports and links to community.

Refer to the Administrative Form 64A At Risk Assessment Report.

13.5 Risk Assessment Team (RAT) meeting

Requirements for the RAT meeting are:

a) The RAT must be chaired by the Senior Psychologist/Team Leader, Allied Health Services or relevant manager where the Senior Psychologist/Team Leader, Allied Health Services is not available. If chaired by a relevant manager, the manager should be familiar with, and have completed the accredited suicide awareness/prevention training. It is recommended that a Senior Psychologist/Team Leader, Allied Health Services consulted to endorse any recommendations for removal from observations or a reduction in level of observations.

b) Staff that chair the RAT meeting who are not in a Senior Psychologist/Team Leader, Allied Health Services position may be eligible for accreditation to do this role based on equivalency training skills. This will be considered on a case by case basis by the Psychology Services Unit (PSU).
c) The chair of the RAT meeting should not have completed an assessment of a prisoner under review at the meeting to ensure that objectivity is maintained.
d) The chair must ensure minutes are recorded (refer to the Administrative Form 65 Minutes of Risk Assessment Team Meeting).
e) RAT meetings should be held at least once per week (i.e. seven days) for each at risk prisoner.
f) RAT members must consider all reports (including any current/recent ARMP, EBLR plans, and suitable containment and intervention options for each at risk prisoner).
g) RAT members must consider the suitability of the current or proposed cell accommodation for the prisoner (this includes determining adequacy of cell infrastructure, any specific risks posed by the accommodation such as hanging points and if necessary, making recommendations to the centre to mitigate against risk posed by cell infrastructure).
h) RAT members must consider infrastructure considerations to assist with decision making regarding the adequacy of cell infrastructure and the specific risks presented by specific accommodation units and cells. This must be documented in the meeting minutes and ARMP.
i) RAT members should consider conditions for the at-risk prisoner, including use of safer design clothing, bedding, and towels, and use of restraints.
j) RAT members must also ensure that any special needs of the prisoner are properly considered including cultural, religious, medical or dietary requirements.
k) RAT members must consider the suitability of shared cell accommodation for the prisoner (refer to the Further shared cell considerations for at-risk prisoners section of this COPD). This must be documented in the meeting minutes and subsequent ARMP/ARMPs.
l) An ARMP must be developed and documented for each at risk prisoner.
m) If members propose different plans, the team should adopt the most conservative approach to observations and cessation of the ARMP (e.g. if most of the team suggests 60 minute observations, but one member wants 30 min observations, 30 min observations must be conducted) (refer to the Administrative Form 63 At Risk Management Plan).
n) The RAT must consider whether a Safety Order is made with conditions which are consistent with ARMP (refer to the COPD Prisoner Behaviour Management: Safety Orders).
o) The RAT chair or approved nominee must present to the Chief Superintendent or nominee of a corrective services facility for ratification and signature for each prisoner:
    i. an Administrative Form 63 At Risk Management Plan; and
    ii. Administrative Form 65 Minutes of Risk Assessment Team Meeting.

Hard copies of the Administrative Form 65 Minutes of Risk Assessment Team Meeting and Administrative Form 63 At Risk Management Plan must be completed by the meeting chair and placed on the offender management file. As soon as possible after the meeting, a designated person must enter the required information in IOMS and attach a copy of the documents as an electronic attachment.

[redacted]

The frequency of observations must take into account the nature of the situation and the level of risk. Refer to the Appendix AR4 Risk Level/Observation Guidelines. The correctional supervisor must ensure the required observations occur in a manner that ensures the continued wellbeing of the prisoner.

13.6 Further shared cell considerations for at-risk prisoners

An at-risk prisoner should ordinarily be accommodated in a single cell; however, the RAT may determine that an at-risk prisoner is suitable for shared cell accommodation.

