FREEDOM OF INFORMATION REQUEST – FOI REF: CSD 20/06

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Applicant	THE PARAMETERS OF THE REQUEST	File No
[redacted]	*'I seek any documents held and/or created by the directorate in response to the riot incident at the Bimberi youth detention facility on August 26. I also seek any briefing materials prepared and/or created by the directorate for ACT government ministers and/or Opposition spoke people in response to the August 26 incident at Bimberi.* ***Excluding any information relating to young people detained at Bimberi (eg. specific incident reports or client information for the young people) as the information is protected under the 'Children and Young People Act 2008, section 844'.***	**Final Independent Review of the Incident at Bimberi Youth Justice Centre 26 August 2019**

No	No Folios	Description	Date	Decision	Reason for non-release or deferral	Open Access release status
1-50	50	Final Independent Review of the Incident at Bimberi Youth Justice Centre 26 August 2019	26/08/2019	Partial release	Schedule **2, 2.2 (a)(ii)** – 'prejudice the protection of an individual's right to privacy or any other right under the *Human Rights Act 2004'* Schedule **1, 1.14** Information the disclosure of which would, or could reasonably be expected to (i) prejudice a system or procedure for the protection of people, property or the environment'. Some information is outside scope of request.	Partial release

FINAL REPORT TO THE COMMUNITY SERVICES DIRECTORATE ACT GOVERNMENT

Independent Review of the Incident at Bimberi Youth Justice Centre on 26 August 2019.

Final: I November 2019

SENSITIVE AND PERSONAL INFORMATION

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EXECUTIVE SUMMARY

BACKGROUND AND CONTEXT

Peter Muir Consulting Pty Ltd has been engaged by the Community Services Directorate, ACT Government to undertake a Major Incident Review following the events of 26 August 2019 at Bimberi Youth Justice Centre (Bimberi) when a group of young people attacked staff in the Majura Wing of the Centre.

The purpose of this review is to consider the response to the major incident that occurred at the Bimberi Youth Justice on 26 August 2019.

Specifically, I have been asked to consider:

1) whether there were any obvious precursors to the event
2) the appropriateness of the management of young people leading up to the event, including classifications and the implementation of the behaviour management framework.
3) the response by Bimberi staff to the incident
4) the management of the incident and alignment with policy and procedures
5) the application of the emergency procedures
6) the suitability of the physical design and infrastructure
7) the work health and safety system as it pertains to the incident

This Incident was at the more serious end of what you would expect to see in a Youth Justice Centre in that five young people engaged in an unprovoked attack on staff in an attempt to gain keys and to escape the centre.

In the process of that attack, one staff member was injured by the office computer which was used to attack him and a sharp, improvised weapon was used to inflict further wounds on at least two other staff members.

I have interviewed 15 staff and stakeholders who were involved or have a direct interest in the Incident on 26 August. I have had the opportunity to view the CCTV of the events and read the statements of staff who had not as yet returned to work at the time of my initial visits to Bimberi.

I have conducted three physical inspections of Bimberi.

The Community Services Directorate has given me unfettered access to its information management systems and client files. I have conducted two inspections of the relevant sites in the Centre.

The Management and Staff at Bimberi manage young people every day who are deemed too high a risk to be in the community due to their offending. In addition to this many of the young people involved in this event have histories of abuse, neglect and exposure to significant family and domestic violence. All have been previously known to the Child Protection system. Six young men were the subject collectively of over 160 child concern reports over the course of their lives to date.

A number of the participants have diagnosed mental health conditions.

I record this not to excuse the actions of these young men but to demonstrate the complexity of cases that staff and management face on a day-to-day basis.

SUMMARY OF FINDINGS[1]

1) Whether there were any obvious precursors to the event

Based on the evidence available to me, I cannot find any precursors to this Incident to which the Centre Management or staff should have responded to above systems and actions that were already in place.

The only known precursor was suspicious activity by the young people in the hour leading up to the event. That was detected and acted upon appropriately by staff.

The most credible hypothesis on this incident is that it was initiated and led by a known young person as a means for him to avoid extradition to NSW. I found no evidence that this was known to any staff member prior to the incident.

2) The appropriateness of the management of young people leading up to the event, including classifications and the implementation of the behaviour management framework.

I cannot find any significant failing in the systems of behaviour management over the young people involved in this incident.

The Daily Assessment Sheets could be more consistently applied but this is not an issue of substantial concern.

The operation of the Incentive Scheme in relation to the fairness with which it was applied to this group of young people is a positive feature of behaviour management.

One staff member who was directly supervising the young person presumed to be the main instigator of the incident stated that the positive incentive achievements recorded between May and August 2019 accurately reflects his behaviour whilst in custody.

The Audit on the Incentive Scheme has highlighted areas for improvement. I concur with the findings of that Audit. I am confident in the Directorate's IMS Governance Committee to manage the response to this Audit.

Bimberi is housing a cohort of young people with highly complex needs. A number of the young people have mental health concerns and come from families where they have witnessed significant incidents of family and domestic violence.

There is a risk that the forms and processes supporting behaviour management have become overly complex and may not be fully integrated.

There is insufficient therapeutic capability in Bimberi to support the management of this highly complex group of young people.

[1] Some findings have been omitted or not expanded upon due to privacy or security concerns.

There is insufficient capability in Bimberi to support the Intelligence and Classification functions. These however did not contribute to this event but will provide increased capability to assess and manage emerging risks.

3) The response by Bimberi staff to the incident.

Staff responded to this event with a high degree of professionalism, courage and teamwork.

In the midst of being attacked by young people, there is evidence of staff demonstrating a high degree of care and restraint in their dealings with these young people.

Further investigation is needed as to the impact that staff absences may be having on the operating environment at the centre but at this stage I can find no evidence that these absences played any part in the lead up to or handling of the events of 26 August.

A strategy to ensure that all staff are provided with refresher training on the use of force is required as a matter of priority. There is no evidence available to me that that staff were inadequately trained to respond to this situation

4) The management of the incident and alignment with policy and procedures.

I found no breaches of the Behaviour Management Policy in relation to this incident.

I found no breaches of the Admission and Classification Policies and Procedures in this incident.

I found no breaches of the Discipline Policy and Procedures in this incident.

I found no breaches of the Use of Force Policy and Procedures in this incident.

There was one breach of the Safety and Security Policy and Procedures in relation to the probable failure of a staff member to properly secure their keys. Management has taken corrective action in relation to the lanyards to minimise this occurring in a future instance.

There are a small number of matters that I consider should be included in a revision of the Safety and Security Policy and Procedures.

5) The application of the emergency procedures.

On the evidence available to me, the staff responded to the emergency in accordance with the procedures and did so with courage, commitment and professionalism.

The Sched 2.2 (a)(ii) FOI Act 2016 made decisions in the midst of the incident that caused her to reflect on best-practice in incident management. Given the circumstances with which she was faced, my assessment is that she made good decisions based on the wellbeing of her staff and the young people under her care.

There are weaknesses in systems to contact staff in emergency situations that require immediate rectification.

There is no protocol with ACT Police for assisting and no operational preparedness for working with them in such situations.

6) The suitability of the physical design and infrastructure.

Bimberi's physical design and infrastructure remains at the higher end of Centres across Australia.

The findings and commentary in this section of the report contain matters that are critical to the safety and security of the Centre.

I am satisfied that the issues identified in the aftermath of the incident are known to the Directorate and that remedial action is underway or has already occurred.

7) The work health and safety system as it pertains to the incident.

My finding against this term of reference is that the WHS system is not functioning as effectively as it should. The level of engagement from key stakeholders is low. There is no evidence that the Committee is working to a proactive plan that continually assesses the workplace risks and the effectiveness of controls to address those risks.

There is evidence that actions are being initiated to review risks and data in relation to WHS. What is not clear is that these actions have been completed and found their way into improved systems of safety.

Improvements could be made to the WHS Risk Register that better identify the controls in place over the behaviour of young people in custody. These controls are known and better reflected in the Bimberi Operational Risk Register.

My opinion is that there is a comprehensive set of systems in place designed to deal with detainee behaviour and in the case of the young people in this incident I can see that those systems were largely applied. These systems would benefit from periodic review. This review should be a part of the ongoing work of the IMS Governance Committee.

Recommendations

I have made a total of 27 recommendations in relation to this review. Some recommendations have been omitted in this Executive Summary where they touch on personal or sensitive information or where they pertain to security arrangements in Bimberi. In the case of the latter, it is my opinion that publishing these recommendations may compromise the security of the Centre.

1. **The Community Services Directorate increases the therapeutic staff available to Bimberi to manage the complex needs of residents.**
2. **The Community Services Directorate increases the staff available to manage classification and intelligence functions at the Centre.**

3. **The IMS Governance Committee monitors the implementation of the recommendations of the Audit on the Incentive Scheme.**
4. **The Community Services Directorate undertakes a review of the operation of behaviour management systems currently in place to ensure that they are integrated and support staff in their management of young people in custody. This review should take into account improvements made in the deployment of the CYRIS.**
5. **The Community Services Directorate formally acknowledges the staff response to this incident.**
6. **The Community Services Directorate ensures that its Workforce Strategy facilitates the adequate supply of staff to Bimberi to allow for the effective operation of the centre at its correct staffing level and incorporates a strategy to ensure that ongoing training is accessible to staff.**
7. **This recommendation relates to security arrangements at Bimberi.**
8. **This recommendation relates to security arrangements at Bimberi.**
9. **The Safety and Security Policy and Procedures are reviewed to take into account the matters raised in this section of the Report.**

Recommendations 10-25 relate to security arrangements at Bimberi.

26. **The Directorate should provide short-term support to Bimberi to ensure that the WHS system is operating as it is intended. A program of work and reviews should be established. There should be a greater focus on stakeholder engagement.**
27. **Complete a review of the Emergency Operating procedures in the light of this event that takes into account emergencies of greater magnitude and assesses the capability of staff to respond to those scenarios.**

DETAILED REPORT

BACKGROUND

Peter Muir Consulting Pty Ltd has been engaged by the Community Services Directorate, ACT Government to undertake a Major Incident Review following the events of 26 August 2019 at Bimberi Youth Justice Centre (Bimberi) when a group of young people attacked staff in the Majura Wing of the Centre.

The purpose of this review is to consider the response to the major incident that occurred at the Bimberi Youth Justice on 26 August 2019.

Specifically, I have been asked to consider:

1) whether there were any obvious precursors to the event
2) the appropriateness of the management of young people leading up to the event, including classifications and the implementation of the behaviour management framework.
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4) the management of the incident and alignment with policy and procedures
5) the application of the emergency procedures
6) the suitability of the physical design and infrastructure
7) the work health and safety system as it pertains to the incident.

In addition, I have been asked to comment on the adequacy of the:

- Emergency Operating Procedures
- Behaviour Management System
- Training in responding to Critical Incidents

The full Terms of Reference are found at ***Attachment A***.

METHODOLOGY

To compile this interim report, I have attended the Bimberi on

- 27, 28 and 29 August;
- 2, 3 and 6 September;
- 10 and 11 October 2019.

In this time I have conducted 15 interviews. These have been with:

- Members of the Management Team at Bimberi, two of whom were directly involved in the incident.
- Five Youth Workers involved in the incident;
- The Executive Teacher Murrumbidgee Education and Training Centre (METC);
- The Principal Practitioner for the Centre;
- Representatives from WorkSafe Act;
- Representatives from the Community and Public Sector Union (CPSU).