The RAT must make a determination based on the considerations detailed in the COPD Prisoner Accommodation Management: Cell Allocation - Shared Cell Accommodation Allocation, and an assessment of risk. This includes a decision on the prisoner who will be accommodated with the at-risk prisoner, the social benefit of the shared cell decision and the duration of the shared cell placement.
A decision will also need to be made regarding the individual accommodation arrangements for the prisoners in the shared cell arrangement. Each RAT member must consider the suitability of shared cell accommodation during their respective risk assessment reports.

If members propose different recommendations about the suitability of shared cell accommodation for the at-risk prisoner, the RAT team should adopt the most conservative approach (e.g. if most of the team recommends that the at-risk prisoner is suitable, however one member determines that the prisoner is not suitable for shared cell accommodation, then the at-risk prisoner must not be accommodated in this type of accommodation).

The decision by the RAT panel must be documented in the Administrative Form 63 At-Risk Management Plan, together with any restrictions or conditions on the arrangements. These will apply to both the at-risk prisoner and the other prisoner who is accommodated in the shared cell. Any restrictions or conditions that may impact on the other prisoner should be taken into consideration when assessing the suitably of the shared cell arrangement. If the other prisoner who is accommodated in the shared cell arrangement is not on observations, the details and conditions of this arrangement must be documented in an IOMS case note for the other prisoner.

In circumstances where concerns are raised for the safety or wellbeing of either prisoner, then the shared cell arrangement must be ceased and the at-risk prisoner accommodated in a single cell until the matter can be referred to the RAT panel for further consideration.

The RAT team must continue to review the suitability of the shared cell arrangement at each subsequent RAT meeting involving the at-risk prisoner, and any resulting decisions must be documented in the Administrative Form 63 At Risk Management Plan. Where the RAT team considers a prisoner is no longer suitable for a shared cell arrangement, then the prisoner must be accommodated in a single cell.

13.7 Implement At-Risk Management Plan (ARMP) and ongoing management

Following authorisation by the Chief Superintendent or nominee of a corrective services facility, an at-risk prisoner must be managed in accordance with the ARMP ensuring that the prisoner has a high level of support and intervention. Refer to the Appendix AR6 At-Risk Management Plan Guidelines.

All original forms completed for an at-risk prisoner must be placed on the offender management file with copies on the medical file and in IOMS.

13.8 Review of At-Risk Management Plan (ARMP)

The reports of all RAT team members must be provided and considered during the RAT meeting. The most conservative approach must be taken when determining the frequency of observations an at-risk prisoner should be subject to.

For example, if two members of the RAT consider a prisoner to be at medium risk and two members of the RAT consider a prisoner to be at low risk, the prisoner would be considered as being at medium risk of self-harm or suicide.

Where a prisoner is under extreme, high, or medium levels of risk, they must be progressed down through each observation level prior to removal from the ARMP, at which time all members of the RAT must agree that the prisoner is no longer at an acute risk of self-harm or suicide.
As 30 and 15 minute observation levels are both considered to represent a high level of risk, progression through both levels of observations is not required prior to reduction to a medium level of risk but can be utilised if necessary.

When considering the frequency of review of a prisoner's observation levels through the RAT, the presenting risks must be addressed and staff should ensure that there has been sufficient time to assess for stability and a change in any risk factors.

14. Termination of the At-Risk Management Plan

A prisoner's initial accommodation needs should be considered following termination of the ARMP. Such considerations should include whether the prisoner is suitable for accommodation on the upper level of an accommodation unit, whether the prisoner has social support nearby or whether the prisoner is suitable for shared cell accommodation. Specific accommodation needs are to be considered for all prisoners being removed from observations and documented within the Administrative Form 65 Minutes of Risk Assessment Team Meeting.

Upon termination of the ARMP, the RAT must consider a prisoner for chronic or elevated baseline risk factors to determine if further monitoring via the EBLR procedure is required. The details of the referral decision (including rationale and consultation process) must be recorded in the Administrative Form 65 Minutes of Risk Assessment Team Meeting and Administrative Form 63 At Risk Management Plan and in the relevant EBLR forms. Refer to the COPD At Risk Management: Elevated Baseline Risk.

Following review of the ARMP, the correctional supervisor must discontinue the ARMP using the Administrative Form 63 At Risk Management Plan and present to the Chief Superintendent or nominee of the corrective services facility for ratification and signature. This information must be electronically attached in IOMS using a New Self Harm Document, At-Risk Management Plan.

If a prisoner is not considered to be at an acute risk of self-harm or suicide and the ARMP is no longer required, the Chief Superintendent of a corrective services facility or nominee may determine that the prisoner is still not ready to be managed within the agency's mainstream correctional environment and may benefit from additional management and intervention to address other behaviours or specific needs, such as for behavioural management purposes. In such circumstances, an IMP should be devised (refer to the COPD Prisoner Behaviour Management: Intensive Management Plans).

If the prisoner is placed on a Safety Order, an IMP may be developed to assist in the prisoner's reintegration into the mainstream population.

15. Discharge of Prisoner Currently or Previously At-Risk

If a prisoner in custody who is subject to a current ARMP is to be discharged to the community (e.g. release to liberty, release to parole), the prisoner's at-risk status must be considered for transitional and pre-release planning. This should also occur for prisoners who have previously been assessed to be at-risk or have a history of self-harm or suicide attempts.

For prisoners in custody who are subject to a current ARMP and are to be discharged from custody and subject to community supervision, where possible, contact must be made prior to the prisoner's release with the relevant Community Corrections office to advise them of the prisoner's risk status.

[redacted]

Staff must ensure that appropriate notifications are conducted and the referring officer must record the event as a case note. Refer to IOMS – Offender Management > Self Harm > Current Self harm episode List > Actions > New Self harm document > Case note.

15.1 Responsible officers

Corrective services officers are responsible for remaining vigilant to, and alerting Correctional Supervisors to, the indicators and events related to potential self-harm or suicide and any self-harming prisoners engage in.

Corrective services officers are responsible for supervising and monitoring prisoners presenting at-risk or at-risk of self-harm or suicide in accordance with this COPD.

Correctional Supervisors are responsible for raising relevant notifications and participating in the RAT assessment/meeting and any subsequent reviews and the ongoing supervision and monitoring of the prisoner.

Psychologists/allied health clinicians or registered nurses are responsible for identifying prisoner(s) with self-harm history and managing the initial assessment and response prior to the RAT meeting and participating in the RAT assessment/meeting and the on-going supervision and monitoring of the prisoner.

Senior Psychologists/Team Leaders, Allied Health Services are responsible for raising the Self Harm Episode History flag where relevant.

Cultural Liaison Officers are responsible for participating in the RAT meeting/assessment and the on-going supervision of the prisoner, where applicable.

The Correctional Supervisor is responsible for the oversight of prisoners under Self-Harm Observations.

The correctional manager is responsible for the oversight of prisoners under Self-Harm Observations.

The Chief Superintendent of a corrective services facility is responsible for oversight of the process and involvement in the prisoner transferring to a secure facility, where applicable.

16. Hunger Strikes

16.1 Identifying a hunger strike

A hunger strike is the deliberate refusal of food or fluid and in a number of cases is used for the purpose of obtaining a desired outcome. A prisoner who chooses not to eat a meal for any other reason (feeling unwell or a dislike for what is being offered), is not classed as being on a hunger strike.

If a prisoner declares or appears to be participating in a hunger strike to a corrective services officer, an officer must:

a) immediately advise a correctional manager and/or correctional supervisor;
b) advise the prisoner that placing himself or herself on a hunger strike is not considered appropriate and that this may result in:
    i. separation on a Safety Order; and/or
    ii. transfer from a low custody facility to a secure facility (if applicable); and
c) inform the prisoner that a hunger strike will be recorded as an incident.

A prisoner will be provided a period of no longer than 24 hours (but a minimum of at least two meal periods) to confirm whether they wish to commence a hunger strike. The officer must confirm with the prisoner after the designated period of time if the prisoner intends to commence a hunger strike.