Members of the Management Team at Bimberi have engaged in continuous discussion during the course of the review to clarify questions or matters of concern.

I have met with the Senior Project Manager responsible for the implementation of the Directorate's new client information system known as CYRIS, to better understand the impact of the system on Bimberi operations. This meeting was held on 28 October 2019.

I have been able to obtain all necessary policies, procedures and practice guidelines from the Directorate's Information Portal to which I was given direct access.

I have been provided with unfettered access to the Directorate's current information Management Systems; the Children and Young Peoples' System (CHYPS) and the Youth Justice Information System (YJIS). I have reviewed the young people's information on both of these systems.

I have been provided with the client records of all of the young people involved in the incident and I have reviewed each of these files.

I have been provided with detailed case summaries of the young people involved in the incident by the Directorate's Case Analysis Unit. These are comprehensive summaries of each young person's Care and Protection as well as their Youth Justice histories.

I have conducted three physical inspections of the Centre (This is not the first time that I have been into the Centre.) In particular I have focussed on the Units in question and the Sched 2.2 (a)(vi) FOI Act 2016

I have completed two viewings of the CCTV footage of the incident. I was able to view the footage for myself before I had heard any staff member's account of the incident.

I have conducted reviews of relevant Bimberi documents including:

- Morning Briefings for the month prior to the event;
- Shift and Unit Handover Documents;
- Incident Report Logs and Registers;
- Emergency Planning and Management Documents;
- Relevant Policy and Procedural Documents obtained from the Directorate's Knowledge Portal;
- Workplace Consultative Committee Documentation;
- The Bimberi Operational and WHS Risk Registers;
- Training Records for Bimberi YJC; and
- Bimberi population records.

I have been provided with recordings of the young people's telephone calls.

In the early stages of my review, the Management and staff at Bimberi were actively managing the aftermath of the incident. This included managing the risk of the young people involved in the incident; managing staffing issues as some staff involved in the incident had not returned to work; managing the emotional aftermath of other staff and themselves;

managing ongoing operations in the Centre; and following up the inquiries of internal and external stakeholders.

To say that the aftermath of the incident was challenging to the Management and staff would be an understatement.

Despite these challenges, I was afforded a very high degree of access to information, staff and the Centre. The Sched 2, 2.2 (a) (ii) FOI Act 2016 and her staff offered a high degree of cooperation.

1. Chronology

Sched 2.2 (a)(vi) FOI Act 2016

The Unit had three staff rostered on for this evening; one Team Leader (TL) and two Youth Workers (YW). The Team Leader was Sched 2.2 (a)(ii) FOI Act 2016 ; and the Youth Workers were Sc he d

Outside scope

There were 10 staff rostered on for the Centre that evening. In addition to these 10 staff the Sched 2, 2.2 (a) (ii) FOI Act 2016 Sched 2.2 (a)(ii) FOI Act 2016 was still present in the Centre as was the Sched 2, 2.2 (a) (ii) FOI Act 2016 Sched 2.2 (a)(II) FOI Act 2016 .

In the lead up to the event Youth Workers Sched 2.2 a)(ii) F and Sched 2.2 (a) (Sched 1 14(1 were supervising young people in their Wings. Sched 2 2 (a) in Sche d and Sched 2.2 (a) in Sched 2 2 (a) was completing evening chores with the three young people and Sched 2.2 (a) was supervising young people playing table tennis.

Both had the suspicion that the young people were planning something. (I will discuss this in detail in Section 2 of the Report).

At approximately 18:20 on the day in question YW Sched 2.2 ii) FOI entered the Duty Point to discuss his concerns with the Sched 2, 2.2 (a) (ii) FOI Act 2016. YW Sched 2.2 (a) (ii) FOI Act had also entered the Duty Point a few minutes earlier to similarly express her concerns. She had returned to Sched before Sched 2.2 (a)(ii) FOI entered the Duty Point.

Whilst YW Sched 2, 2.2 (a) (ii) FO was in the Duty Point talking with TL Sched 2.2 (a)(ii) , there was a knock at the door. As Sched 2.2 Sched 2.2 (a)(vi) FOI Act 2016 , Outside scope

Sched 2.2 (a)(ii) FOI Act 2016 Sched 2.2 (a) (ii) FOI Act was monitoring cameras to the unit and immediately saw what had occurred and called a “Code Black” over the Centre radio system. Sched 2.2 (a)

Both Sched 2.2 (a) (ii) FOI Act and Sched 2.2 (a)(ii) FOI report trying to push the young people out of the Duty Point without success.

Shed 2, 2.2 (a)(ii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

Shed 2, 2.2 (a)(ii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

Shed 2, 2.2 (a)(ii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

Shed 2, 2.2 (a)(ii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

Shed 2, 2.2 (a)(ii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

2. Were there any precursors to the event?

In reviewing this question I have relied on:

- A review of the paper files and YJIS records for each of the young people involved;
- Interviews with staff members;
- The Bimberi Incident Log for 2018/19 and the current financial year to date;
- The behavioural records for each young person. This includes Incentives, Behavioural Breaches and internal disciplinary charges;
- The Classification of each young person;
- An examination of all case notes pertaining to the young people over July and August 2019;
- Records of Daily Briefings and Handover notes for the young people; and
- Telephone recordings of the detainees involved in the incident for the week before the event.

Sched 2, 2.2 (a)(ii) FOI Act 2016; Sched 2, 2.2 (a)(iii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

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Sched 2, 2.2 (a)(ii) FOI Act 2016; Sched 2, 2.2 (a)(iii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

Sched 2.2 (a)(ii) FOI Act 2016, Sched 2.2(a)(iii) FOI Act 2016 & Sched 2.2(a)(vi) FOI Act 2016

Sched 2.2 (a)(ii) FOI Act 2016, Sched 2.2(a)(iii) FOI Act 2016 & Sched 2.2(a)(vi) FOI Act 2016

Sched 2.2 (a)(ii) FOI Act 2016

My conclusion in relation to Outside scope **is that there was no known precursors to the events in which he was involved other than the known risks for which there were significant systems of management in place.**

Outside scope

Outside scope

Subsequent to the Incident on 26 August Sched 2, 2.2 (a) (ii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

The only known relationship to the role of the school was that Deputy Principal had announced a new policy that day that a new behaviour management framework would be implemented.

The Deputy Principal had assessed as behaviours in the school needed to be “tightened up.” Essentially students were misbehaving for the morning when numeracy and literacy was being taught but coming in the afternoon for more desired activities.

The framework was that students would receive two warnings and then be excluded for the day on the third. Two interviewees confirm that this announcement was not well received by the young people.

Sched 2, 2.2 (a)(ii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

Sched 2, 2.2 (a)(ii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

There is not a lot of information available post-incident (without interviewing the young people involved) that gives any clear indication as to the cause of this incident. I have not interviewed young people as there is an active police investigation that is ongoing at the time of completing this report.

Sched 2, 2.2 (a)(ii) FOI Act 2016 & Sched 2, 2.2 (a)(vi) FOI Act 2016

Findings

Based on the evidence available to me, I cannot find any precursors to this Incident to which the Centre Management or staff should have responded above systems and actions that were already in place.

Sched 2, 2.2 (a) (ii) FOI Act 2016

The most credible hypothesis on this incident is that it was initiated and led by
Sched 2, 2.2 (a) (ii) FOI Act 2016
as a means for him to avoid extradition to NSW.

3. The appropriateness of the management of young people leading up to the event, including classifications and the implementation of the behaviour management framework.

When considering the appropriateness of the management of the young people, I have considered the background of each young person; the adequacy of systems that are in place to manage their behaviour; and the effectiveness of those systems. I will also consider how these systems were applied to the young people who participated in this incident.

The first system is the Disciplinary System that deals with negative behaviour. These systems are enshrined in Legislation and in the Children and Young People (Discipline) Policy and Procedures 2018 (No.1) Notifiable instrument NI2018-433. I do not intend to outline this document in detail. It outlines a hierarchy of behavioural controls as outlined

below. This Policy includes the Use of Force Policy and is designed to deal with a continuum of misbehaviour from minor to major incident.

No risk or harm to a person or property or security or	Minor risk or harm to a person or property or security	Moderate risk or harm to a person or property or security	Serious risk or harm to a person or property or security
Negative Behaviour →	**Minor Behaviour Breach** →		**Behaviour Breach**

Bimberi has an Incentive Scheme. This scheme is specifically designed to promote and reward positive behaviour. Young people are assigned points for positive behaviour at all points across the day. These points are tallied across the week and young people are able to purchase rewards according to the number of points that they have accumulated during the week. I have not reviewed this system in detail. It has however been the subject of an Internal Audit. I have been provided with a copy of that Audit.

There is a system of observation sheets that report on a young person's behaviour on a daily basis. These are called Daily Assessment Sheets. In these staff are able to provide direct observations of a young person's actions over the day, issues of concern, program participation and interactions with others.

Bimberi has developed a Classification System. Classification systems are designed to take into account a number of static and dynamic behavioural indicators and assign a security risk rating to each young person. Young people are able to improve their security rating through positive behaviour and conversely receive an increased rating through poor behaviour. Such systems are intended to inform what a young person has access to and their level of security risk to staff, other young people and themselves.

Two systems that sit above these are Special Management Directions (SMD's) and Behaviour Management Plans (BMP's). The former is a detailed document that clearly outlines the risks that young people pose in the centre; what the triggers for their behaviours are and how staff are to respond to that behaviour. The latter is a document negotiated with young people on behavioural expectations.

My opinion is that both of these approaches represent good practice.

I can see evidence in the Directorate records that each of these systems were applied to the group of young people at various times:

Outside scope

Outside scope

Outside scope

Outside scope

Observations on the Operation of the Incentive Scheme

Bimberi's Incentive Scheme is based on a model called the *Circle of Courage*. I am aware that this is a well-regarded model of youth development. I have not examined the evidence base behind the model. It is based on positive psychology and stands as an antithesis to the negative and punitive cultures that have existed in some youth justice systems.

I have reviewed the documentation on the Incentive Scheme as it was administered for the young people in question; I have to reflect that I am impressed by the fairness in which staff operated the scheme.

By this, staff were able to differentiate across the day when young people were behaving positively and negatively and still applying incentives when they saw positive behaviour even if the young person had not been behaving at other parts of the day.

One of the problems with incentive schemes in Youth Justice Centres generally is that if a young person has a bad period of the day, staff often fail to recognise when they go well at other points in the day. This often breeds frustration with young people who believe they have earned their incentive points but have not been awarded them because of poor behaviour at other parts of the day.

This is not what I observed with this group of young people.

What I have observed is that even if they had a bad morning, staff noticed improvement and effort and rewarded these actions. This approach in my opinion represents good practice and generally fosters a greater sense of fairness that reduces tension in Centres.

In interviews with staff, there were some suggestions that the scheme was not implemented consistently by staff.

As a part of the regular management practices of the Directorate, an audit was carried out on the Incentive Scheme under the Integrated Management Scheme (IMS) Governance Committee. I have been supplied with a copy of this audit in full.

The Auditors make a number of observations and findings which go the heart of staff concerns. One of these is the repetitive nature of the forms required to be completed by staff under the scheme. I have previously conducted Audits of the IMS Governance System under which this Audit was carried out. I am confident that the Audit has identified the key issues in need of improvement and that the IMS Governance Committee has the systems in place to ensure the implementation of the improvements that arise from the Audit findings.