16.2 Initial notification

Following confirmation that a prisoner is on a hunger strike it must be reported immediately to;

a) the Nurse Unit Manager or senior nurse on duty;
b) the Chief Superintendent of the corrective services facility or nominee (the duty manager must be advised after hours); and
c) other relevant persons by means of an incident report.

The Chief Superintendent or Superintendent of the corrective services facility must make the final decision in consultation with health centre staff regarding the management of a prisoner while on a hunger strike.

In low custody facilities, the Chief Superintendent of the corrective services facility or Superintendent of the corrective services facility must assess the need to transfer the prisoner to a secure facility. Refer to the COPD Sentence Management: Transfers.

The Chief Superintendent of the corrective services facility or nominee, or after hours the duty manager, must arrange within eight hours of being advised of a confirmed hunger strike, for the prisoner to be interviewed in order to ascertain the circumstances and reasons for the prisoner refusing to eat and/or drink.

A prisoner on a hunger strike must be considered at risk of self-harm or suicide and managed in accordance with the Risk of Harm to Self section of this COPD.

16.3 Initial requirements

The Chief Superintendent of the corrective services facility or nominee must provide for the management of a prisoner on a hunger strike including:

a) the Nurse Unit Manager is notified of any concerns, including significant events or changes in the prisoner's behaviour;
b) a psychological assessment is undertaken (refer to the Risk of Harm to Self section of this COPD); and

c) ensuring that:
    i. the prisoner is accommodated in an area that provides for the management of the prisoner in accordance with the Risk of Harm to Self section of this COPD and, where relevant, the COPD Prisoner Behaviour Management: Safety Orders (refer to section 53 of the CSA);
    ii. access to buy-ups continues;
    iii. offers of all meals are made at each scheduled meal period and the response to each offer recorded in a designated log book;
    iv. significant events or changes in the prisoner's behaviour are case noted in IOMS; and
    v. the prisoner is not permitted to engage in any physical activity, such as sport, that may impact on the physical effects of refusal to eat or drink.

16.4 Mental health assessment

A psychologist/allied health clinician must assess the prisoner as soon as practicable following confirmation of the prisoner's refusal to eat and/or drink.

The psychologist/allied health clinician must provide the Chief Superintendent of the corrective services facility with a written report outlining factors contributing to the refusal to eat and/or drink and make recommendations for intervention.

16.5 Health services requirements

A prisoner capable of making informed choices with regard to the management of their health issues must have those choices respected unless this results in an adverse event that places the prisoner or others at risk.

A health practitioner will determine if a prisoner requires treatment within the corrective services facility or at an external health facility.

16.6 Documenting the hunger strike

The Chief Superintendent of the corrective services facility or nominee must maintain details of actions taken subsequent to the identification that a prisoner is on a hunger strike. This must ensure all stages of the incident are fully documented by the corrective services officers involved in the prisoner's management, including any religious or philosophical beliefs of the prisoner.

Medical assessments and reports will be filed on the prisoner's medical file.

Non-medical assessments and reports must be scanned and attached to IOMS.

16.7 Situational report of the hunger strike

A situational report must be forwarded to the Deputy Commissioner in circumstances where a health practitioner is considering admitting a prisoner on hunger strike to an external health facility, the Chief Superintendent or Superintendent of the corrective services facility will nominate a staff member to complete the report. The report must include:

a) a report on the prisoner's physical health provided by a health practitioner;
b) a psychologist's/allied health clinician's assessment of the prisoner's emotional/psychological state and appraisal of intervention strategies employed;
c) the prisoner's behaviour detailing any significant events; and
d) any other relevant comments.

16.8 Cessation of hunger strike

When a corrective services officer becomes aware that a prisoner has ceased a hunger strike and has commenced eating and/or drinking, the officer must notify the Chief Superintendent of the corrective services facility or nominee and the Nurse Unit Manager.

A case note must be entered in IOMS detailing the cessation of the hunger strike.

The incident report must be updated to reflect the cessation of the hunger strike and if known the reason/s the prisoner ceased the hunger strike.

All corrective services staff are responsible for remaining vigilant to risk of a hunger strike and undertake intervention in accordance with this COPD.