The Backgrounds of the Young People

Custodial facilities in Australia today house the most difficult and complex young people in our society. This group of young men was no exception.

Outside scope

Outside scope

Outside scope

I have been dealing with cases such as these for more than 35 years, yet to read the histories of these young men is disturbing reading. Many of these young people have faced situations that no child should face.

Staff at Bimberi are not just dealing with troubled young people; they are managing complex, dangerous and highly traumatised young people.

I am not writing this to excuse the behaviour of these young men but rather to highlight the complexity of cases that Management and Staff at Bimberi deal with every day.

The Directorate has responded to this need by appointing a Principal Practitioner to the Centre on a part-time basis. The role of this position is to place a more therapeutic framework around young people and to assist them in working with the young people.

The Centre already has a standard behaviour management framework around these young people but their needs are greater than what this framework can deliver to assist them and to support staff in managing a level of complexity that is often not seen in any other part of the adolescent service system.

Centre resources are augmented by those provided by Justice Health but that support is in relation to the management of mental health conditions and does not provide behavioural support.

My opinion is that the Centre resources to deal with this complex group of clients may not be sufficient to ensure that the level of therapeutic care needed is implemented on a day-to-day basis. It most certainly does not meet the Directorate's stated priority to be a therapeutic, trauma-informed service.

My experience in NSW was that every Detention Centre was staffed by a full-time Psychologist and Alcohol and other Drug Counsellor in recognition of the needs of these young people.

Our work on the *Young People in Custody Health Surveys* which have been carried out since 2003, provide a very clear picture that these are the most unwell group of young people in our society. This body of work provides an ongoing analysis of their needs.

It is my observation that the findings in NSW over the last 16 years, apply to the young people in Bimberi.

I am aware through my role on the Child and Youth Services Council that a high number of children with very complex needs have moved frequently between the out-of-home care system and Bimberi.

Many staff have spoken of some of these young people in my interviews.

It is my firm opinion that the current level of resourcing for therapeutic services to Bimberi is insufficient.

Gathering and Assessing Information on Young people in Bimberi

Over the time that I have been managing and reviewing critical incidents in Youth Justice Centres I have formed the view that in managing the day-to-day operations of a Centre, it is easy to overlook information as it accumulates. It is often only after events that reviews such as this one put all of the pieces of information together.

In writing this section of the Report, I want to make it clear that I do not believe that this issue contributed to the events on 26 August but rather make the observation as a system weakness that if addressed will strengthen Bimberi's capacity to asses and manage emerging risks.

One example of what I have observed in this review is that when I presented the collective histories of the young people involved in the incident to then Sched 2.2 (a)(ii) FOI Act 2016 she indicated that there was information about the young people of which she was unaware. This is not a criticism of her or her staff; it is a question of whether the Centre has the capacity to access and assess information on young people and to actively assess emerging trends and risk.

Sched 2.2 (a)(vi) FOI Act 2016

The current staff are busy managing young people and the Centre. There is one position that covers Family Liaison and another that covers Programs and Services as well as Classifications.

In part the Directorate's new client database CYRIS will address this issue by having a single source of truth for young people in that information about them will be available in one place with a provision of summaries. I have been briefed on this system. It substantially improves the availability and management of information available. Information that is currently split between CHYPS and YJIS is or will be integrated into a single document. Summaries and *Child Narratives* will make critical information both more available and more visible.

What is still missing in my assessment is staff capability to use this information and present it to management and staff to assist them in the dynamic assessment and management of risks.

This then touches on the Classification System which is designed to provide an objective rating of risk that takes into account a range of static and dynamic factors. The effectiveness

of that system rests on its ability to capture and assess the information necessary to make that system an effective control that identifies the objective risk-level of each young person.

This system is only as good as the information available to it. Classification is carried out by the Family Liaison Officer and is considered at the Client Services Meeting. This is a secondary task to her role. In my opinion it should be a specialist function.

Outside scope

I have reviewed the classification system and documents. I know the consultant who designed the system as she was employed in NSW. She has designed a sound system in my opinion.

My question is in how it is being applied and what it informs in terms of custodial management.

All of the young people in this event were classified but it is unclear to me that the Classification System is fully integrated into behaviour management. I will discuss this in the next section of my report.

It is my opinion that increased staffing is required to cover Classification and Intelligence. This could be a single position. This in my opinion will give Bimberi the capacity to proactively assess all of the information available on young people and to provide classification and advice on detainee risk to allow the Centre to be proactive in managing the complex risks that it manages on a daily basis.

The Integration of Behaviour Systems

In examining behaviour management systems at Bimberi, I am not convinced that they are integrated as well as they could be.

Specifically:

- How classification drives a young person's management in terms of accommodation and program levels.
- How then Incentive points and levels schemes interact with classification.
- How SMD's and ACTIA risk assessments inform all of the above.

My impression is that there is a patchwork of systems introduced at different times and for good reasons that should be reviewed to assess whether they are fit-for-purpose and whether they are achieving the aims for which they were introduced.

I concur with the Incentive Scheme Audit that there seems to be a level of system complexity which could be streamlined.

In my interviews, I have had mixed views on these systems. Some have found the SMD's helpful; other argue that they do not see them. As stated earlier in the report, I believe that the SMD's represent good practice.

Findings

I cannot find any significant failing in the systems of behaviour management over the young people involved in this incident.

The Daily Assessment Sheets could be more consistently applied but this is not an issue of substantial concern.

The operation of the Incentive Scheme in relation to the fairness with which it was applied to this group of young people is a positive feature of behaviour management.

Outside scope

The Audit on the Incentive Scheme has highlighted areas for improvement. I concur with the findings and recommendations of that Audit.

Bimberi is housing a cohort of young people with highly complex needs. A number of the young people have mental health concerns and come from families where they have witnessed significant incidents of family and domestic violence.

There is a risk that the forms and processes supporting behaviour management have become overly complex and may not be fully integrated.

There is insufficient therapeutic capability in Bimberi to support the management of this highly complex group of young people.

There is insufficient capability in Bimberi to support the Intelligence and Classification functions.

Recommendations:

1. **The Community Services Directorate increases the therapeutic staff available to Bimberi to manage the complex needs of residents.**
2. **The Community Services Directorate increases the staff available to manage classification and intelligence functions at the Centre.**
3. **The IMS Governance Committee monitors the implementation of the recommendations of the Audit on the Incentive Scheme.**
4. **The Community Services Directorate undertakes a review of the operation of behaviour management systems currently in place to ensure that they are integrated and support staff in their management of young people in custody. This review should take into account improvements made in the deployment of the CYRIS.**

4. The response by Bimberi staff to the incident.

This incident was at the more serious end of what you would expect to see in a Youth Justice Centre. Staff being assaulted, attacked with an improvised weapon, hit with a large object

Sched 2.2 (a)(vi) FOI Act 2016

There is much to commend in the staff response to this incident.

Adjectives such as courage, commitment, professionalism and teamwork are what I would use to characterise the staff response to this incident.

The speed of response from the Sched 2.2 (a)(ii) FOI Act 2016 in identifying and calling the Code on the Incident allowed a swift response from all available staff.

Every staff member in the Centre with the exception of the Sched 2.2 (a)(ii) FOI Act 2016 was actively involved in responding to this Incident.

There was a high degree of teamwork. I cannot find any staff member that did not respond to the best of their ability.

At the height of the violence, no one froze or fled. Everyone stayed the course to support their fellow staff.

What is more impressive is that in the midst of this there is evidence of acts of staff compassion to the very detainees who were attacking them.

Staff have reported to me in interviews that they overheard other staff members re-assuring young people even while they were being attacked.

I must make particular mention of Sched 2.2 I have outlined his circumstances earlier in this report. Sched 2.2 (a)(ii) FOI Act 2016 Outside scope
he showed professionalism and restraint that warrants my attention.

Outside scope

I would not have blamed him had he done so. Indeed given what occurred, I believe that it was a reasonable and proportionate response to what was occurring. To show such restraint is a testament to his character and professionalism.

Some staff have expressed that in Sched 2.2 (a)(ii) FOI Act 2016

Sched 2.2 (a)(ii) FOI

Staffing and Lockdowns

Sched 2, 2.2 (a) (vi) FOI Act 2016

Training

Sched 2, 2.2 (a) (vi) FOI Act 2016

Findings

Staff responded to this event with a high degree of professionalism, courage and teamwork.

In the midst of being attacked by young people, there is evidence of staff demonstrating a high degree of care and restraint in their dealings with these young people.

Sched 2.2 (a)(vi) FOI Act 2016

Further investigation is needed as to the impact that staff absences may be having on the operating environment at the centre but at this stage I can find no evidence that these shortages played any part in the lead up to or handling of the events of 26 August.

A strategy to ensure that all staff are provided with refresher training on the use of force is required.

Recommendations

5. **The Community Services Directorate formally acknowledges the staff response to this incident.**
6. **The Community Services Directorate ensures that its Workforce Strategy facilitates the adequate supply of staff to Bimberi to allow for the effective operation of the centre at its correct staffing level and incorporates a strategy to ensure that ongoing training is accessible to staff.**

5. The management of the incident and alignment with policy and procedures.

In considering this term of reference, I have had regard to the:

- Behaviour Management Policy and Procedures;
- Admission and Classification Policies and Procedures;
- Discipline Policy and Procedures;
- Safety and Security Policies and Procedures;
- Use of Force Policies and Procedures;
- Treatment of Convicted and Non-Convicted Young People Policy and Procedures; and
- Emergency Operating Plan Manual.

In satisfying myself in relation to this term of reference, I have read all of the above Policies and Procedures and measured them against the facts that I have been able to establish in this case. I have only considered the Policies and Procedures against this incident and have not made any broader consideration of their application across Bimberi.

Behaviour Management Policies and Procedures

In the course of conducting my review, I have seen examples of all of the strategies in this Policy and Procedure applied to the young people in question at various times.

I have commented on these in other places in the report.

I have seen examples of proactive and reactive strategies applied to them; the operation of both the Incentive and Disciplinary Schemes; very good examples of staff attempting alternative strategies and attempting to build positive relationships with young people.

Some areas for improvement have already been identified by the Directorate's own business processes in the Incentive Scheme and corrective action is underway to rectify these areas.

My assessment is that in both the incident and the lead up to the incident, that the Centre was compliant as far as is reasonably practicable with this Policy and Procedure.

Admission and Classification Policies and Procedures

I have reviewed this document largely in relation to classification.

Apart from there areas where I believe improvements can be made to the system, it is my assessment that Bimberi was compliant with this Policy and Procedure in this incident.

Discipline Policy and Procedures

I have not conducted any detailed review of the disciplinary system. However, I have seen the system applied at various stages to a number of the young people involved in this incident.

I have not detected any breaches in this Police and Procedure.

Safety and Security Policies and Procedures

Sched 2, 2.2 (a) (vi) FOI Act 2016

Use of Force Policies and Procedures

I have reviewed the Policy and Procedure in detail.

It is my opinion that staff were fully compliant with this document.

Sched 2.2 (a)(vi) FOI Act 2016

It is my strong opinion that their actions were reasonable and proportionate in the circumstances and that their actions should be supported.

Treatment of Convicted and Non-Convicted Young People Policy and Procedures

I can see no breaches of this Policy and Procedure in relation to this incident.

Emergency Operating Plan Manual

The emergency response in this Incident is to be highly commended.

The Sched 2.2 (a)(ii) FOI Act 2016 was vigilant and proactive. Code calls and locations were clear and prompt. The staff and management response was swift and effective.

Sched 2.2 (a)(vi) FOI Act 2016

Findings

I found no breaches of the Behaviour Management Policy in relation to this incident.

I found no breaches of the Admission and Classification Policies and Procedures in this incident.

I found no breaches of the Discipline Policy and Procedures in this incident.

I found no breaches of the Use of Force Policy and Procedures in this incident. In moving four young people to their room, tactics were employed that were contrary to training.

Sched 2.2 (a)(vi) FOI Act 2016

Recommendations

7. Sched 2.2 (a)(vi) FOI Act 2016
8.
9. **The Safety and Security Policy and Procedures is reviewed to take into account the matters raised in this section of the Report.**

6. The application of the emergency procedures.

Sched 2, 2.2 (a) (vi) FOI Act 2016

Sched 2, 2.2 (a) (vi) FOI Act 2016

Sched 2, 2.2 (a) (vi) FOI Act 2016

Sched 2.2 (a)(vi) FOI Act 2016

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7. The suitability of the physical design and infrastructure.

Sched 2.2 (a)(vi) FOI Act 2016

Sched 2, 2.2 (a) (vi) FOI Act 2016

Sched 2, 2.2 (a) (vi) FOI Act 2016

Sched 2, 2.2 (a) (vi) FOI Act 2016

Sched 2, 2.2 (a) (vi) FOI Act 2016

Sched 2, 2.2 (a) (vi) FOI Act 2016

8. The work health and safety system as it pertains to the incident.

I have had the opportunity to examine the Minutes of the Workplace Health and Safety (WHS) Committee for 2019 as well as the Bimberi Operational Risk Register and the Bimberi WHS Risk Register.

The CPSU representatives have also made representations to me on WHS in the interview that I have held with them.

In terms of Risk identification, the risk of injuries to staff, visitors and young people is identified in the Bimberi Operational Risk Register. The risk assigned in this document is that it is a high-risk. The proposed controls for this violence are:

- *Access control and screening processes*
- *Behaviour Management System*
- *Classification system*
- *Emergency operating procedures*
- *Inductions and security briefings for non- operational staff and visitors*
- *Intelligence gathering*
- *Daily briefing*
- *Program risk assessment*
- *Skills maintenance sessions*
- *Policies and Procedures*
- *Facilities and security maintenance schedules*
- *Risk assess contact requests*
- *Recruitment and training*
- *Health and Safety program*
- *Electronic security systems*
- *Analysis of RISKMAN reports*
- *WHS inspections and Committee*
- *Analysis of WC claims/incidents*
- *NH House Governance and Referral systems*

Each of these areas has detailed policies and procedures underpinning them.

Even with the following additional controls, the Residual Risk Rating of violence remains high. The additional Controls listed are:

- *Security upgrade*
- *Relevant and up to date BCP*
- *All policy and procedure (including Practice Guidelines) up to date*
- *Meet WHS requirements*[3]

There are two questions here. The first is; are these total controls that prevent violence?

The second is that are these controls operating effectively?

[3] All matters in italics are taken directly from Bimberi materials.

Prima facie, these look as though they are the key systems that should deal with detainee behaviour. What I have not undertaken is a review of the systems themselves.

From my review to date, I can see clear evidence of the Behaviour Management Systems applying to the young people who have participated in this incident. I can see clear evidence that a range of strategies were employed to deal with negative behaviour. The evidence available to me to date indicates that staff were proactive in addressing poor behaviour and whilst the quality of those systems was not perfect (for example, some documents are missing such as daily monitoring sheets); overall I can see that they systems were functioning.

Behaviour Breach Reports are evident. Some of the young people at various times were charged under the internal scheme.

In terms of positive behaviour, the Incentive Scheme was functional. It is clear that staff were largely applying the scheme fairly to the young people concerned. An audit on the Incentive Scheme has identified opportunities to strengthen it.

What I cannot answer is whether that system is the most effective that could be in place.

The Classification System is in place. Outside scope

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I have questions about the operation and structure of the Classification System at Bimberi as an effective control.

Sched 2, 2.2 (a) (vi) FOI Act 2016

I have addressed this earlier in the report.

I can see that systems relating to Program Risk Assessment were in place for the young people involved in this incident.

It is clear that Daily Briefings are in place. In this case on the day in question, Sched 2.2 (a)(vi) FOI Act 2016

I am uncertain as to the effectiveness of Skills Maintenance Sessions as a means of ensuring staff training is up to date. It appears to me at this stage that staff shortages may be impacting on the effectiveness of this strategy.

Other controls surround the WHS System itself.

I have been provided with Minutes of the WHS Committee for 2019.

Three meetings have been scheduled for 2019. Two of those have formally lapsed due to a lack of a quorum. Union representatives have only attended once this year. The Health and Safety Representative was not present at the only meeting to be formally held.

There is evidence in these documents that some workplace inspections have occurred. I am unable to comment on what these have examined and what corrective action may have flowed.

There is evidence that the Risk Registers were circulated. The Registers were reviewed in management meetings according to minutes provided to me but I cannot as yet find evidence that the WHS Committee has conducted any reviews of these Registers.

There is evidence that de-identified *Riskman* data was circulated but no record of what actions were taken in response to this data.

A review of CCTV has been held at Bimberi. I have not seen the contents of that review. It has however underpinned the successful Sched 2.2 (a)(vi) FOI Act 2016

What perhaps strikes me the most from the WHS Committee Minutes is that there is no mention at all of workplace violence and injuries Sched 2, 2.2 (a) (vi) FOI Act 2016

Sched 2.2 (a)(vi) FOI Act 2016
It lists the following controls:

- *Business continuity plan*
- *Emergency Operating Procedures*
- *Annual emergency drill schedule*
- *Functioning Emergency Planning Committee*
- *Functioning Emergency Control Organisation*.

I have questions about the effectiveness of these controls. I have not been provided with evidence that the Emergency Planning Committee is functioning, that emergency planning is adequate and that drills are carried out.

Sched 2.2 (a)(vi) FOI Act 2016

The Bimberi WHS Risk Register identifies the following relevant risk to this event; *workers exposed to occupational violence in the workplace*.

Representatives of the CPSU have raised concerns as to the effectiveness of the controls listed in this Register. I share those concerns but for a different reason. My concern is that they do not accurately reflect the controls that are in place as listed in the Bimberi Operational Risk Register.

I have invited the Health and Safety Representative(s) to meet with me in relation to this review. I have provided the CPSU with my direct email address to allow them to contact me.

I had a meeting scheduled on 10 October with both the CPSU and the HSR's. Neither attended the meeting

Findings

My finding against this term of reference is that the WHS system is not functioning as effectively as it should. The level of engagement from key stakeholders is low. There is no evidence that the Committee is working to a plan that continually assesses the workplace risks and the effectiveness of controls to address those risks.

Improvements could be made to the WHS Risk Register that better identify the controls in place over the behaviour of young people in custody. These controls are better reflected in the Bimberi Operational Risk Register.

There is evidence that actions are being initiated to review risks and data in relation WHS. What is not clear is that these actions have been completed and found their way into improved systems of safety.

My opinion is that there is a comprehensive set of systems in place designed to deal with detainee behaviour and in the case of the young people in this incident I can see that those systems were largely applied. These systems would benefit from periodic review. This review should be a part of the ongoing work of the IMS Governance Committee.

I do however have questions about the effectiveness and structure of the following systems:

- **Classification;**
- **Intelligence;**
- **Emergency Management and Planning.**

Recommendations

26. **The Directorate should provide short-term support to Bimberi to ensure that the WHS system is operating as it is intended. A program of work and reviews should be established. There should be a greater focus on stakeholder engagement.**

9. THE ADEQUACY OF THE EMERGENCY OPERATING PROCEDURES, BEHAVIOUR MANAGEMENT SYSTEM AND TRAINING IN RELATION TO CRITICAL INCIDENTS

EMERGENCY OPERATING PROCEDURES

The Emergency Operating Procedures are largely consistent with what I have seen in other jurisdiction where I have either worked or held reviews.

I have highlighted earlier my concerns about Emergency Preparedness and won't repeat them here.

What I will observe is that the procedures simply do not envisage an incident of the scale and magnitude to what occurred.

Sched 2, 2.2 (a) (vi) FOI Act 2016

Sched 2, 2.2 (a) (vi) FOI Act 2016

BEHAVIOUR MANAGEMENT SYSTEMS

With the exceptions of the issues raised earlier in this report; namely therapeutic support, classification and intelligence, I do not see any major structural flaws in the systems of behaviour management.

The challenge in custodial environments is always their application and consistency across teams and shifts.

My view is that this is best managed under the IMS Governance System and that regular systems audits and reviews should occur.

TRAINING IN RESPONDING TO CRITICAL INCIDENTS

The staff that I have interviewed for this review believe that their training prepared them well to respond. Sched 2.2 (a)(ii) FOI Act 2016

The major issue is access to refresher training in the current staffing environment.

Sched 2.2 (a)(vi) FOI Act 2016

Recommendations

27. **Complete a review of the Emergency Operating procedures in the light of this event that takes into account emergencies of greater magnitude and assesses the capability of staff to respond to those scenarios.**

END OF REPORT

ATTACHMENT A – TERMS OF REFERENCE

Bimberi Youth Justice Centre
MAJOR INCIDENT REVIEW

Purpose

The purpose of this review is to consider the response to the major incident that occurred at the Bimberi Youth Justice on 26 August 2019.

Specifically, the reviewer should consider:

1)whether there were any obvious precursors to the event
2)the appropriateness of the management of young people leading up to the event, including classifications and the implementation of the behaviour management framework.
3)the response by Bimberi staff to the incident
4)the management of the incident and alignment with policy and procedures
5)the application of the emergency procedures
6)the suitability of the physical design and infrastructure
7)the work health and safety system as it pertains to the incident.

In addition, the review should comment on the adequacy of the:

- Emergency Operating Procedures
- Behaviour Management System
- Training in responding to Critical Incidents

Report

The reviewer will provide an interim report by 13 September 2019 to identify if there are any immediate changes that needs to occur to contribute to improved practice, policy, procedure or physical improvements, having consideration for the scale of operations at the Bimberi Youth Justice Centre.

A final report will be provided by 1 November 2019 dealing with the substantive issues as identified in these terms of reference.

In the context of the final report, the reviewer will provide an executive summary for public release recognising that much of the information that will be contained in the report will be unable to be released subject to the requirements of the *Children and Young People Act 2008*.

ATTACHMENT B – STATEMENT OF RESPONSIBILITY AND ACCOUNTABILITY

Peter Muir Consulting Pty Ltd takes responsibility for this report, which is prepared on the basis of the limitations set out below.

The matters raised in this report are only those that came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made.

The Community Services Directorate, ACT Government should assess recommendations for improvements for their full commercial and operational impact before they are implemented.

This report is confidential, has been prepared solely for the use of the Community Services Directorate, ACT Government and ownership of the report and any attachments lies with your organisation. It is the responsibility of your organisation to determine if you wish to release this report, in whole or in part. However, this should not occur without our prior written consent.

No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose.