Investigation into deaths and harm in custody
March 2014

Ombudsman Act 1973
Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the Ombudsman Act 1973, I present to Parliament a report into an Investigation into deaths and harm in custody.

G E Brouwer
OMBUDSMAN
25 March 2014
Contents

Key issues 5
Executive summary 9
Background 16
Reasons for conducting my investigation 18
Investigation 24
Common issues 26
Overcrowding 27
  Victorian prisons 28
  Conclusions 41
  Recommendations 42
Victoria Police cells 44
  Conclusions 51
  Recommendations 52
The management of detainees at risk of suicide or self-harm 54
  Monitoring of people at risk of suicide or self-harm 54
    Victorian prisons 54
    Conclusions 57
    Recommendation 57
  Placement of people at risk of suicide or self-harm 57
    Victorian prisons 57
    Youth justice 60
    Conclusions 60
    Recommendation 60
Strategies to minimise suicide or self-harm 61
  Victorian prisons 61
  Conclusions 63
  Recommendation 63
Incident reporting 63
  Victorian prisons 63
  Conclusions 66
  Recommendations 66
The safety of detainees in custody 68
  Compliance with safety standards 68
    Youth justice 68
    Conclusions 69
    Recommendation 70
  Victorian prisons 71
  The Building Design Review Project 72
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk assessment of cells</td>
<td>73</td>
</tr>
<tr>
<td>$11 million reprioritisation of project funding</td>
<td>74</td>
</tr>
<tr>
<td>Obvious hanging points</td>
<td>75</td>
</tr>
<tr>
<td>Cell safety for the future</td>
<td>85</td>
</tr>
<tr>
<td>Conclusions</td>
<td>85</td>
</tr>
<tr>
<td>Recommendations</td>
<td>87</td>
</tr>
<tr>
<td>The Thomas Embling Hospital</td>
<td>89</td>
</tr>
<tr>
<td>Conclusions</td>
<td>92</td>
</tr>
<tr>
<td>Recommendation</td>
<td>92</td>
</tr>
<tr>
<td>Monitoring systems</td>
<td>93</td>
</tr>
<tr>
<td>Closed circuit television monitoring</td>
<td>93</td>
</tr>
<tr>
<td>Youth justice</td>
<td>93</td>
</tr>
<tr>
<td>The Thomas Embling Hospital</td>
<td>94</td>
</tr>
<tr>
<td>Conclusions</td>
<td>96</td>
</tr>
<tr>
<td>Recommendation</td>
<td>96</td>
</tr>
<tr>
<td>Transitional support services</td>
<td>97</td>
</tr>
<tr>
<td>Victorian prisons</td>
<td>99</td>
</tr>
<tr>
<td>Conclusions</td>
<td>103</td>
</tr>
<tr>
<td>Recommendations</td>
<td>103</td>
</tr>
<tr>
<td>Access to appropriate health care</td>
<td>105</td>
</tr>
<tr>
<td>Medical assessments</td>
<td>106</td>
</tr>
<tr>
<td>Victorian prisons</td>
<td>106</td>
</tr>
<tr>
<td>Conclusions</td>
<td>109</td>
</tr>
<tr>
<td>Recommendations</td>
<td>109</td>
</tr>
<tr>
<td>Victoria Police cells</td>
<td>110</td>
</tr>
<tr>
<td>Conclusions</td>
<td>111</td>
</tr>
<tr>
<td>Recommendation</td>
<td>111</td>
</tr>
<tr>
<td>Mental health care</td>
<td>111</td>
</tr>
<tr>
<td>Victorian prisons</td>
<td>111</td>
</tr>
<tr>
<td>Conclusions</td>
<td>114</td>
</tr>
<tr>
<td>Recommendations</td>
<td>115</td>
</tr>
<tr>
<td>Victoria Police cells</td>
<td>115</td>
</tr>
<tr>
<td>Conclusions</td>
<td>117</td>
</tr>
<tr>
<td>Recommendations</td>
<td>118</td>
</tr>
<tr>
<td>The Thomas Embling Hospital</td>
<td>119</td>
</tr>
<tr>
<td>Conclusions</td>
<td>121</td>
</tr>
<tr>
<td>Recommendation</td>
<td>121</td>
</tr>
<tr>
<td>Health care services</td>
<td>122</td>
</tr>
<tr>
<td>Victorian prisons</td>
<td>122</td>
</tr>
<tr>
<td>Conclusions</td>
<td>125</td>
</tr>
<tr>
<td>Recommendations</td>
<td>126</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Accountability and transparency</td>
<td>127</td>
</tr>
<tr>
<td>Monitoring and review</td>
<td>127</td>
</tr>
<tr>
<td>Lack of independence</td>
<td>129</td>
</tr>
<tr>
<td>Investigation outcomes</td>
<td>130</td>
</tr>
<tr>
<td>Lack of transparency</td>
<td>131</td>
</tr>
<tr>
<td>Independent visitors</td>
<td>134</td>
</tr>
<tr>
<td>Conclusions</td>
<td>135</td>
</tr>
<tr>
<td>Recommendations</td>
<td>136</td>
</tr>
<tr>
<td>Summary of recommendations</td>
<td>138</td>
</tr>
<tr>
<td>Appendix 1: Photographs of Victorian prisons showing hanging points</td>
<td>144</td>
</tr>
<tr>
<td>Appendix 2: Victorian custodial facilities</td>
<td>146</td>
</tr>
</tbody>
</table>
Key issues

Overcrowding

Victorian prisons

My investigation identified that:

- there has been a failure to provide sufficient funding for new and existing prison infrastructure over the past decade
- prisoners are placed in overcrowded and at times substandard conditions leading to increasing tensions and violence
- the likelihood of prisoners being physically or sexually assaulted or self-harming leading to deaths is greater now than at any time in recent years
- prison staff are at greater risk of being assaulted by prisoners as a consequence of overcrowding.

Victoria Police cells

My investigation identified that as a consequence of overcrowding:

- police cells designed for short-term stays are being used as de-facto prisons to at times hold in excess of 350 detainees
- the resources required to supervise higher numbers of detainees in police custody has placed a significant burden on police resources and resulted in less police being available to patrol local areas
- detainees are being held at the Melbourne Custody Centre for extended periods of time without access to fresh air or natural light, in breach of the Victorian Charter of Human Rights and Responsibilities
- detainees are frequently transferred to police cells across the State, limiting their access to family and legal representation
- detainees in police cells do not always have access to clean clothes
- some detainees are being held in police cells for in excess of 14 consecutive days at the same location, contrary to gazetted requirements
- the Melbourne Custody Centre is often full meaning that Corrections Victoria has been unable to ensure that some prisoners attend scheduled court appearances, resulting in disruption to the criminal justice system.
Management of detainees at risk of suicide or self-harm

Approximately 55 per cent of the prison population have an identified suicide/self-harm risk rating, while 42 per cent have a psychiatric risk rating indicating mental health concerns.

My investigation identified that:

- the risk rating system used by Corrections Victoria to identify and manage prisoners at risk of suicide/self-harm requires review to provide greater clarity and guidance
- differences between the assigned suicide/self-harm risk rating can have significant consequences for prisoners in relation to the mental health treatment they receive
- Corrections Victoria has been slow to implement changes to its suicide prevention strategies – continuing to allow prisoners identified at risk of suicide or self-harm to access potentially dangerous items such as razor blades, leading to self-harm.

The safety of detainees in custody

Over 22 years ago the Royal Commission into Aboriginal Deaths in Custody called for police and corrective services to carefully scrutinise equipment and facilities with a view to eliminating and/or reducing potential hanging points.

Despite this longstanding recommendation, my investigation identified many obvious hanging points in Victorian prisons and the Thomas Embling Hospital placing prisoners and patients at risk of suicide or self-harm.

Victorian prisons

My investigation identified that:

- Corrections Victoria poorly managed a $50 million project to eliminate hanging points, including removing $11 million in project funding without adequate assessment of the impact on cell safety
- 38 per cent of all prison cells still have hanging points and fail to comply with Corrections Victoria’s Cell and Fire Safety Guidelines and the recommendations of the Royal Commission into Aboriginal Deaths in Custody in relation to safe cells
- there have been six prisoners in the past six years (several of whom had mental health issues) who committed suicide by hanging, nearly all in cells which did not comply with the cell and fire safety guidelines
- Corrections Victoria failed to comply with the recommendations of the State Coroner in relation to improving cell safety and the accommodation of prisoners with mental health issues
- Corrections Victoria continues to place prisoners with a history of suicide/self-harm or mental health issues in cells with hanging points
• the many obvious hanging points in more than one third of all prison cells raise concerns whether Corrections Victoria is meeting its duty of care to prisoners and complying with the Charter of Human Rights and Responsibilities

• Corrections Victoria has no immediate plans to eliminate hanging points from 1,236 cells accommodating 1,650 prisoners.

The Thomas Embling Hospital

My investigation identified that:

• there are a number of obvious hanging points in accommodation for mentally unwell patients throughout the hospital highlighted by the hanging death of a patient in June 2013

• the hospital has only recently taken steps to identify and address the many obvious hanging points throughout the hospital

• the lack of closed circuit television coverage in patient units throughout the hospital compromises the safety and security of the hospital for both its patients and staff.

Transitional support services

The deaths of recently released prisoners are a hidden toll which are far greater in number than the number of deaths in custody in Australia each year.

My investigation identified that:

• intensive transitional support services in the community are limited to 695 prisoners per year (6,609 prisoners were released from Victorian prisons into the community during 2012-13)

• finding suitable housing for ex-prisoners in the community is a significant issue

• despite the large number of prisoners with a psychiatric condition, the community integration program for prisoners with mental health issues is limited to 100 prisoners per year and operates at only two prisons.

Access to appropriate health care

Despite my office having raised concerns with the Department of Justice in 2011 regarding the grossly inadequate number of psychiatric beds for prisoners with mental health issues, the department has failed to increase the number of mental health beds in the Victorian prison system.

With overcrowding and the shortage of psychiatric beds, prisoners with mental health issues are at increased risk of self-harm and even death. The lack of psychiatric beds at the Thomas Embling Hospital means that only prisoners who are exceptionally mentally unwell are admitted for treatment.
Corrections Victoria is failing to identify and safely manage prisoners with an intellectual disability or an acquired brain injury, placing them at risk of harm in the prison system.

The current prisoner health model has significant shortcomings with the potential to adversely affect the health of prisoners. The shortcomings include:

- inadequate inpatient facilities
- the lack of medical services available at some regional prisons
- difficulties with prisoners attending specialist appointments due to limited transport arrangements
- the requirement for prisoners to attend Port Phillip Prison to receive certain types of specialist medical treatment
- the inability of prisoners to choose their own doctor in certain circumstances, or to access the Medicare or Pharmaceutical Benefits schemes.

**Accountability and transparency**

My investigation identified that the Office of Correctional Services Review (OCSR) which is responsible for monitoring and reviewing the performance of Victorian prisons, Community Correctional Services and other correctional services:

- lacks independence from Corrections Victoria
- lacks transparency
- has repeatedly failed to take appropriate action in relation to systemic issues affecting the Victorian prison system, including prisoner deaths.

As the OCSR does not publicly report the outcomes of its investigations, the public and Parliament have no way of knowing whether appropriate remedial action has been taken by prison authorities.
Executive summary

1. The State owes a duty of care to every person detained in custody to ensure their safety and wellbeing. For example, in the Victorian prison system the Secretary of the Department of Justice has a statutory duty\(^1\) to ensure the safe custody and welfare of prisoners and offenders in the Secretary’s custody.

2. There are a number of rights that are engaged under the Victorian *Charter of Human Rights and Responsibilities Act 2006*\(^2\) when a person is detained in custody, including a person’s right to humane treatment and the right not to be arbitrarily deprived of life.

3. The Victorian community should have confidence in what happens behind the closed doors of custodial facilities – that detainees are managed in a fair and consistent manner; that they are treated with dignity and respect for their human rights; and that those responsible for caring for detainees are held accountable for their actions.

4. Many people in custody are vulnerable, often with complex social, legal and medical histories. Each year a number of people die in custody, while many more experience some form of harm, injury or illness.

5. For over 40 years, the welfare of people in custody has been a concern of the Victorian Ombudsman. In a number of my reports\(^3\) to Parliament I have identified concerns about the treatment of people in custody and made recommendations to address such concerns.

6. Given continuing overcrowding in Victorian prisons and police cells, coinciding with an increase in the number of prisoner deaths in 2012-13, I decided that an own motion investigation into deaths in Victorian custodial facilities was warranted. My investigation focussed on Victorian prisons, police cells, the youth justice precincts and the secure psychiatric hospital\(^4\) for people with serious mental illness admitted under the *Mental Health Act 1986*.

Common issues

7. My investigation identified a number of common issues impacting on the ability of custodial operators to ensure the safety and wellbeing of people in their care. These issues include:

   • overcrowding
   • the management of detainees at risk of suicide or self-harm
   • the safety of detainees in custody
   • transitional support services
   • access to appropriate health care
   • accountability and transparency.

---

1 Section 7, *Corrections Act 1986*.
2 Victoria is the only State in Australia to have a human rights Act.
4 The Thomas Embling Hospital located at Fairfield, Melbourne.
Overcrowding

8. There is a crisis in overcrowded prison and police cells caused by inadequate beds in the Victorian prison system. In the past 10 years, the number of prisoners in the Victorian prison system has increased by 38 per cent.

9. Overcrowding has resulted in police cells designed for overnight or short-term stays being used as de-facto prisons to at times hold in excess of 350 detainees. On 10 March 2014, there were 306 detainees in police cells. I am of the view that holding detainees for up to 14 days or longer at the Melbourne Custody Centre, a facility which has no access to fresh air or daylight, is a breach of the Victorian Charter of Human Rights and Responsibilities.

10. As a result of overcrowding, people detained in custody in Victoria face a greater risk of harm than at any time in the past decade. Prisoners are placed in overcrowded and at times substandard conditions with a risk of physical and sexual assault, and with limited access to appropriate health care services.

11. The failure to provide sufficient funding for new and existing prison infrastructure over the past decade has resulted in Victorian prisons being overcrowded. This problem has been compounded by changes to sentencing and parole laws and the deployment of more police on our streets, resulting in greater numbers of prisoners in Victorian prisons and police cells than in recent history.

12. With construction of a new men’s prison not scheduled for completion until late 2017 and the expansion of several existing prisons some years away from completion, I am concerned about the likelihood of an increase in the number of prisoner deaths and violent incidents in the meantime.

The management of detainees at risk of suicide or self-harm

13. It is important that prisoners potentially at risk of suicide or self-harm are promptly identified and appropriately managed, so that they are kept safe from harm. I consider that the risk rating system used by Corrections Victoria to identify and manage prisoners at risk of suicide or self-harm requires review to provide greater clarity and guidance.

14. The suicide/self-harm risk rating assigned to a prisoner by medical staff can have significant implications in relation to the level of mental health treatment a prisoner receives. This is despite the differences identified between prisoners assessed at ‘significant’ or ‘potential’ risk of suicide or self-harm often being minimal.

5 The Melbourne Custody Centre is the main reception facility in Melbourne for people who have been arrested by police. The facility is managed by G4S Australia Pty Ltd, a contractor for Victoria Police.


7 Corrections Victoria is a business unit of the Department of Justice, with responsibility for managing Victoria’s adult corrections system.
15. The traditional method of managing a prisoner identified at immediate risk of suicide or self-harm – placing them in a canvas gown and isolating them in an observation cell under observation by custodial staff, raises concerns as to whether this type of treatment can, in the long-term, be detrimental to the mental health of some prisoners. By way of contrast, the youth justice precincts have successfully implemented strategies which rely less on physical isolation of detainees identified at risk of suicide or self-harm and more on a therapeutic approach.

16. Corrections Victoria has been slow to implement changes to its suicide prevention strategies. For example, continuing to allow prisoners identified at risk of suicide or self-harm to access potentially dangerous items such as razor blades, leading to self-harm.

The safety of detainees in custody

17. It is of concern that 22 years after the Royal Commission into Aboriginal Deaths in Custody called for police and corrective services to eliminate and/or reduce the potential for harm to detainees, including steps to screen potential hanging points, my investigation identified many obvious hanging points in Victorian prisons and the Thomas Embling Hospital.

18. My investigation identified that Corrections Victoria:
   - poorly managed a $50 million project to eliminate hanging points and improve prison cell safety
   - reallocated $11 million from the $50 million project fund without adequate assessment of the impact on cell safety
   - failed to comply with the recommendations of the State Coroner following the death of a prisoner at Port Phillip Prison in 2008, in relation to the removal of hanging points (heating pipes) from cells and ensuring that prisoners identified at potential risk of suicide/self-harm or with psychiatric issues are not accommodated in such cells
   - does not conduct reviews of refurbished cells to ensure compliance with current cell and fire safety guidelines
   - does not have equivalent cell and fire safety guidelines in place for cottage-style accommodation.

19. I am concerned that 38 per cent of all prison cells (1,236 cells) still have hanging points and do not comply with Corrections Victoria’s Cell and Fire Safety Guidelines. My investigation established that Corrections Victoria has no immediate plans to eliminate hanging points from the 1,236 cells accommodating 1,650 prisoners.

---


9 A solid fixture such as a bunk bed ladder or shower head which could be used as an anchor point to attach a ligature.

10 Self-contained cottages with kitchen, living room and bedrooms.
20. There have been six prisoners in the past six years who have committed suicide by hanging, nearly all in cells which did not comply with the guidelines. In several of these cases, the prisoner had been identified by Corrections Victoria as being at potential risk of suicide/self-harm or having mental health issues. Nonetheless, a decision was made by Corrections Victoria to place the prisoner in a cell with obvious hanging points.

21. It is unsatisfactory that Corrections Victoria has failed to comply with the recommendations of the State Coroner in relation to making the heating pipes at Port Phillip Prison safe following the hanging death of a prisoner in 2008. The lessons from this death have not been learnt.

22. In consideration of prison overcrowding and the large number of prisoners with either a suicide/self-harm risk rating (55 per cent) or a psychiatric risk rating (42 per cent), it is unacceptable that Corrections Victoria continues to place prisoners in prison cells with hanging points.

23. Corrections Victoria should act to eliminate hanging points from existing prison cells and to comply with the Royal Commission’s recommendations. The focus should be on practical, time and cost effective solutions aimed at reducing obvious hanging points and making cells safer. Without improvements taking place, I am concerned that there may be more prisoner deaths which could have been prevented.

24. Given the mentally unwell state of patients accommodated at the Thomas Embling Hospital, it is of concern that the hospital has only recently taken adequate steps to identify and address the many obvious hanging points throughout the hospital. This oversight is highlighted by the hanging death of a patient in June 2013.

25. The lack of closed circuit television (CCTV) coverage in patient units throughout the Thomas Embling Hospital also compromises the safety and security of the hospital for both its patients and staff.

26. By way of contrast, the Department of Human Services has taken positive steps to eliminate hanging points and improve accommodation safety and monitoring systems, such as CCTV, in the youth justice precincts following my investigation into conditions there.

Transitional support services

27. The deaths of recently released prisoners are a hidden toll, which according to one study, are far greater in number than the number of deaths in custody in Australia each year.

28. Post-release deaths raise concerns about the duty of care owed to people after they leave custody. It requires a multi-disciplinary approach from government and community agencies to ensure that ex-prisoners are provided with adequate housing, health, employment and education opportunities in the community so as to minimise the risks of death upon their release and limit the chances of them re-offending.

---

11 The Department of Human Services is responsible for the administration of youth justice services in Victoria.


13 Mr Stuart A Kinner, Mr David B Preen, Mr Azar Kariminia, Mr Tony Butler, Ms Jessica Y Andrews, Mr Mark Stoové and Mr Matthew Law, *Counting the cost: estimating the number of deaths among recently released prisoners in Australia*, Medical Journal Australia 2011 195 (2), 64-68.
29. While approximately 6,600 prisoners were released from Victorian prisons into the community during 2012-13, only 695 prisoners per year have access to intensive transitional support services in the community. Finding suitable housing for people re-entering the community is also a significant issue.

**Access to appropriate health care**

30. Prisoners present with complex health issues requiring accurate assessment and treatment of their health concerns. Given the high number of prisoners released into the community each year, the health of prisoners can have significant effects on the wider community. Particularly, the spreading of infectious diseases. Therefore, it is important that prisoners are provided with a reasonable standard of health care.

31. Despite having identified in my 2011 report\(^\text{14}\) to Parliament the grossly inadequate number of psychiatric beds for the treatment of prisoners with mental health conditions, and calling for an increase in the number of beds, there has been no increase. With overcrowding in the prison system the situation has worsened for prisoners with mental health issues.

32. Compounding this issue is the lack of mental health beds at the secure Thomas Embling Hospital. My investigation established that only the most acutely unwell prisoners are receiving treatment at the hospital.

33. Without an immediate increase in mental health beds, the mental health of some prisoners will deteriorate, leading to increased incidents of self-harm and potentially death. As a result, measures are urgently needed to adequately care for prisoners with mental health issues.

34. Corrections Victoria is failing to identify all prisoners with an intellectual disability or an acquired brain injury. There are also limited options in the prison system for dealing with such prisoners, placing them at risk of harm.

35. Physical health care services in Victorian prisons are also under pressure as a consequence of overcrowding. The current prisoner health model has significant shortcomings with the potential to adversely affect the health of prisoners. The shortcomings include:

- inadequate inpatient facilities
- the lack of medical services available at some regional prisons
- difficulties with prisoners attending specialist appointments due to limited transport arrangements
- the requirement for prisoners to attend Port Phillip Prison to receive certain types of specialist medical treatment
- the inability of prisoners to choose their own doctor in certain circumstances, or to access the Medicare or Pharmaceutical Benefits schemes.

36. I consider there needs to be significant change to the prisoner health care model to ensure that prisoners receive access to appropriate health care.

**Accountability and transparency**

37. The Victorian community should have confidence that the custodial system is subject to independent, robust and transparent oversight. By any measure, the Office of Correctional Services Review (OCSR)\(^\text{15}\), which is responsible for monitoring and reviewing the performance of Victorian prisons, Community Correctional Services and other correctional services, does not achieve any of these objectives.

38. In a number of my reports to Parliament\(^\text{16}\) I have highlighted concerns about the OCSR’s lack of independence from Corrections Victoria; its lack of transparency; and its repeated failure to take appropriate action in relation to matters of concern regarding the Victorian prison system.

39. As the OCSR does not publicly report the outcomes of its investigations, the public and Parliament have no way of knowing whether appropriate remedial action has been taken by prison authorities.

**Recommendations**

40. I have made a number of recommendations, including that:

   - the Department of Justice develop and implement comprehensive strategies for dealing with the effects of prison overcrowding
   - the Department of Justice engage an independent consultant to conduct an immediate review of all prison cells and implement solutions to eliminate obvious hanging points
   - the Department of Justice review and increase health services to prisoners, particularly mental health services
   - the Department of Justice review and expand the range of transitional support services available to people leaving prison
   - Victoria Police ensure that detainees are not held at the Melbourne Custody Centre for longer than five consecutive days
   - Forensicare\(^\text{17}\) engage an independent consultant to review hanging points throughout the Thomas Embling Hospital with a view to eliminating them
   - Forensicare install CCTV coverage in all common areas throughout the Thomas Embling Hospital
   - the Department of Health increase the number of mental health beds at the Thomas Embling Hospital as a priority.

---

\(^{15}\) The Office of Correctional Services Review is a unit of the Department of Justice.


\(^{17}\) The Victorian Institute of Forensic Mental Health, known as Forensicare, is responsible for providing adult forensic mental health services in Victoria including the Thomas Embling Hospital.
41. I also recommended that the Minister for Corrections and the Minister for Community Services consider establishing an independent custodial inspectorate with monitoring and oversight responsibilities for Victorian prisons and the youth justice precincts.

Response to my report

42. In response to my report, the Department of Justice stated:

... the Corrections system is under pressure and all agencies across the justice system are managing the risks and challenges this involves. The Department of Justice (DOJ) is continually identifying practical, cost effective solutions to maintain the safety and wellbeing of all prisoners, particularly those most vulnerable or at risk of harm.

... The majority of the [Ombudsman’s] recommendations are supported in principle and will be used to inform the future development of strategies to minimise deaths and harm in custody.

43. The Secretary of the Department of Human Services made the following comments about my report:

I welcome your comments regarding the efforts of the department [Department of Human Services] to ensure a safe and secure physical environment across youth justice precincts, including the elimination of obvious hanging points and the extensive use of audio and visual CCTV [closed circuit television].

44. The Chief Commissioner of Victoria Police responded to my report by stating:

Your report captures the risks and challenges that are involved in ensuring the safety of those in custody and the difficulties that exist in such a complex environment. I note it also recognises the efforts made by Victoria Police.

... The tenor of your recommendations allocated to Victoria Police is supported however there are a number of financial practical and technical reasons that prevent the achievement of some of them.

... Where there are recommendations made allocated to the DoJ [Department of Justice] that impact Victoria Police, we will of course work with them [the Department of Justice] to assist where possible.

45. The Secretary of the Department of Health stated:

The Department of Health supports the removal of ligature points at Thomas Embling Hospital where assessed as posing risk, particularly in private and less observable spaces, such as ensuites, bathrooms and toilet areas. This is consistent with current Victorian design and planning practice for hospital-based new acute mental health facilities.

... The Department of Health welcomes the planned expansion of prison health services as part of the Ravenhall prison development and is actively involved in planning for the new mental health services to be incorporated into that facility.
Background

46. For over 40 years, the wellbeing of people deprived of their liberty in closed environments in Victoria has been a concern of the Victorian Ombudsman. It has been an area of my work which I have consistently paid attention to, and which I have commented on, in many of my reports to Parliament, including my annual reports.

47. In my 2006 report, Conditions for persons in custody\(^{18}\), I raised concerns about the conditions for detainees held in police cells and prisons. My investigation identified:
   - substandard conditions – lack of basic amenities and poor hygiene
   - significant overcrowding – double bunking and non-segregation of remand and sentenced detainees
   - safety issues – hanging points in cells and duress alarms not working
   - inadequate access to health care services, particularly mental health care services.

48. In 2010, I conducted an investigation into the Melbourne Youth Justice Precinct at Parkville\(^{19}\), which is operated by the Department of Human Services. I was highly critical of the condition and management of the precinct. The criticisms contained in my report included:
   - the shocking physical state of the complex, which was damaged, deteriorated and unsafe
   - conditions at the precinct reflecting little regard for human rights principles
   - lack of access to mental health services and formal education for detainees.

49. As a result of my investigation, the Department of Human Services took positive steps to improve accommodation safety and access to health services for young offenders held at the youth justice precincts.

50. Access to medical services was the focus of my 2011 report into prisoner health care\(^{20}\). My investigation identified serious deficiencies in the health care provided to Victoria’s prisoners and concerns regarding Corrections Victoria’s compliance with the Charter of Human Rights and Responsibilities, including:
   - grossly inadequate mental health services, particularly in the male prison population
   - inadequate communicable disease\(^{21}\) prevention and treatment.

---


\(^{19}\) Victorian Ombudsman, Investigation into conditions at the Melbourne Youth Justice Precinct, October 2010.

\(^{20}\) Victorian Ombudsman, Investigation into prisoner access to health care, August 2011.

\(^{21}\) Communicable disease is a disease which can be transmitted by fluid exchange, contaminated substances or close contact with an infected individual.
51. My 2012 report titled, *The death of Mr Carl Williams at HM Barwon Prison - Investigation into Corrections Victoria*\(^2\), also highlighted several shortcomings in Corrections Victoria’s administration of Victoria’s correctional system, including its decision-making about the placement and monitoring of high risk prisoners.

Reasons for conducting my investigation

Key issues
The reasons for conducting my investigation included:
• continuing overcrowding in Victorian prisons and police cells and the potential for human rights abuses to occur
• an increase in the number of deaths in Victorian prisons in 2012-13 and higher rates of self-harm in custody
• an increase in the number of vulnerable detainees in custody.

In consideration of the duty of care owed to people in custody and the need for custodial facilities to comply with the Charter of Human Rights and Responsibilities, I decided that an investigation into deaths in Victorian custodial facilities was warranted.

52. The issues identified in each of my investigations since 2006 required significant changes in procedures and practices of custodial staff and the management of the custodial facilities at each location. Despite the agencies responsible for the custodial facilities mentioned in my reports accepting my recommendations and taking some action to address them, I remain concerned whether adequate measures have been taken by some agencies to minimise the risk of harm to people and even their death while detained in custody.

53. When a person is detained in custody, the State assumes responsibility for the welfare and wellbeing of that individual. This includes respect for that person’s human rights. One of the fundamental human rights enshrined in the Victorian Charter of Human Rights and Responsibilities is the right to life and the right to not be arbitrarily deprived of life.

54. While the loss of any human life is regrettable, when it happens behind the closed doors of a prison or police facility, it is not unreasonable to expect that questions will be asked about whether the death was preventable. For the family members and friends of a person who dies in custody, questions may arise about the appropriateness of the care and monitoring provided by the custodial facility.

55. Nearly 43 per cent of all male prisoners sentenced by a court in 2010-11, received a sentence of less than six months. A further 30 per cent received sentences between six and 12 months. It is also the case that 52 per cent of the male prison population had never been held in prison under sentence prior to their incarceration, while 14 per cent were less than 25 years of age²³.

56. It only takes one error of judgement for a person with no previous criminal history to find themselves in custody. Take the driver of a motor vehicle involved in a fatal road accident who is found guilty of causing the death of another person and sentenced to several years’ imprisonment.

57. For people detained in custody for the first time, the environment in which they may find themselves can be extremely confronting. For example, being held at the Melbourne Custody Centre – an underground facility with no access to natural light or fresh air; limited access to telephone facilities; sharing a cell with other detainees and an area with up to 18 other detainees; with nothing but the clothes they came in; and being held in these conditions for up to 14 days or longer.

58. Many people in custody are vulnerable, often with complex social, legal and medical histories, including mental health, drug and alcohol problems.

59. In Victoria, recent reforms to the criminal justice system, such as the introduction of mandatory sentencing for some offences and changes to the parole system, together with a stricter approach to criminal offending, has resulted in greater numbers of people being held in custody than in recent history.

60. Deprived of their liberty and faced with the challenge of having their voice heard in a custodial system overcome by increasing numbers, people detained in custody in Victoria face a greater risk of harm.

61. In the past 10 years, the number of prisoners in prison custody has increased by 38 per cent. As a result, Corrections Victoria has faced the challenge of providing sufficient prison beds and services to keep pace with an increasing prison population.

62. In November 2012, the Victorian Auditor-General in his report titled, *Prisoner Capacity Planning* found that ‘current indications are that the [male prison] system is reaching levels that are unsustainable’. The Auditor-General reported that Corrections Victoria’s forecasts ‘indicate that by 2016 the male and female prison systems will not have sufficient capacity to meet increases in prisoner numbers’. That stage has already been reached in most prisons.

63. Increasing numbers in the male prison population has in turn placed significant pressure on Victoria Police’s management of people detained in police custody.

64. In June 2012, the Department of Justice informed Victoria Police that the number of detainees held in police cells would range between 150 and 200 per day based on prisoner number forecasts. Victoria Police considers 180 detainees in police cells overnight to represent a high risk to the safety and security of detainees and officers.

65. In November 2013, the number of detainees held in police cells overnight reached 372. This is more than double the 180 upper limit considered by Victoria Police to represent a high risk to safety and security.

66. Throughout 2013 the number of detainees held in police cells at times exceeded 350 people. While the number of detainees held in police cells briefly fell below 200 in late 2013, by February 2014 detainee numbers had again risen in excess of 250. On 10 March 2014, there were 306 detainees in police cells.

---

Duty of care

67. In Victoria, agencies responsible for the management of people in custody have a statutory duty to ensure the safety and security of individuals in their care. For example, under the Corrections Act 1986, Corrections Victoria has a statutory responsibility to take all reasonable steps to ensure the safe custody and welfare of prisoners. Similarly, the Children, Youth and Families Act 2005, places a statutory duty on the Department of Human Services to provide for the care, custody and supervision of children who have been sentenced to detention or remanded in custody pending the finalisation of legal proceedings.

The Charter of Human Rights and Responsibilities

68. The Victorian Charter of Human Rights and Responsibilities Act 2006 provides a framework for the protection and promotion of human rights. The Charter makes it unlawful for a public authority to act in a manner that is incompatible with a human right, or, in making a decision, to fail to give appropriate consideration to a relevant human right.

69. The Victorian Ombudsman provides an independent avenue for people in custody to complain and have their conditions and treatment scrutinised and investigated. In this regard, my responsibilities are augmented by my role under the Charter. I am empowered under the Charter to investigate decisions that may otherwise be lawful, but that may limit a human right. Section 13(2) of the Ombudsman Act 1973 states:

The function of the Ombudsman under subsection (1) includes the power to enquire into or investigate whether any administrative action that he or she may enquire into or investigate under subsection (1) is incompatible with a human right set out in the Charter of Human Rights and Responsibilities Act 2006.

70. This provision extends my jurisdiction to address whether the administrative actions of public agencies are in breach of human rights under the Charter.

Deaths in custody

71. For the five-year period 1 July 2008 to 30 June 2013, there were 43 deaths in Victorian prisons, compared to 6 in police cells and 9 at the Thomas Embling Hospital, the secure psychiatric hospital for people with serious mental illness. There were no deaths in the Victorian youth justice precincts during this period.

---

25 Excludes deaths in police custody-related operations such as sieges, raids and motor vehicle pursuits.
In 2012-13, there were 13 deaths in Victorian prisons, compared to four in 2011-12, and 10 in 2010-11. Three of the deaths that occurred in Victorian prisons in 2012-13, appear to be unnatural deaths, most likely suicide. In 2011-12, there were no unnatural deaths in Victorian prisons. In the 10-year period between 2003 and 2013 there were 13 prisoner suicides, compared to 25 in the previous 10-year period.

Two unnatural deaths occurred at the Thomas Embling Hospital in 2012-13, the first was a patient who was allegedly killed by another patient, and the second involving a patient who appears to have taken his own life.

As the following chart shows, in 2012-13 the rate of Victorian prisoner deaths per 100 prisoners, rose to 0.25, as compared to 0.08 in 2011-12 and 0.22 in 2010-11. By contrast, seven years ago the rate of prisoner deaths per 100 prisoners was 0.05.
Data collected by the Australian Bureau of Statistics points to an increase in the age of Victoria’s prison population in recent years, with the mean age of prisoners increasing from 36.1 years in 2006, to 37.5 years in 2012. Since 2007, there has also been an increase in the number of prisoners over 60 years of age, up from 167 prisoners in 2007, to 248 in 2012. This trend has implications in relation to the number of deaths in prison due to natural causes and the provision of health services to an ageing prison population.

Source: Department of Justice, Annual Report 2012-13, Prison service statistics.
The incidence of self-harm in custody

76. The following chart reflects the higher number of reported incidents of self-harm and attempted suicide in Victorian prisons in comparison to other Victorian custodial facilities. This is not surprising given the higher number of prisoners in prison custody.

77. In the three year period between 2010-11 and 2012-13, there were 1,147 reported incidents of self-harm, including four prisoner suicides.

Chart 4: Reported incidents of self-harm and attempted suicide in Victorian custodial facilities (2008-09 to 2012-13)

Source: Information provided by the Department of Justice, Victoria Police, Department of Human Services and Forensicare.
Investigation

78. On 23 May 2013, I informed the Secretary of the Department of Justice, the Secretary of the Department of Health, the Secretary of the Department of Human Services, the Chief Commissioner of Victoria Police, the Minister for Corrections, the Minister for Community Services, the Minister for Mental Health and the Minister for Police and Emergency Services, of my decision to commence an own motion investigation into deaths in custody in Victoria. The investigation included prisons, police cells, youth justice precincts and the Thomas Embling Hospital.

79. In conducting my investigation, I was mindful of the Victorian Coroner’s role in investigating the cause of death of any person who dies in custody. As a result, I consulted with the Victorian Coroner in relation to my investigation.

80. Early in my investigation, my officers identified concerns in relation to a number of obvious hanging points in prison cells at several prisons they visited. In my view, the hanging points present a serious risk to prisoners as they could be used by a prisoner to commit suicide.

81. As a result, I decided to write to the Secretary of the Department of Justice bringing these matters to his urgent attention so that he may consider appropriate action. My letter to the Secretary dated 7 August 2013 included photographs of several obvious hanging points at prisons which my officers identified during their visits (see Appendix 1).

82. Of particular concern were the bunk bed ladders present in several prison cells at various prisons (see Appendix 1, Photographs 11 and 12). In May 2010 a prisoner at the Melbourne Assessment Prison used the top rung of a bunk bed ladder as a ligature point to tie a bed sheet and commit suicide by hanging.

83. At the Dame Phyllis Frost Centre (Women’s Prison), my officers also identified an overhead metal beam in one of the exercise yards (see Appendix 1, Photograph 13) which presented an obvious ligature point from which a prisoner could potentially hang themselves by using a bed sheet or similar piece of material.

84. The Secretary responded by letter dated 9 September 2013, advising that ‘the department has a strong commitment to reducing and preventing suicide and acts of self-harm by prisoners in Victorian correctional facilities’.

85. On 8 October 2013, I met with the Secretary to again raise my concerns regarding this issue.

Objectives

86. The objectives of my investigation included determining:
   • the prevalence and nature of deaths and the incidence of harm in custody
• the factors contributing to deaths and harm in custody
• whether agencies responsible for the management of custodial facilities are taking adequate steps to minimise the risk of deaths and the incidence of harm in custody
• whether agencies and custodial facilities are learning the lessons from deaths and the incidence of harm in custody
• what more can be done to minimise the risk of deaths and the incidence of harm in custody.

Methodology

87. My investigation involved:

• visiting each of Victoria’s prisons, the Melbourne Custody Centre, selected police cells, the youth justice precincts and the Thomas Embling Hospital
• interviewing 46 witnesses, including detainees and family members, custodial staff, custodial managers, service providers, advocacy groups and key stakeholders
• examining extensive documentation and material obtained from the Department of Justice, the Department of Human Services, Victoria Police, Forensicare, private entities and witnesses
• reviewing relevant legislation and policy documents.

88. I also took the step of publicising my investigation and inviting anyone with any information relevant to the investigation to contact my office. I received submissions from the following bodies:

• the Law Institute of Victoria
• the Federation of Community Legal Centres Victoria
• the Human Rights Law Centre
• the Victorian Mental Illness Awareness Council
• the Loddon Campaspe Community Legal Centre
• the Victorian Aboriginal Legal Service
• the Mental Health Legal Centre – Inside Access.

89. All witnesses voluntarily attended my office for interview and were offered the opportunity to be legally represented or to be accompanied by a support person. One witness chose to attend with a legal representative.

90. In accordance with section 25A(3) of the Ombudsman Act 1973, I advise that individuals identified in this report are not the subject of any adverse comment or opinion.
Common issues

91. My investigation identified a number of common issues impacting on the ability of custodial operators to ensure the safety and wellbeing of people in their care. These issues include:

- overcrowding (see pages 27-53)
- the management of detainees at risk of suicide or self-harm (see pages 54-67)
- the safety of detainees in custody (see pages 68-96)
- transitional support services (see pages 97-104)
- access to appropriate health care (see pages 105-126).

92. My report addresses each of these issues in the following chapters. In doing so, I have considered the extent to which each custodial environment has been affected by these issues and I have focussed my attention accordingly.

93. The final chapter of my report deals with accountability and transparency in custodial environments (see pages 127-137). In my view, there needs to be appropriate accountability and transparency in relation to the actions taken by agencies responsible for the management of custodial facilities, in response to a death in custody or incidents involving harm to a detainee. This enables the community to have confidence that agencies have taken appropriate action to minimise the risks of any such incidents from occurring again in the future.
Overcrowding

Key issues
There is a crisis in overcrowded prisons and police cells caused by inadequate beds in the Victorian prison system.

Overcrowding in prisons has resulted in police cells designed for short-term stays being used as de-facto prisons to at times hold in excess of 350 detainees.

94. In simple terms, overcrowding occurs when custodial facilities exceed the maximum number of people they were originally designed or built to hold, and where there is no corresponding growth in the supporting infrastructure.

95. Overcrowding has the potential to negatively impact on all aspects of custodial life – from the initial assessment of detainees on entering custody through to their transition into the community.

96. The effects of overcrowding in custodial facilities can include:
   • restricted living space and loss of privacy resulting in increasing tensions amongst detainees; increased risk of harm to detainees, such as assaults; and the potential for human rights abuses
   • limited access to custodial services, such as health care
   • the spreading of communicable diseases, such as Hepatitis C
   • difficulties in the segregation of different types of detainees, for example detainees in need of protection
   • contributing to deaths in custody.

97. In the past year, overcrowding in Victorian prisons and police cells has stretched the capacity of both Corrections Victoria and Victoria Police to keep people in custody safe from harm.
Key issues

My investigation identified that:

- there has been a failure to provide sufficient funding for new and existing prison infrastructure over the past decade
- prisoners are placed in overcrowded and at times substandard conditions leading to increasing tensions and violence
- the likelihood of prisoners being physically or sexually assaulted or self-harming leading to deaths is greater now than at any time in recent years
- prison staff are at greater risk of being assaulted by prisoners as a consequence of overcrowding.

98. Overcrowding in the Victorian prison system is not a new phenomenon. The warning signs have been there for over a decade. As far back as 2002, the Victorian Ombudsman raised concerns about the capacity of the Victorian prison system to hold the growing number of prisoners in the prison system. In my 2006 report into conditions for persons in custody, I again raised concerns about overcrowding in the prison system and the potential negative impact on vulnerable prisoners.

99. As the following chart shows, in the period between 2008-09 and 2011-12 the number of prisoners in the Victorian prison system progressively increased by up to 200 prisoners each year. However in 2012-13, the number of prisoners in prison custody had increased by 460.

100. As at 30 November 2013, the adult prison population had risen to 5,815. This is 745 more prisoners than at the same time last year.

Chart 5: Snapshot of the Victorian prison population as at 30 June each year (2009 to 2013)


101. The increase in the prison population follows recent changes to sentencing laws in Victoria, including the abolition of suspended sentences for some serious crimes (May 2011) and the ending of home detention as a sentencing alternative (January 2012).

102. In May 2013, the Minister for Corrections and Minister for Crime Prevention appointed former High Court Justice Ian Callinan to conduct a review of the Victorian Adult Parole Board’s operations. This review came about following concerns in relation to several high profile violent crimes where the Board had either granted parole to an offender, or where an offender had been in breach of the conditions of their parole, and no action had been taken.

103. The implementation of Mr Callinan’s recommendations are anticipated to lead to further increases in the number of people in custody as a result of a stricter approach to the granting of parole and for breaches of parole. In September 2013 new legislation was passed by the Victorian Parliament making it a criminal offence for a person to breach their parole.

104. Against this backdrop, there has also been the deployment of additional police on our streets, including protective services officers, resulting in more offences being detected by Victoria Police.

Prison capacity planning

105. The Victorian government’s sentencing reforms and the deployment of additional police on our streets, come at a time when the Victorian prison system has been operating close to maximum capacity for a number of years.

106. In 2012, the Victorian Auditor-General conducted an audit to assess the effectiveness of the Department of Justice’s prison capacity planning in reliably forecasting prison demand and effectively planning for future prison capacity. The Auditor-General found that:

- in the past 10 years (30 June 2002 to 30 June 2012), the number of prisoners in the Victorian prison system had increased by 38 per cent (1,344 prisoners)
- Corrections Victoria’s own forecasts indicate that by 2016 the male and female prison systems will not have sufficient capacity to meet increases in prisoner numbers
- the male prison system has been operating at close to or above its operational capacity of 95 per cent since May 2011
- the Victorian government did not support the Department of Justice’s funding applications for a new male prison in the 2008–09, 2009–10 and 2010–11 State budgets.

29 Mr Ian Callinan AC, Review of the Parole System in Victoria, July 2013.
30 Corrections Amendment (Breach of Parole) Act 2013.
31 Victorian Auditor-General, Prison Planning Capacity, November 2012.
32 Victorian Auditor-General, Prison Planning Capacity, November 2012.
107. In response to increasing prisoner numbers and demand pressures on the prison system, the Victorian government agreed in successive state budgets for the past three years to provide funding for new prison infrastructure. This includes funding for over 1,000 new prison beds in existing prisons and the construction of a new 1,000-bed medium security men's prison at Ravenhall.

108. At interview on 15 October 2013, Mr Rod Wise, Deputy Commissioner, Corrections Victoria was asked what actions Corrections Victoria is taking in response to the increasing prison population. He said:

... we've put double bunks in a whole range of prisons. We’ve got an aggressive building program and some of those new infrastructure buildings have come on line recently and we’ve got others being built at the moment ... and then we’ve put stretcher beds or fold-up beds in a number of locations as well so I think there are probably over 200 surge beds which include both the fold-up beds and beds that we’ve put in places that, perhaps, weren't designed in the first instance for prisoner accommodation ...

109. Mr Wise also said that Corrections Victoria was considering other initiatives, including the establishment of prisoner work camps for some minimum security prisoners. However, these projects were undeveloped.

110. Ms Jan Shuard, Commissioner, Corrections Victoria said at interview on 22 October 2013 that Corrections Victoria had engaged in probably one of the biggest ongoing prison building programs across the State, including the expansion and conversion of prisoner accommodation at existing prisons; the construction of a new prison; and the provision of temporary prison beds. Ms Shuard said that as a result of these initiatives the capacity of the Victorian prison system was increasing each week; however ‘all of these [initiatives] take time’.

111. Ms Shuard said that while Corrections Victoria had been in discussions with the Victorian government about a range of different initiatives in the short-term to deal with the increasing prisoner population, she could not comment further about the outcome of these discussions as a decision was not yet made. Ms Shuard also said:

We have looked at other options. Some of these things are difficult ... because with the standards that you’re required to meet ... the cost can be incredibly high ...

112. In December 2013, Corrections Victoria announced plans to increase the capacity of several minimum security prisons such as Dhurringile Prison, by using modified shipping containers to accommodate up to 100 minimum security prisoners. It also announced plans to establish prisoner work camps for some minimum security prisoners.

113. At interview, Ms Shuard said that it was difficult for Corrections Victoria to accurately forecast increases in the prison population, as evidenced by recent changes to the criminal justice system, such as changes to the parole system.
Temporary beds

114. In his November 2012 report, the Auditor-General found there to be a heavy reliance by Corrections Victoria on temporary beds and double bunking, resulting in male prisons containing 22 per cent more beds than the infrastructure can currently support.

115. The Auditor-General also found temporary beds and double bunking to be contrary to Corrections Victoria’s standards, which recommend the use of single cells to maintain higher health, safety and rehabilitation outcomes. At the time of his report, the Auditor-General identified that 34 per cent of the prison population was housed in accommodation that did not comply with Corrections Victoria’s recommended single cell standards.

116. In the year since the Auditor-General tabled his report, the prison population increased by over 700 prisoners and Corrections Victoria has introduced hundreds more temporary beds across the prison system to cope with demand pressures.

117. For example, at Dhurringile Prison, a visiting area has been recommissioned and used as a dormitory to sleep up to 10 prisoners overnight on fold-up beds.

118. The following photograph taken at the Hopkins Correctional Centre shows a storage area where up to six fold-up beds and prisoner property are stored during the day. At night, the fold-up beds are wheeled into a secure common area within the prison unit to create a dormitory for sleeping.

Photograph 1: Fold-up beds used to create a dormitory for sleeping prisoners at Hopkins Correctional Centre, 19 July 2013.
119. For some prisons where cottage-style accommodation is available to accommodate prisoners, a number of fold-up beds have been placed in communal areas, such as living rooms, and in cottage bedrooms originally designed to sleep one prisoner. The following photograph taken at Loddon Prison shows a fold-up bed which has been placed in the corner of the living room in a cottage used to accommodate prisoners.


120. Corrections Victoria has also undertaken a program to convert hundreds of single bed prison cells, to accommodate two prisoners in a double bunk bed arrangement. Many cells originally designed to accommodate two people are now holding three prisoners or more.

121. In recent months, my office has received a number of complaints from prisoners concerned about the use of temporary beds and the overcrowded conditions at many prisons.

122. The following case study is an example of the effects overcrowding can have in the prison system.

Case study 1: Access to shower and toilet facilities

In October 2013, Prisoner A complained to my office about overcrowded conditions at Langi Kal Kal Prison, a working prison farming property for minimum security prisoners.
Prisoner A complained that many single prison cells at the prison had been converted to accommodate two and three prisoners and that there had been no additional increase in basic facilities such as showers and toilets. Prisoner A stated that this made having a shower or going to the toilet difficult.

My office raised concerns about prison overcrowding with the Commissioner of Corrections Victoria. In response, the Department of Justice stated that ‘it has been aware of overcrowding and has taken steps to alleviate overcrowding in the short term and create capacity in the long term’. The department also stated that ‘there are not any single cells in which there are three occupants’.

Increasing tensions

123. During my investigation, several witnesses working with prisoners and their families, raised concerns about increasing tensions amongst prisoners as a consequence of overcrowding. At interview, a prison chaplain with over 20 years’ experience working in prisons described overcrowding in the male prison system as the worst she had ever seen. The prison chaplain said that overcrowding is causing prisoners a great deal of stress. She described crowded conditions at several prisons with many prisoners sleeping on fold-up beds, with little space or privacy.

124. The prison chaplain referred to the August 2013 stabbing of a prisoner at Port Phillip Prison as an example of what can happen as a consequence of increasing tensions caused by prison overcrowding.

125. My officers interviewed Mr Charandev Singh, a paralegal working with prisoners and their families. At interview, Mr Singh was asked about the effects of overcrowding in the prison system. He said:

   The physical overcrowding is having implications for prisoner safety in terms of people being housed in one out cells [designed for one person] with ... other people.

   There are quite ... remarkable consequences of [sic] placing people in a situation where they are unsafe at a whole lot of levels. So they may be unsafe from physical assault, sexual assault, unsafe in terms of their medical conditions, and the stresses that are involved ... 

126. My officers observed poor conditions in overcrowded cells at several prisons they visited. Some of the prison cells and facilities were dirty, unhygienic and ill-maintained. For example, towels and pillows which were stained and torn, and the presence of mould in some shower facilities.

127. Prison staff also raised similar concerns with my investigators. At interview, a prison officer said that a number of the pillows, towels and mattresses used by prisoners at a regional prison were soiled and no longer fit for use. The prison officer said some of the shower facilities at the prison were ‘filthy’ and potentially a source of infection for prisoners using these facilities.

128. The poor conditions reflect non-compliance with human rights principles and present potential health and safety issues for both prisoners and staff.
Prisoner assaults

129. With increasing tensions caused by overcrowding, there is a greater risk that prisoners may engage in violence. Research\(^{33}\) has identified a direct correlation between prison overcrowding and violence within prisons.

130. Data collected by Corrections Victoria on the rate of reported assaults in the Victorian prison system shows that with overcrowding, Victorian prisons are becoming more violent. In the past five years, the rate of reported prisoner assaults within Victorian prisons has risen steadily each year, as the following chart illustrates.

**Chart 6: The rate of reported assaults on Victorian prisoners by other prisoners per 100 prisoners (2008-09 to 2012-13)**

![Graph showing the rate of reported assaults on Victorian prisoners by other prisoners per 100 prisoners (2008-09 to 2012-13).]


131. My officers interviewed a number of prisoners about their experiences in the Victorian prison system, including the risks of being physically assaulted. Serious assaults can and do lead to deaths in custody.

**Case study 2: Assaults on a young prisoner**

Prisoner B, a 25 year-old male prisoner serving his first term of imprisonment at a medium security prison, was allocated a shared cell with another prisoner – a member of an outlaw motorcycle gang.

Prisoner B described his cellmate as ‘psychotic’ and ‘dangerous’. Prisoner B said that he was bashed senseless by his cellmate after changing the channel on the television in their shared cell.

Prisoner B was eventually transferred to another prison where he said that he was physically assaulted on three separate occasions. While Prisoner B said that he had sought physical protection from other prisoners in order to survive, he said he still feared being stabbed by other prisoners at any time.

Prisoner B said that he did not report any of the physical assaults against him as he feared being branded a ‘dog’ by other prisoners and subjected to further violence.

---


132. There is a perception amongst many prisoners that to report any type of assault within prison is to ‘lag’ or ‘inform’ against a fellow prisoner, which in turn places them at risk of greater violence from other prisoners. In some cases, prisoners have been seriously injured in retaliation for reporting a matter to prison authorities. Consequently, prisoners are less likely to report assaults.

133. It is also the case that sexual assaults within prisons are seldom reported to prison authorities. A 2009 study of 150 male ex-prisoners conducted by Murdoch University’s Centre for Social and Community Research in Western Australia\(^3\) found that:

- 54 per cent said they had knowledge of sexual assault within prison
- 23 per cent said that they had been placed under pressure to provide unwanted sexual acts, the majority within the first six months of their sentence
- 4 per cent admitted to predatory sexual behaviour
- 14 per cent (21 prisoners) said they had been sexually assaulted
- of the 21 prisoners who were sexually assaulted, only eight made an official report to prison authorities.

134. The co-author of this report\(^5\), Dr Dot Goulding, had the following to say about the reasons why prisoners do not report sexual assault:

> Non-reporting of sexual assault within the prison environment is most often put down to the high levels of personal shame associated with male-to-male rape and, most importantly, a real fear of the prospect of further and escalating violence if such assaults are reported to the authorities.

135. Data obtained from Corrections Victoria shows that there were only 30 reports of alleged sexual assault made by prisoners in 2011-12.

136. At interview, the Chief Executive Officer of the Victorian Association for the Care and Resettlement of Offenders\(^6\) (VACRO) raised concerns about the increased risks of sexual assault to vulnerable prisoners as a result of overcrowding. She said:

> … [Prisoners] won’t report it [sexual assault] because they’re at high risk if they do. And I guess it’s how you keep people safe. If you’re double and triple bunking or you have got open areas with roll-out beds and you have got young men going into that system, they’re at high risk [of sexual assault].

137. The Chief Executive Officer of VACRO also said:

> It [sexual assault] is just hidden. I don’t have a solution for it other than you provide single cells so that people have some ability to protect themselves basically.

---

\(^3\) Dr Brian Steels and Dr Dot Goulding, Predator or Prey? An exploration of the impact and incidence of sexual assault in West Australian Prisons, Murdoch University’s Centre for Social and Community Research, Western Australia, November 2009.

\(^5\) Dr Brian Steels and Dr Dot Goulding, Predator or Prey? An exploration of the impact and incidence of sexual assault in West Australian Prisons, Murdoch University’s Centre for Social and Community Research, Western Australia, November 2009.

\(^6\) VACRO is a non-government, non-denominational organisation, providing support and information for individuals charged with a criminal offence, offenders, prisoners and their families.
138. In my 2012 annual report\(^{37}\), I reported on the case of a young prisoner who had been sexually assaulted at a Victorian prison. The prisoner, who had been identified by the prison as being vulnerable, was alleged to have been raped with an object by another prisoner. I concluded that the prison had failed in its duty to manage the risk of harm to the vulnerable prisoner and in the timely reporting of this incident.

139. In some circumstances, the trauma and humiliation associated with prisoner rape can lead to a prisoner attempting to take their own life. For others, the trauma of being sexually assaulted in prison does not end after leaving custody. At interview, the Chief Executive Officer of VACRO said:

They bring that [the trauma of being sexually assaulted in prison] out with them. So when they are reconnecting with their family, the only way to deal with it is alcohol and drugs, because they are so traumatised. For young people it is very, very traumatic.

**Stand-overs**

140. As a consequence of overcrowding there is also the increased risk of threats of intimidation, bullying, or assault against prisoners – commonly referred to as ‘stand-overs’. For example, a physically intimidating prisoner threatening a vulnerable prisoner to hand over their running shoes.

141. In some cases, stand-overs may involve the giving of sexual favours in order to obtain protection against the risk of physical violence by other prisoners. At interview, the Chief Executive Officer of VACRO told my investigators about one such case. She said:

We had a young client [in prison] ... who basically gave [sexual] favours to one older man who was quite violent ... to protect him. That happens a lot as well, where they [vulnerable prisoners] will align themselves with a prisoner who is known to be violent in the system to protect themselves. And that's very common.

142. Prisoner stand-overs are often well organised, for example in relation to the supply of drugs and other contraband, or the provision of physical protection. This type of activity is often linked to prison gangs – groups of individuals with common interests or associations.

143. One such gang operating in Victorian prisons is the ‘Prisoners of War’ gang, a group of prisoners responsible for a series of violent assaults on prisoners and prison staff. In December 2012, Mr Matthew Johnson, one of the leaders of the Prisoners of War gang was convicted of the murder of fellow prisoner, Mr Carl Williams\(^{38}\) on 19 April 2010, while imprisoned together at Barwon Prison.

---

\(^{37}\) Victorian Ombudsman, Annual Report 2012, Case Study 38, Page 45.

\(^{38}\) Mr Carl Williams, a convicted murderer and drug trafficker was a central figure in the Melbourne gangland killings in the 1990s.
144. Stand-overs and prison gangs are problems faced by all prisons, which if not addressed have the potential to undermine a prison’s ability to keep prisoners safe from harm. The Western Australian Office of the Inspector of Custodial Services in his 2003 report titled, Vulnerable and Predatory Prisoners in Western Australia: A Review of Policy and Practice, commented on the negative effects of stand-overs within prisons:

Bullying and stand-overs have become a commonplace or routine feature of prison life, so as to become acceptable to both staff and management. Passive acceptance of the hurt and pain caused by predators appears to be the collateral damage of prison life.

Assaults on prison staff

145. Prisoners are not the only ones at risk of greater violence as a consequence of overcrowding. As the prison population has increased, so has the number of assaults on prison staff. In the past five years assaults on prison staff and other people (e.g. staff providing education programs in prisons) by prisoners, nearly doubled.

Chart 7: The rate of reported assaults on Victorian prison staff or other people by prisoners (2008-09 to 2012-13)

Source: Department of Justice, Annual Report 2012-13, Prison service statistics.

Prisoner self-harm

146. Within Victorian prisons, the incidence of prisoner self-harm has also increased at a time of significant overcrowding. Between 2008-09 and 2012-13, the rate of reported prisoner self-harm incidents more than doubled. In 2012-13, there were eight reported self-harm incidents for every 100 prisoners. Self-harm can lead to suicide.
The following case study is an example of a prisoner who self-harmed in response to threats and intimidation by other prisoners.

**Case study 3: Self-harm in response to threats**

In February 2013, Prisoner C used his cell intercom to inform prison staff that he had ‘done something stupid’. Prison staff found Prisoner C in his cell bleeding from several cuts he had made to his left wrist.

Prisoner C informed prison officers that the reason for slashing his wrist was that he was being ‘stood-over’ by his cellmate and that he could no longer cope with the situation.

Prisoner C was separated from his cellmate and transferred to the prison’s medical centre where he was deemed at risk of potential suicide; placed in an observation cell; and his condition monitored by prison staff.

**Prisoner segregation**

Upon entering the Victorian prison system, an assessment is undertaken by Corrections Victoria to determine whether a prisoner is at risk of harm from other prisoners. Prisoners assessed as requiring protection from other prisoners are segregated and placed in specific units within the prison system away from mainstream prisoners.

The reasons for a prisoner requiring protection may include:

- the nature of the offences committed, such as murder or sex offences
- providing information or evidence against other prisoners or people, such as a police witness
- previous employment in the criminal justice system, such as former police officers
• owing debts to others
• having known enemies in the prison system
• an intellectual disability or being perceived as vulnerable.

150. Overcrowding in the prison system makes the segregation of prisoners more difficult to manage. At interview, an Assistant Commissioner, Corrections Victoria acknowledged the pressures that overcrowding is having on the ability of Corrections Victoria to segregate prisoners. He said:

It is true ... that the management and high security units, just like the [prison] system, are under pressure ...

... whereas perhaps ... [a prisoner] might have spent six months in a restricted environment [segregated from other prisoners for their protection] before, because of the pressure on the system they might only spend three or four [months].

151. In some prisons, there are limited options for accommodating prisoners in need of protection. For example, at Loddon Prison, a medium security prison, there is no specific protection unit. As a consequence, the Management Unit at Loddon Prison has been utilised for this purpose. The difficulty with this approach is that the Management Unit, commonly referred to as 'the slot', is primarily used to punish prisoners for misconduct by way of loss of privileges. This generally involves the solitary confinement of a prisoner in a cell for up to 23 hours per day, with no access to personal property, visits, or a television.

152. At interview, a prison officer was asked about the treatment of prisoners seeking protection at Loddon Prison. He said:

In the end, they [the prisoners seeking protection] feel like they are being punished because it's the same conditions as prisoners who are there [in the Management Unit] for a punishment regime.

153. The prison officer said that prisoners can remain in the Management Unit for several days until they are transferred to another prison, as the following case study illustrates.

**Case study 4: Treatment of a prisoner seeking protection**

Prisoner D was transferred to Loddon Prison in May 2013. On arriving at the prison, Prisoner D said that he immediately noticed some other prisoners that he believed had reason to hurt him. Prisoner D said that he was fearful as to what would happen to him if he was placed in the mainstream prison population. As a consequence, Prisoner D approached prison staff and asked to be placed on protection.

Prisoner D said that after being granted protection, he was placed in the Management Unit at Loddon Prison. Prisoner D described the conditions in the management cells as 'not fit for a dog'. Prisoner D said that it was 'freezing cold' at night and that he was not provided with adequate blankets to keep warm.

Prisoner D said that he was in the Management Unit on protection for 14 days before being transferred to another prison.
154. The prison officer also said that there was a general reluctance by senior staff at Loddon Prison to place prisoners on protection because of limited accommodation, which meant that some prisoners were at risk of physical harm from other prisoners, as a result of being placed in the prison mainstream.

**Out of cell hours**

155. Under the *Corrections Act 1986*[^40], every prisoner has the right to have at least one hour per day out of their cell in the open air. As a consequence of overcrowding in the Victorian prison system, this is not always happening and the confinement of prisoners to their cells for up to 23 hours per day can have a detrimental effect on the mental health of some prisoners.

156. At interview, the Executive Director of the Human Rights Law Centre was asked about the effects of overcrowding and ability of Corrections Victoria to provide prisoners with the required one hour out of cell per day. He said:

> … it’s getting worse, particularly at the [Metropolitan] Remand Centre where we have spoken to prisoners who have been locked in their cells, 24 hours a day for days on end, without the required … one hour out of cell under the [Corrections] Act.

157. The following case study shows that as a result of overcrowding in the Victorian prison system some prisoners are not receiving one hour out of cell per day.

### Case study 5: Failure to provide a prisoner with out of cell hours

In September 2013, my office received a complaint from Prisoner E about the amount of time he was allowed out of his cell while at the Melbourne Assessment Prison. Prisoner E had been held at the prison in isolation for 14 months with only one hour per day out of his cell. Prisoner E complained that he had been repeatedly restricted to less than one hour per day out of his cell. Prisoner E stated that he had no access to natural light or contact with any other prisoners.

Enquiries with the prison established that on nine separate occasions Prisoner E did not receive the minimum one hour out of his cell. At my request, Corrections Victoria agreed to provide him with the out of cell hours that he did not receive and to take steps to ensure that this situation is not repeated.

Following my office’s enquiries, Prisoner E was transferred to another prison where there are better options for providing prisoners with at least one hour out of cell per day.

158. My investigation identified a number of cases where prisoners held in solitary confinement for up to 23 hours per day had attempted suicide or self-harm. For example, in January 2013 a prisoner being held in the Exclusion Placement Area of the Charlotte Management Unit at Port Phillip Prison smashed the television in his cell and used the shards to slash his forearm.

[^40]: Section 49.
Access to medical services

159. Overcrowding in the Victorian prison system also has the potential to negatively impact on the health care needs of all prisoners. With the prison population expanding so quickly, there is a need for reciprocal growth in the medical services available to prisoners.

160. My investigation identified significant concerns in relation to prisoner access to health care services, particularly mental health care services, as a consequence of overcrowding. I discuss these issues in greater detail in the chapter of my report dealing with access to appropriate health care services.

Conclusions

161. The failure to provide sufficient funding for new and existing prison infrastructure has resulted in Victorian prisons being overcrowded. The warning signs have been there for over a decade. The Auditor-General identified that ‘prison infrastructure has not kept pace with the increases in prisoner numbers over the past 10 years’.

162. The situation has been compounded by changes to sentencing and parole laws and the deployment of additional police on our streets leading to more people being arrested. This has resulted in greater numbers of prisoners in Victorian prisons than in recent history.

163. In my view, there needs to be careful forward planning to consider the effects on the prison system of any significant changes to the criminal justice system or approaches to law enforcement. It is clear that the Victorian prison system had been operating close to maximum capacity for several years and that any increase in the number of people being imprisoned would place considerable strain on the prison system.

164. It is of concern that prisoners are placed in overcrowded and at times substandard conditions with a risk of physical and sexual assault, and with limited access to appropriate health care services. As a result of increasing tensions in the Victorian prison system, the likelihood of a prisoner being physically assaulted or self-harming leading to death, is greater now than at any time in recent years.

165. Corrections Victoria is failing to ensure that prisoners are provided with at least one hour per day out of their cell, as required under the Corrections Act. This can have potentially serious consequences for the mental health of some prisoners and lead to self-harm. It is also questionable as to whether this complies with the Charter of Human Rights and Responsibilities in relation to a person’s right to humane treatment when deprived of their liberty.

166. The ability of Corrections Victoria to safely segregate prisoners is also compromised as a consequence of overcrowding. It is unsatisfactory that some prisoners assessed as requiring protection have effectively been punished by being placed in a management unit on loss of privileges, such as in the case study at Loddon Prison.
167. With the new men’s prison at Ravenhall not scheduled for completion until late 2017 and the expansion of several existing prisons some years away from being finished, I am concerned about the likelihood of an increase in the number of prisoner deaths and violent incidents in the meantime.

168. While it is promising to see Corrections Victoria discussing trialling new initiatives, such as the use of modified shipping containers and prisoner work camps to accommodate minimum security risk prisoners, these types of initiatives are long overdue. For example, prisoner work camps, where prisoners perform work in the community such as maintenance of national parks, have been operating successfully in Western Australia for more than ten years.

169. I consider that there is a risk that the use of temporary beds in the short-term to cope with overcrowding in the Victorian prison system will eventually become part of the ongoing prison infrastructure. This is not desirable as evidenced by the increased prisoner tensions caused by temporary beds and double-bunking, leading to greater violence and potentially deaths in prison.

170. In response to my concerns regarding overcrowding, the Department of Justice stated:

The independent review by VAGO [the Victorian-Auditor General’s Office] validates that the department has been aware of overcrowding and has taken steps to alleviate overcrowding in the short term and create capacity in the long term via business cases for new prisons and prison facilities.

Recommendations

I recommend that the Department of Justice:

Recommendation 1

Conduct an independent review to determine whether the planned building works to expand the capacity of existing prisons and to construct a new men’s prison will adequately address growth in the prisoner population as a result of changes to sentencing and parole laws and increased law enforcement in the next three to five years.

Recommendation 2

Develop and implement comprehensive strategies for dealing with the effects of prison overcrowding, including violence reduction, harm minimisation, protection of vulnerable prisoners and access to services.

Recommendation 3

Promptly implement short-term strategies for housing prisoners deemed at minimum security, such as prisoner work camps and the establishment of new temporary correctional facilities using portable buildings.
Recommendation 4

Conduct regular reviews of the cleanliness and hygiene of prisoner accommodation and take appropriate action to rectify identified issues.

Recommendation 5

Ensure that all prisoners receive the required one hour out of cell per day.

Recommendation 6

Ensure that prisoners assessed as requiring protection are not placed in management units on loss of privileges.

Department of Justice response:

... [the department] will meet the intent of these recommendations.
Victoria Police cells

Key issues

My investigation identified that as a consequence of overcrowding:

• police cells designed for short-term stays are being used as de-facto prisons to at times hold in excess of 350 detainees

• the resources required to supervise higher numbers of detainees in police custody has placed a significant burden on police resources and resulted in less police being available to patrol local areas

• detainees are being held at the Melbourne Custody Centre for extended periods of time without access to fresh air or natural light, in breach of the Victorian Charter of Human Rights and Responsibilities

• detainees are frequently transferred to police cells across the State, limiting their access to family and legal representation

• detainees in police cells do not always have access to clean clothes

• some detainees are being held in police cells for in excess of 14 consecutive days at the same location, contrary to gazetted requirements

• the Melbourne Custody Centre is often full meaning that Corrections Victoria has been unable to ensure that some prisoners attend scheduled court appearances, resulting in disruption to the criminal justice system.

171. Victoria Police is responsible for the management of police cells, which are used to hold people in police custody on a temporary basis (see Appendix 2). The maximum number of days that a detainee can be held in police cells at the one location, with the exception of the police cells at the Mildura Police Station, is 14 consecutive days.

172. Police cells were originally built to hold detainees on a temporary basis, such as overnight. The police cells have very little in them except for a concrete plinth to accommodate a mattress; a toilet; wash basin and drinking fountain. Closed circuit television (CCTV) operates in each holding room/cell and exercise yard, and is subject to monitoring by staff.

173. For over a decade, the Victorian Ombudsman has raised concerns about the increasing numbers of detainees in police cells and the length of time they are spending in police custody. Since April 2012, I have hosted three forums, the latest being in December 2013, drawing together key stakeholders, such as Corrections Victoria, the Department of Justice, Victoria Police and the Magistrates’ Court, in an effort to help encourage communication between the various stakeholders and

41 Pursuant to Orders in Council signed by the Governor In Council under the Corrections Act 1986 and published in the Victorian Government Gazette.


to reach agreement on strategies to reduce the number of detainees in police cells. This has resulted in several practical outcomes, such as the increased use of teleconferencing for routine court appearances, reducing prisoner transportation costs to court and the numbers in police custody.

174. Despite my warnings and calls for action, the number of people in police cells in November 2013 reached 372. This is more than double the number of detainees Victoria Police considers to represent a high risk to safety and security. On 10 March 2014, there were 306 detainees in police cells.

175. At interview, Ms Shuard was asked about this issue. She said:

We’re [Corrections Victoria] doing everything that we can to bring people through into our system, and out of the police cells. You know, we’re opening as many beds as we can safely.

176. Ms Shuard also stated:

I would like to provide for consideration ... an overview of a number of strategies that have been implemented across the justice system to address immediate pressures in police cells:

* Corrections Victoria has been working with Victoria Police to better enable prisoners’ attendance at court by moving prisoners from police cells through to reception prisons as quickly as possible. To ensure a greater degree of collaboration and coordination between Victoria Police and Corrections Victoria, a dedicated Frontline Vacancy Management and Court Flow Unit was established in November to manage the flow of prisoners between prisons, police cells and courts.

* Corrections Victoria is working to ensure that Telecourt facilities are being used wherever possible to reduce unnecessary prisoner movements. Planning is also underway to expand the use of video conferencing across the justice system to reduce the required number of prisoner movements and facilitate improved information flow between courts, prisoners and the legal profession.

* The Magistrates’ and County Courts have also implemented innovative strategies to assist with managing the number of prisoners in police cells. The Magistrates’ Court has been conducting court sittings on weekends since November 2013. This Court hears cases where the individual has been arrested and charged between Friday afternoon and 3pm on Sunday. By processing these individuals through the Court on the weekend, individuals are moving through the system faster with their case either being remanded to another day or through the granting of bail. Weekend sittings are therefore able to reduce levels of cell congestion at the beginning of the week.

* In addition, in October 2013 the Magistrates’ Court commenced hearings in the Melbourne County Court in order to take advantage of its custody facilities. This pilot will continue until June 2014. As part of the pilot, cases to be heard will include pre-booked bail applications and consolidated pleas where the accused is in custody.
177. At interview, the General Manager of the Melbourne Custody Centre was asked about overcrowding in police cells. He said:

... 40 prisoners should really be in prison, out of the 74 we [the Melbourne Custody Centre] have got [as at 24 September 2013]. There is no room in prison ... there is no beds [in prison].

178. While there have been relatively few deaths in police cells in recent years, concerns arise about the suitability of using police cells to hold significant numbers of detainees for extended periods of time and the potential risk of detainees harming themselves or others in this environment.

Human rights

179. With overcrowding in police cells, there is the potential for human rights abuses to occur. The Victorian Charter of Human Rights and Responsibilities requires that detainees deprived of their liberty must be treated humanely. Conditions in which people are detained in Victoria are required to conform with internationally accepted standards, including conditions of accommodation.

180. The Melbourne Custody Centre is an underground facility used for holding people in police custody. It has no access to fresh air or natural light. At interview, the Chief Executive Officer of the Victorian Aboriginal Legal Service raised concerns about the human rights of detainees held at the Melbourne Custody Centre. He said:

If that was the RSPCA [Royal Society for the Prevention of Cruelty to Animals] they would have shut that ... [the Melbourne Custody Centre] down. It’s disgusting, there is no natural light, there’s no appropriate spaces for people to get anything that resembles reasonable exercise, and it stinks.

181. The General Manager of the Melbourne Custody Centre acknowledged the human rights concerns associated with holding detainees there. At interview, he said:

No fresh air, no access to ... [daylight], it’s some of the worst conditions in the state.

182. The General Manager was also asked at interview how the Melbourne Custody Centre complies with the Charter of Human Rights and Responsibilities. He said:

It doesn’t, we breach it [the Charter]. We all know that the Centre was designed to cater, to manage prisoners for a daily court occurrence, and then go to prison, or get bail or whatever. Not to be kept overnight and certainly not to be kept for 14 or 17 days.

Transfer of detainees

183. With the high number of detainees in police custody and the gazetted requirement that prisoners are not held at one location for more than 14 consecutive days, Victoria Police regularly transfers detainees to police cells across Victoria to clear space at various locations and to ensure court appearances. This practice has the potential to cause detainees and their families considerable stress as the following case study demonstrates.

Case study 6: Transfer to various police cells

Prisoner F wrote my office in November 2013 complaining about the stress caused as a result of being transferred to several different police cells while in police custody.

Prisoner F said that he was initially held at the police cells at Wangaratta for eight days, before being moved to Wodonga police cells for approximately six days and then back to Wangaratta for several more days. He was then transferred to the Melbourne Assessment Prison for several days before again being moved to the police cells at Mildura and held for approximately 12 days. Prisoner F said that he was then transferred to the police cells at Swan Hill and held for approximately six days, before being moved to Melton police cells and held for a few more days.

Prisoner F maintains that he suffered stress and depression as a result of his time spent in police custody.

184. The movement of prisoners to various police cells across Victoria has implications for the detainee in relation to informing family, friends and legal representatives of their location and for arranging visits and a change of clothing. An Inspector from the Victoria Police Prisoner Management Unit commented about these issues at interview. He said:

It could be that a prisoner [is] at the Melbourne Custody Centre today and Wangaratta tomorrow. And under the privacy provisions we actually can't tell someone where their relative is unless … [the detainee] is prepared to let them know.

185. In recent months, my office has received a number of complaints from detainees about being held in police custody at the same location for greater than 14 days. At interview, the General Manager of the Melbourne Custody Centre confirmed that with overcrowding in police cells it was becoming more difficult to meet the 14-day maximum timeframe and that there had been times recently when detainees had been held for longer than 14 days at the one location.

Access to clean clothes

186. While relatives are allowed to bring a change of clothes to a detainee held in police cells, this may not be possible in some cases. For example, where relatives are not made aware of a detainee’s location, or the detainee is homeless. In such circumstances, the Salvation Army and other charity organisations provide clean clothes to detainees. However, overcrowding in police cells has placed a strain on the ability of charitable organisations to provide clean clothing to all detainees.

187. My office has received several complaints from detainees held in police cells about not receiving access to clean clothes. The following case study is one such example.
Case study 7: Access to clean clothes

In September 2013, my office received a complaint from Prisoner G at the Melbourne Custody Centre complaining that he had been held in isolation for 14 days without a change of clothes. Prisoner G stated that he was upset and frustrated about being held in isolation without clean clothes.

My office made enquiries with the Melbourne Custody Centre. As a result, that day Prisoner G was provided with clean clothes and then transferred to prison.

Court attendance

188. The Melbourne Custody Centre is the primary facility used to hold detainees for attendance at court. On a daily basis, detainees scheduled to attend court are transported to the Melbourne Custody Centre.

189. For safety and security reasons, Victoria Police recently imposed a maximum cap of 80 detainees at the Melbourne Custody Centre during the daytime. This has resulted in the situation on a daily basis where significant numbers of detainees have been unable to attend court for scheduled appearances as a result of the Melbourne Custody Centre being full.

190. At interview, the Chair of the Victorian Custody Reference Group\(^{44}\) said that on 11 September 2013 four trucks transporting detainees for court appearances had been parked outside the Melbourne Magistrates’ Court because there was no room at the Melbourne Custody Centre to receive them. As a result, several detainees were unable to attend scheduled court hearings. The Chair described the situation as reaching ‘an all-time crisis’.

191. Several Magistrates have also recently made public comments raising concerns about Corrections Victoria’s failure to ensure that detainees attend scheduled court appearances. In October 2013, a Magistrate described the situation as ‘getting so far beyond a joke’. He also said that ‘for the executive branch of government to ignore court orders is absolutely staggering’\(^{45}\).

192. In October 2013, another Magistrate took the step of giving bail to a prisoner on the grounds that there was a greater likelihood of the person attending court if bailed, as opposed to being remanded into custody\(^{46}\). This followed two previous occasions where Corrections Victoria had failed to bring the person to court for a scheduled court appearance.

193. The inability of Corrections Victoria to ensure that prisoners attend scheduled court appearances has also resulted in Magistrates awarding legal costs against Corrections Victoria.

---

\(^{44}\) A consultative group responsible for identifying and addressing custodial issues, comprising representatives from Corrections Victoria, Victoria Police, the courts, the legal community and various welfare and support agencies.


\(^{46}\) ‘Free, remand ruled out’, The Age, 26 October 2013.
194. In October 2013, the Magistrates’ Court of Victoria commenced hearing matters at the County Court of Victoria in an attempt to assist with the management and transportation of prisoners to court proceedings. The Magistrates’ Court via its website stated that ‘the sittings will allow the Magistrates’ Court to utilise the custody facilities at the County Court and make more space available within the Melbourne Custody Centre’.

195. The use of the County Court’s facilities for hearings of the Magistrates’ Court, includes the use of holding cells at the County Court to accommodate detainees attending for court appearances. For some time, Victoria Police has sought access to the holding cells at the County Court to assist with the demand pressures on the Melbourne Custody Centre. However, the County Court cells are managed by Corrections Victoria and no agreement has been reached on their use for this purpose.

196. At interview, an Inspector from the Victoria Police Prisoner Management Unit said that the County Court cells had the capacity to hold up to 70 detainees, with three exercise yards and access to natural light. He said that while the cells were not being fully utilised, Corrections Victoria had refused to allow Victoria Police to use these cells to assist with holding detainees and getting detainees to scheduled court appearances.

197. Ms Shuard was asked about the potential use of the County Court holding cells at interview. She said:

> Firstly, I don’t think the Melbourne County Court is suitable for overnight accommodation. It doesn’t have showers and the like, so if people went there, then you might have a problem come six o’clock ... what you do with them. And not only that, there’s another [problem], the other dilemma is what do you do on Monday morning, when all the people for the County Court have got to come into the County Court to go to court?

198. The Chief Commissioner of Victoria Police also stated:

> … CV [Corrections Victoria] and the Department of Justice (DoJ) have been meeting cooperatively with us [Victoria Police] to work through a myriad of issues that currently inhibit or prevent this [the use of the County Court cells] from occurring.

**Increasing stress and anxiety**

199. As a result of detainees being held in overcrowded police cells for lengthy periods of time; denied access to basic human rights; and experiencing the uncertainty as to where they are being taken to next or when they will attend court; some detainees are suffering significant distress and anxiety.

200. This can adversely affect the mental health of detainees and lead to self-harm and even death. In the past five years, there has been an average of 19 reported self-harm incidents involving detainees each year.
201. The number of reported assaults by detainees on other detainees at the Melbourne Custody Centre alone more than tripled – from 22 reported assaults in 2011, increasing to 73 in 2012. There has, however, been a decline in the number of reported assaults in 2013.

202. On any given day, nearly half the detainees held at the Melbourne Custody Centre are Corrections Victoria’s prisoners. As a result, it is important for custody officers to understand the recent behaviour of a prisoner in order to effectively manage their conduct while in police custody.

203. However, Victoria Police does not have access to Corrections Victoria’s Prisoner Information Management System (PIMS). At interview, the General Manager of the Melbourne Custody Centre said that access to PIMS would greatly assist staff at the Centre with the effective management of detainees. He said that this issue had been recently raised with Corrections Victoria who were considering the matter.

Impact on police resources

204. The resources required to supervise higher numbers of detainees in police custody has placed a significant burden on police resources. Victoria Police estimates that up to 500 police officers per day are drawn from policing activities in the community to supervise detainees in police custody resulting in fewer police to patrol local areas.

205. In September 2013, the Secretary of the Victoria Police Association made the following comments about overcrowding in police cells and the impact on police resources:

> If 30 police stations around the state house prisoners, that equates to 1,260 shifts, every week unavailable to police your local areas, without counting the drain on supervising sergeants. That means more than the entire 1,522 additional police provided by this Government since November 2010, are being used as gaolers weekly.

206. In response to this issue, the Department of Justice stated:

> The reference … to 500 police officers being drawn from policing duties does not take into account the number of police required to staff watch-houses regardless of prison capacity pressures.

207. The total cost to Victoria Police of looking after increasing numbers of detainees in police custody, excluding police officer salaries, is estimated by Victoria Police at approximately $8.5 million in 2012-13. Victoria Police estimate that this will increase to nearly $10 million in 2013-14. Salary costs associated with 500 police officers per day who are looking after detainees are estimated at several million dollars each year.

208. Several witnesses interviewed commended Victoria Police for its work in managing the high numbers of people in police cells. At interview, the Chair of the Victorian Custody Reference Group said that Victoria Police was doing a great job in difficult circumstances and was ‘bending over backwards’ to assist Corrections Victoria when it was not the role of police officers to be jailers.

---

48 Victoria Police Association Newsletter, September 2013, page 5.
Conclusions

209. There is a crisis in overcrowded police cells caused by inadequate beds in the Victorian prison system. This has resulted in a situation where police cells are being used as de-facto prisons to hold detainees. The police cells are overcrowded with some detainees being held in excess of 14 consecutive days at the same location, contrary to gazetted requirements, in cells originally designed for overnight or short-term accommodation stays.

210. Despite recent actions taken by Corrections Victoria to relieve some of the congestion in police cells, I consider that Corrections Victoria has been slow to respond to this problem. Further work needs to be undertaken to ensure that police cells hold no more than 150 detainees overnight at any given time.

211. In my view, Victoria Police, faced with the task of managing at times in excess of 350 detainees in police cells, is performing well in difficult circumstances. While there have been relatively few serious incidents in police custody to date, as the number of detainees and the length of stay in police custody continue to rise, so does the risk of serious incidents or deaths occurring in police cells.

212. I consider that the holding of detainees at the Melbourne Custody Centre for extended periods of time, a facility which has no access to fresh air or daylight, is a breach of the Charter of Human Rights and Responsibilities. In my view, detainees should not be held at the Melbourne Custody Centre for greater than five consecutive days. I am also concerned that some detainees may not have access to basic necessities such as clean clothes.

213. The inability of Corrections Victoria to ensure that all detainees attend court for scheduled appearances also has the potential to impact on the wellbeing of detainees and cause disruption to the criminal justice system.

214. In my view, the use of the County Court holding cells, following some modifications for overnight accommodation, would reduce the need for detainees to be moved to police cells across Victoria and assist with ensuring that detainees attend scheduled court appearances. This in turn would reduce Victoria Police’s transportation costs and free up valuable police resources.

215. The Melbourne Custody Centre should be able to obtain accurate, contemporary information about a prisoner’s behaviour. Corrections Victoria and Victoria Police ought to be able to share appropriate information regarding a prisoner’s behaviour to ensure the safety of staff and others detainees.
Recommendations

I recommend that the Department of Justice:

Recommendation 7

In conjunction with Victoria Police, develop and implement immediate strategies to reduce the number of prisoners and the length of stay in police cells.

*Department of Justice response:*

... [the department] will meet the intent of ... [this] recommendation[s].

Recommendation 8

Ensure that prisoners attending court, wherever possible, are returned to prison within 72 hours of their court appearance.

*Department of Justice response:*

Corrections Victoria aims to return all prisoners from court to prison in a timely manner as is appropriate considering a range of security and logistical considerations.

Recommendation 9

Refurbish the County Court holding cells to allow for overnight accommodation of detainees and make the cells available to Victoria Police to assist with the holding of detainees.

*Department of Justice response:*

... this recommendation will be referred to the Chief Judge [of the County Court] for his consideration.

Recommendation 10

Provide Victoria Police with access to the PIMS database for detainees held at the Melbourne Custody Centre.

*Department of Justice response:*

... [the department] will meet the intent of ... [this] recommendation[s].

I recommend that Victoria Police:

Recommendation 11

Ensure that detainees are not held at the Melbourne Custody Centre for longer than five consecutive days.

*Victoria Police response:*

Supported in principle. However not achievable in the current environment.
Recommendation 12

Arrange for the provision of clean clothes to all detainees within 48 hours in police custody.

Victoria Police response:

Needs to be further explored regarding the costs, logistics and practicality.
The management of detainees at risk of suicide or self-harm

Key issues

Approximately 55 per cent of the prison population have an identified suicide/self-harm risk rating, while 42 per cent have a psychiatric risk rating indicating mental health concerns.

My investigation identified that:

- the risk rating system used by Corrections Victoria to identify and manage prisoners at risk of suicide/self-harm requires review to provide greater clarity and guidance
- differences between the assigned suicide/self-harm risk rating can have significant consequences for prisoners in relation to the mental health treatment they receive
- Corrections Victoria has been slow to implement changes to its suicide prevention strategies – continuing to allow prisoners identified at risk of suicide or self-harm to access potentially dangerous items such as razor blades, leading to self-harm.

216. From a duty of care perspective, the operators of custodial facilities have a responsibility to ensure that people at risk of suicide or self-harm in custody, are identified and appropriately managed.

217. In Victoria, the operators of custodial facilities have traditionally relied on suicide and self-harm screening tools to identify people at potential risk of suicide or self-harm. Where a person is identified at immediate or significant risk of suicide or self-harm, a multi-disciplinary approach is initiated involving custodial and clinical staff continually monitoring and assessing the progress of each individual and developing an individual management plan.

218. All custodial facilities in Victoria are required to have safe observation cells to accommodate people at risk of suicide or self-harm. These cells, commonly referred to as Muirhead cells, are designed to prevent detainees from harming themselves and to maximise observation by custodial staff.

Monitoring of people at risk of suicide or self-harm

Victorian prisons

219. Corrections Victoria’s Commissioner’s Requirement defines the term ‘at risk’ as:

... any prisoner considered to be immediately or significantly at risk of suicide or self-harm ...

49 Named after Justice James Muirhead.
50 Corrections Victoria, Commissioner’s Requirement, Management of Prisoners At Risk of Suicide or Self Harm 1.02, November 2013.
220. The Commissioner’s Requirement also provides for prisoners with a potential risk or previous history of self-harm behaviour to meet a broader definition of ‘at risk’.

221. Table 1 outlines the different risk levels for prisoners assigned a Suicide and Self-harm ‘S’ risk rating, their meaning and the required levels of observation for such prisoners.

**Table 1: ‘S’ risk rating – suicide and self-harm**

<table>
<thead>
<tr>
<th>Level</th>
<th>Meaning and observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>Immediate risk requiring observations every 15 minutes</td>
</tr>
<tr>
<td>S2</td>
<td>Significant risk requiring observations every 30 minutes</td>
</tr>
<tr>
<td>S3</td>
<td>Potential risk requiring observations every hour</td>
</tr>
<tr>
<td>S4</td>
<td>Previous history of self-harm behaviour, no observations required</td>
</tr>
</tbody>
</table>


222. Table 2 outlines the different levels of the Psychiatric ‘P’ risk rating, their meaning and the required level of care for prisoners assigned such ratings.

**Table 2: ‘P’ risk rating – psychiatric**

<table>
<thead>
<tr>
<th>Level</th>
<th>Meaning and observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Serious psychiatric condition requiring intensive and/or immediate care</td>
</tr>
<tr>
<td>P2</td>
<td>Significant ongoing psychiatric condition requiring psychiatric treatment</td>
</tr>
<tr>
<td>P3</td>
<td>Stable psychiatric condition requiring appointment or continuing treatment</td>
</tr>
<tr>
<td>PA</td>
<td>Suspected psychiatric condition requiring assessment</td>
</tr>
</tbody>
</table>


223. In relation to the purpose of the risk ratings, the Department of Justice stated:

> The risk rating system is intended to alert correctional staff to high level needs and thereby inform correctional placement and management decisions, as well as those of Victoria Police. A rating is not a clinical diagnosis and does not guide health care decisions or treatment pathways. Rather, the Justice Health Quality Framework (2011) sets the expectation of the health care to be provided to meet the individual needs of the prisoner.

224. The assessments conducted to determine prisoner suicide/self-harm and psychiatric risk ratings differ for each rating. The Department of Justice also stated:

> Only suicide and self harm risk ratings, and not psychiatric risk ratings, are relevant when referring to whether a prisoner is assessed as being at risk of suicidal or self harming behaviour.
225. As at 30 June 2013, 55 per cent of the Victorian prison population had an identified suicide/self-harm risk score. In addition, 42 per cent of the prison population had an identified psychiatric risk rating, indicating mental health concerns.

226. In response to this data, the Department of Justice stated:

... the S rating is based on a four tier classification of risk, with only two of these (S1 and S2) relating to current risk. In comparison, the S3 rating relates to a prisoner who is not currently at risk, but for whom there is a potential risk. The S4 rating only denotes a past history of suicidal behaviour.

In 2012-13, the average daily number of prisoners assessed as S1 was 3 prisoners and as S2 was 6 prisoners, equating to a daily average of 0.176 per cent of the prison population.

227. While Corrections Victoria’s Deputy Commissioner’s Instruction\textsuperscript{51} provides detailed definitions for S1 and S2 risk ratings, the definition of an S3 risk rating is less clear and open to interpretation. For example, the definition states an S3 prisoner is:

- identified as having a number of risk factors where, without intervention, there is the potential for escalation of his/her risk, but who is not at high/moderate risk of suicide or self-harm; and/or
- in need of some intervention to ensure his or her risk level does not escalate; and/or
- no longer moderate risk but still requires follow-up management and support; and/or
- a person who has previously been categorised as having no current risk but a history of self-harm behaviour and whose risk has escalated.

228. As at 30 June 2013, there were 46 prisoners with an S3 risk rating.

229. At interview, the Assistant Director Clinical Services, Acute Assessment Unit at the Melbourne Assessment Prison raised concerns about the differences between the S2 and S3 suicide/self-harm risk rating. He said that there is a ‘big jump’ between the S2 and S3 categories which means that a prisoner on an S3 risk rating will be managed in the mainstream prison population with access only to outpatient psychiatric services, as opposed to an S2 risk rated prisoner who may receive intensive psychiatric inpatient services.

230. The Commissioner’s Requirement states that prisoners identified at risk of suicide or self-harm are to be assessed by a mental health professional within two hours of being identified. The management of prisoners identified at risk of suicide or self-harm is carried out by a multidisciplinary Risk Review Team, comprised of mental health professionals; prison staff, including an Operations Manager; a clinician in some circumstances and a support worker such as an Aboriginal Wellbeing Officer.

\textsuperscript{51} Corrections Victoria, Deputy Commissioner’s Instruction 1.02, At Risk Procedures, 2013.
231. The team develops an individual risk management plan for prisoners identified at risk of suicide or self-harm and on a daily basis, reviews the status and management of these prisoners. A prisoner’s risk rating can only be downgraded following risk assessment by the team.

Conclusions

232. Corrections Victoria should have a more specific definition of prisoners at potential risk of suicide or self-harm (S3) to assist with the identification and management of such prisoners.

233. The difference between the S2 and S3 risk rating category for prisoners at risk of suicide or self-harm is also too great. This can have significant consequences for a prisoner in relation to the mental health treatment they receive in prison. For example, a prisoner with an S2 risk rating is more likely to receive intensive mental health management than an S3 rated prisoner. However, in some cases the differences between an S2 and S3 suicide/self-harm rating can be marginal.

Recommendation

I recommend that the Department of Justice:

Recommendation 13

Review the adequacy of the suicide and self-harm risk rating system, with a view to developing more specific categories, including a clear definition of what constitutes attempted suicide and self-harm for incident reporting purposes.

Department of Justice response:

... [the department] will review the S [suicide and self-harm] ratings as part of the development of a correctional suicide prevention framework.

Placement of people at risk of suicide or self-harm

Victorian prisons

234. Depending on the suicide/self-harm or psychiatric risk rating assigned to a prisoner, there are restrictions52 on the type of cells they can be held in the Victorian prison system. For example, a prisoner identified at immediate danger of self-harming or attempting suicide is required to be transferred to an observation cell where they are placed in a canvas gown and placed under physical observation every 15 minutes by prison staff. Some observation cells are subject to CCTV monitoring and the cells have no hanging points. The cells are completely bare except for a toilet, a canvas mattress and blanket.

52 Corrections Victoria, Deputy Commissioner’s Instruction 1.02, At Risk Procedures, November 2013.
235. Corrections Victoria’s Commissioner’s Requirement in relation to the management of prisoners at risk of suicide or self-harm, dated April 2013 states that:

- S1 and S2 rated prisoners are to be accommodated in cells that comply with the Cell and Fire Safety Guidelines.
- S3 prisoners accommodated at the MAP [Melbourne Assessment Prison] are also to be accommodated in cells that comply with the same Guidelines.

236. Corrections Victoria’s Cell and Fire Safety Guidelines set minimum standards for cell design and safety within Victorian prisons. I discuss the cell and fire safety guidelines and the accommodation of prisoners with a suicide or self-harm risk rating in further detail in the chapter of my report – the safety of detainees in custody.

237. The requirement for the Melbourne Assessment Prison to accommodate S3 risk rated prisoners in cells which comply with the cell and fire safety guidelines came about following several prisoner deaths by hanging at the Melbourne Assessment Prison, which occurred between 2008 and 2010. In a number of these cases, the prisoner had a S3 risk rating and had been placed in cells with hanging points.

238. While the Melbourne Assessment Prison made changes to its local operating procedures to ensure that S3 prisoners are not held in cells with hanging points, Corrections Victoria chose not until November 2013 to require other prisons to consider complying with this requirement. As a result, prisoners with a suicide and self-harm rating of S3 or S4 at all other prisons continue to be accommodated in cells which do not comply with the cell and fire safety guidelines.

239. At interview, Mr Wise was asked whether he was concerned about prisoners with suicide/self-harm and psychiatric risk ratings being held in cells with hanging points. Mr Wise said:

- the fact that someone has got a psychiatric rating doesn’t necessarily mean that they’ve got a suicide rating …
- …
- The S3s have the potential for self-harm and the S4s, which gobbles up a whole heap of the prisoner population, are people who might have had a history of it [suicide or self-harm] at some stage and they’re not considered an active risk and so one doesn’t need to place those [S4 rated prisoners] in a cell that has got no hanging points.

240. Following interviews with Ms Shuard and Mr Wise in October 2013 where my office raised concerns about the accommodation of prisoners with an S3 suicide/self-harm risk rating in cells with hanging points, in November 2013 Corrections Victoria revised its requirements$^{53}$ in relation to the accommodation of S3 risk rated prisoners. The revised Commissioner’s Requirement states:

- S3 rated prisoners accommodated at the Melbourne Assessment Prison are also to be accommodated in cells which comply with the same [Cell and Fire Safety] Guidelines.

$^{53}$ Corrections Victoria, Commissioner’s Requirement - Management of At Risk Prisoners and Deputy Commissioner’s Instruction 1.02 – At Risk Prisoners, November 2013.
For S3 rated prisoners at all other secure prisons, consideration is to be given to accommodating an S3 rated prisoner in a BDRP [Building Design Review Project] compliant cell [a cell with no obvious hanging points], taking into account other at risk management and protective factors, such as placing the prisoner in a supportive unit environment.

241. While the requirement states that ‘as a general principle, at risk prisoners are to be placed in the least restrictive accommodation that maximises the prisoner’s safety’, this may not be the most appropriate way to deal with prisoners deemed at risk of suicide or self-harm.

242. Some researchers\(^{54}\) have condemned the use of isolation cells for the accommodation of suicidal prisoners, arguing that placing a suicidal prisoner in an empty prison cell with no external stimuli can reinforce the prisoner’s feelings of isolation, hopelessness and depression.

243. At interview, the General Manager of the Dame Phyllis Frost Centre (Women’s Prison) was asked about the practice of placing prisoners at risk of suicide or self-harm into observation cells. She said:

… for a woman in crisis we remove her clothes and … issue them with a canvas gown … place her in a Muirhead [observation] cell which has limited risk and not a lot in there [the cell] …

…

… sometimes that works for women but sometimes a distraction technique would probably be … more effective … if you remove everything … there is no stimulation and they are left alone with their thoughts of self-harm … whereas potentially if you can offer them some sort of activity … cook, potter with plants … do something else … while it might only be for half an hour it actually distracts them from their thoughts and it might be enough to bring them out of crisis …

244. The following case study is an example of how one prisoner at risk of suicide and self-harm responded to being placed in an observation cell.

**Case study 8: Self-harm by a prisoner in an observation cell**

During the course of my investigation, my office received a complaint about the treatment of Prisoner H who had self-harmed. In June 2013, Prisoner H was in a management cell at Loddon Prison when he broke the ceiling light and used the broken pieces of plastic to cut his arms and wrists. After having his wounds sutured, Prisoner H was deemed at risk of suicide/self-harm and moved to an observation cell where he was stripped of his clothing, placed in a canvas gown and monitored by prison staff.

At interview, Prisoner H said that while he was in the observation cell, he made several requests to prison staff for extra canvas blankets as he was cold and his wounds were sore. Prisoner H said that he told prison staff that if he stayed in the observation cell ‘I’m going to end up killing myself’. Prisoner H said that he did not like being isolated as it brought back trauma from his childhood. Prisoner H said that one prison officer put a heater outside the cell door which provided him with some warmth, however when it was taken away the following morning, he again self-harmed by cutting into his wounds with a piece of plastic he had hidden.

\(^{54}\) Associate Professor Peter Camilleri, Dr Morag McArthur, Ms Honey Webb. Suicidal Behaviour in Prisons: A Literature Review, School of Social Work, Australian Catholic University for ACT Corrections, Canberra, 1999.
Youth justice

245. The youth justice precincts adopt a different approach when dealing with a detainee at risk of suicide or self-harm. Their guidelines\(^{55}\) state that simply because a detainee is on constant observations does not necessarily mean that he or she is to be placed in isolation. A detainee can be held in his or her room or be allowed to interact with other people in the unit. The guidelines state that it is the responsibility of staff to ensure that the environment is free of objects that could be used to self-harm or harm others.

246. When my investigators visited the youth justice precincts, they observed the different options available to staff in dealing with detainees at risk of suicide or self-harm. For example, some units have ‘timeout’ areas where a detainee can be placed and observed if they are at risk. There are also isolation rooms where vulnerable detainees can be separated. For example, a detainee with an intellectual disability who may be at risk of being bullied by other detainees can be moved to a separate area.

Conclusions

247. The traditional method of dealing with a prisoner identified at immediate risk of suicide or self-harm – stripping them of their clothing, placing them in a canvas gown and isolating them in an observation cell under constant observation also raises questions as to whether this practice can be detrimental to the mental health of some prisoners in the long-term.

248. Other custodial facilities, such as the youth justice precincts, have adopted a more therapeutic and rehabilitative approach to the management of people at risk of suicide or self-harm, often with positive outcomes.

Recommendation

I recommend that the Department of Justice:

Recommendation 14

Review the management of prisoners identified at risk of suicide or self-harm with the aim of providing a more therapeutic approach to their management.

Department of Justice response:

... [this recommendation] will require significant resources to implement and further consideration [will be given to this recommendation] in the context of broader budgetary requirements.

Strategies to minimise suicide or self-harm

249. For people identified at risk of suicide or self-harm it is important that the operators of custodial facilities tightly control access to potentially dangerous items such as razor blades.

Victorian prisons

250. Corrections Victoria has established policies and procedures for prisoners identified at risk of suicide or self-harm which restrict access to potentially dangerous items such as plastic bags, plastic wrap, shavers and toothbrushes. These policies and procedures came about following the 2007 death of a prisoner in the Charlotte Unit at Port Phillip Prison. In this case, the prisoner used a plastic bag placed over his head to commit suicide. At the time of his death, the prisoner had an S3 and P3 risk rating, and a well-documented history of mental health issues.

251. Following the death of this prisoner, Port Phillip Prison implemented changes which resulted in prisoners with S1, S2 and S3 risk ratings no longer having access to plastic bags.

252. In July 2009, the Office of Correctional Services Review (OCSR) concluded its review into the 2007 death of the prisoner at Port Phillip Prison and made a recommendation that Corrections Victoria:

... develop and disseminate a formal policy regarding the immediate removal of plastic bags from accommodation units that house prisoners deemed to be at risk of suicide or self-harm.

253. The OCSR took nearly two years to complete its report. In this time, three prisoners at the Melbourne Assessment Prison and one at the Metropolitan Remand Centre attempted suicide using plastic bags. In 2009, there were two further deaths at the Melbourne Assessment Prison both involving the use of plastic bags.

254. In response to my concerns about this issue, Mr Jonathan Kaplan, Director of the OCSR stated:

If Corrections Victoria or a private provider is already aware of the risk and remedial action is under consideration, it is reasonable that the OCSR allows time for implementation before making recommendations regarding any outstanding risk.

... While I acknowledge room for improvement in the timeliness of the OCSR’s report in this matter, I believe that the timing of the report did not leave the risk associated with plastic bags unaddressed. The OCSR was aware that Port Phillip Prison commenced activities to mitigate risks in 2007 and the OCSR continued to monitor progress throughout the course of the review.

... the OCSR has revised its internal processes to improve efficiency and reduce opportunities for delays in final reports relating to prisoner deaths.

255. In 2010, the OCSR conducted a review into prisoner access to plastic bags and cling wrap for management prisoners and prisoners at risk of suicide or self-harm, with the aim of identifying opportunities to improve practices. The OCSR recommended that Corrections Victoria finalise and release its requirement regarding restricted access to plastic bags to ensure consistency across the prison system.

256. Corrections Victoria’s Commissioner’s Requirement sets out that plastic bags and plastic wraps are not permitted in ‘high risk’ areas such as:

- Muirhead cells in all prisons
- the Acute Assessment Unit at the Melbourne Assessment Prison
- the Marrmak Unit at the Dame Phyllis Frost Centre
- St Paul’s Unit at Port Phillip Prison
- management and high security units within maximum security prisons.

257. Prisoners with an S1 or S2 risk rating are not allowed to keep plastic bags or plastic wrap in their cells. The same conditions apply for shavers and toothbrushes. While S1 and S2 prisoners can use these items, they are not allowed to keep them in their cell.

258. The Commissioner’s Requirement also states:

Where an S1 or S2 prisoner is accommodated in a modified cell in a general unit (instead of a ‘high risk’ area), where practicable, prison staff must ensure that the prisoner does not access shavers via communal prisoner areas. All modified cells must be searched prior to lock up to ensure that the prisoner is not in possession of a shaver.

259. My investigation identified a number of instances where prisoners identified at risk of suicide or self-harm were still able to use razor blades to harm themselves. In some cases, the prisoners had hidden the razor blades internally and later used them to self-harm. The following case study highlights this risk.

**Case study 9: Mentally unwell prisoner with access to a razor blade**

In May 2011, Prisoner I attempted suicide by cutting an artery in his arm with a razor blade. Prisoner I was provided with a razor by a staff member to shave. It only took 12 minutes from the prisoner being given the razor and being discovered to have self-harmed by staff.

At the time of this attempt, Prisoner I was being held in the Acute Assessment Unit at the Melbourne Assessment Prison for mentally unwell patients. Thirteen days before this incident, Prisoner I had been at the Hopkins Correctional Centre where he attempted suicide by cutting his wrists.
Conclusions

260. Corrections Victoria has been slow to implement changes to suicide prevention strategies. For example, continuing to allow prisoners identified at risk of suicide or self-harm to have access to potentially dangerous items such as plastic bags and razor blades, bearing in mind the number of attempted suicides and self-harm incidents involving such items. I further comment about the OCSR’s performance later in this report.

261. In response to my concerns, the Department of Justice stated:

The [Ombudsman’s] report finds that Corrections has been slow to implement changes to its at-risk procedures. This is not always about unresponsiveness, but about weighing up the benefits of a normalised, humane environment against a more Spartan, restrictive environment in managing at risk issues. There is a danger in responding to every incident by removing those materials used in self-harming episodes; the end result will be a very non-therapeutic environment, which Corrections tries to minimise.

Recommendation

I recommend that the Department of Justice:

Recommendation 15

Review policies and procedures in relation to the provision of dangerous items, such as razor blades and plastic bags, to prisoners with a suicide or self-harm or psychiatric risk rating.

Department of Justice response:

... [the department] will meet the intent of ... [this] recommendation[s].

Incident reporting

262. Where a detainee dies in custody; attempts suicide or self-harm; or is seriously injured, it is important that the incident is reviewed in order to determine whether there is anything that could have been done to prevent the incident from occurring, and to make changes to practices to minimise the likelihood of it happening again.

Victorian prisons

263. My investigation identified that Corrections Victoria does not routinely conduct reviews of all serious incidents. Corrections Victoria’s Deputy Commissioner’s Instruction\(^57\) provides guidance in relation to the level of reporting required for incidents, both notifiable and reportable, that occur within Victorian prisons. Examples of notifiable incidents include:

- a death in custody
- serious assault where the victim is hospitalised

\(^{57}\) Corrections Victoria, Deputy Commissioner’s Instruction 1.19, Incident reporting and monitoring, April 2013.
• attempted suicide of a prisoner and a serious self-inflicted injury where the prisoner has been hospitalised.

264. Reportable incidents are less significant incidents which require a formal report to be made.

265. The Deputy Commissioner’s Instruction states that all incidents need to have some form of analysis, which is done by way of an incident report. In addition to this, the Deputy Commissioner’s Instruction provides for an Internal Management Review to be conducted in some instances, in order to allow for a comprehensive review of the incident. The Internal Management Review is not limited to a death in custody; it can be conducted on any notifiable incident. It is generally at the discretion of the prison general manager or the Deputy Commissioner, Operations to request an Internal Management Review.

266. Corrections Victoria does not routinely require public prisons to conduct an Internal Management Review following a death in custody, as the OCSR is responsible for investigating and preparing reports to the State Coroner for each prisoner death which occurs in the Victorian prison system. Depending on the circumstances surrounding the death, Victoria Police may also conduct an investigation.

267. Where a death occurs in a privately run prison, such as Port Phillip Prison, the prison is required to conduct an Internal Management Review, as well as the OCSR conducting its review.

268. At interview, when asked whether public prisons were missing an opportunity to implement changes following a death in custody by conducting a review, rather than relying on the OCSR, Mr Wise said:

... we probably wouldn’t want to cut across the OCSR investigation.

... so it’s probably not helpful in the aftermath of a death to have three concurrent inquiries going ...

269. Mr Wise said that in some circumstances, the prison itself may be interested in implementing a change following a death in custody, and that change is isolated to that prison. For example, in February 2013, a prisoner was found dead in his cell at Barwon Prison, having smuggled a mop and some tape into his cell which he used to assist in his suspected suicide. Following this incident, Barwon Prison made changes to prisoner access to mops and other tools which could be used in similar circumstances.

270. Mr Wise also stated:

The more serious incidents will very often have a post-incident briefing and/or formal debrief, both of which identify learnings and ways of mitigating future risks. I can assure you that each prison General Manager will examine and analyse every serious incident in his or her prison to see if the incident were [sic] preventable.

... In most cases, such formal reviews are unnecessary as the options for further action are straightforward and readily apparent.
271. Between 1 July 2006 and 30 June 2013, there were 98 reported incidents of attempted suicide within Victorian prisons. However, in not one of these cases was an Internal Management Review conducted. In addition, there were 1,927 reported incidents of self-harm and only one Internal Management Review conducted for an incident which occurred in July 2009.

272. The OCSR conducted only four reviews between 2008 and 2009 of specific self-harm and attempted suicide incidents that occurred at various prisons. At interview, Mr Kaplan said that generally, if the OCSR is going to conduct a review following an incident, such as self-harm or attempted suicide, then Corrections Victoria will not conduct an Internal Management Review. In relation to Corrections Victoria conducting an Internal Management Review, Mr Kaplan also stated:

> For clarification, the conduct of an OCSR review into an incident does not in any way preclude or prohibit Corrections Victoria from conducting an Internal Management Review.

273. Corrections Victoria provided information to my investigators from its PIMS database which details incidents of attempted suicide and self-harm that have taken place between 2006 and 2013. From this information, systemic issues relating to incidents of attempted suicide and self-harm were identified. For example, prisoners have self-harmed and/or attempted suicide by ingesting chemicals such as liquid disinfectants, bleaches and gardening poisons, accessing and using razor blades to inflict harm and attempting suicide in areas other than in prisoner cells.

274. My investigation also identified concerns in relation to the use of canvas gowns provided to prisoners at immediate or significant risk of suicide or self-harm. There have been several cases where prisoners have used the canvas gowns to attempt suicide, such as tearing the gown into strips to make a noose and attempting to hang themselves.

275. The following case study is an example of a prisoner who was able to use the canvas gown to attempt suicide on multiple occasions.

Case study 10: Suicide attempts using a canvas gown

In October 2012, Prisoner J at the Dame Phyllis Frost Centre was found in the observation cell by prison staff attempting suicide, with her face discoloured and with a canvas gown tied tightly around her neck.

Eleven days later, Prisoner J again attempted suicide by tying the canvas gown around her neck. Two days after this incident, Prisoner J again tied the canvas gown around her neck in an attempt to commit suicide.

276. In spite of a number of recorded prisoner incidents involving the use of canvas gowns, there has been no prison-wide review of this issue.

277. While Corrections Victoria’s service delivery outcome documentation provides prison staff with some guidance on how to define incidents of self-harm or attempted suicide, my investigation identified inconsistencies in the recording of such incidents.
278. A review of prisoner self-harm incidents identified several cases which were recorded by prison staff as self-harm rather than attempted suicide. In several of these cases, an objective observer could reach the conclusion that the incident should more accurately be classified as attempted suicide. For example in 2006, a prisoner slashed his arms and legs and used his blood to write a note. There were nine other cases classified as self-harm in which prisoners inflicted deep cuts to their arms, wrists and legs, resulting in significant blood loss. In most cases, an ambulance was called to transport the prisoner to hospital for emergency treatment.

279. At interview, Mr Wise said that there is an incident analyst who reviews incident reports to ensure continuity and proper classification of incidents. Mr Wise said that if the analyst thinks the incident has not been properly categorised or that there is insufficient detail, contact will be made with the prison and prison staff who were involved in the incident to make amendments. My investigators identified only one case in the Corrections Victoria data provided for the period between 2006 and 2013 which showed that the classification had been subsequently changed.

Conclusions

280. Corrections Victoria does not have a clear and consistent practice of incident reporting. The incident reporting requirements for private and public prisons should not differ.

281. The ad-hoc nature of when an Internal Management Review is conducted means that the opportunity to improve the prison system and mitigate risks to prisoners at risk of suicide or self-harm is being missed.

282. In my view, Corrections Victoria would benefit from having a clearer definition in relation to what constitutes attempted suicide or self-harm. The inconsistent reporting of such incidents by prison staff has resulted in the downgrading of some incidents of attempted suicide.

283. In response, the Department of Justice stated:

> ... [the] clarification between self harm and suicide is being addressed through the department’s Correctional Suicide Prevention Framework Project.

Recommendations

I recommend that the Department of Justice:

Recommendation 16

Establish guidelines for the consistent reporting of incidents of attempted suicide and self-harm for all prisons and ensure that prison staff are made aware of the guidelines.
Recommendation 17

Conduct regular reviews of systemic issues and proactively implement changes to its policies - focussing on mitigating risk to prisoners at risk of suicide or self-harm.

Department of Justice response:

... [the department] will meet the intent of ... these recommendations.
The safety of detainees in custody

Key issues

Over 22 years ago the Royal Commission into Aboriginal Deaths in Custody called for police and corrective services to carefully scrutinise equipment and facilities with a view to eliminating and/or reducing potential hanging points.

Despite this longstanding recommendation, my investigation identified many obvious hanging points in Victorian prisons and the Thomas Embling Hospital placing prisoners and patients at risk of suicide or self-harm.

284. The Royal Commission into Aboriginal Deaths in Custody was established in response to significant public concerns about the frequent and often unexplained deaths of Aboriginal people in custody across Australia.

285. The Royal Commission found systemic defects in relation to police and corrective services failing to maintain appropriate standards of care for persons in custody, mainly in relation to hanging points, fixtures or places where a detainee could self-harm or attempt suicide.

286. The Royal Commission’s report, which called for police and corrective services to carefully scrutinise equipment and facilities with a view to eliminating and/or reducing the potential for harm, including steps to screen potential hanging points, has implications for the safety of all detainees in custody.

287. I am concerned that, over 22 years after the Royal Commission’s report, my investigation identified that there are many obvious hanging points in Victorian prisons and the Thomas Embling Hospital, placing prisoners and patients at risk of self-harm and suicide.

Compliance with safety standards

288. My investigation reviewed the physical safety of accommodation in Victorian prisons, the youth justice precincts, Victoria Police cells and the Thomas Embling Hospital. This included an inspection of each custodial facility.

289. The aim was to determine whether the physical accommodation in custodial facilities provided a safe physical environment which minimised the risk of people in custody from harming themselves or others.

Youth justice

290. In my 2010 report, I raised concerns about the design features within the Melbourne Youth Justice Precinct and identified several hanging points throughout the precinct.

58 Victorian Ombudsman, Investigation into conditions at the Melbourne Youth Justice Precinct, October 2010.
291. Following the commencement of my current investigation, the Department of Human Services conducted an internal audit of all secure bedrooms at the youth justice precincts. The audit compared Corrections Victoria's standards with those complied with by the department and used Corrections Victoria's standards as a benchmark for the level of safety required for secure bedrooms at the precincts.

292. At interview, the Director Secure Services, Department of Human Services was asked about compliance with the safety standards in the youth justice precincts. He said:

... we do meet the Australasian Juvenile Justice Administrators guidelines but my concern was that we needed to be ... ensuring that best practice guidelines were being met ...

... I requested we undertake a review against those guidelines [referring to Corrections Victoria’s Cell and Fire Safety Guidelines] which by far exceeded the AJJA [Australasian Juvenile Justice Administrators] guidelines ... so I wanted to make sure that what we were doing was best practice ...

293. The Manager Infrastructure Projects and Security Units, Department of Human Services said at interview that he chose to use Corrections Victoria’s standards because the standard is high and one which youth justice should be achieving when it comes to obvious hanging points and safety. He also said that he hopes to develop safety standards specific for youth justice which aim to make bedroom accommodation safer, as that is the place where detainees can go and be out of direct supervision with staff.

294. The audit conducted by the department identified a number of deficiencies within the youth justice precincts, including obvious hanging points. The department has since completed all rectification works to make the accommodation safe for detainees.

Conclusions

295. It is pleasing to see the efforts of the Department of Human Services in eliminating obvious hanging points and improving accommodation safety throughout the youth justice precincts. Since my investigation commenced the department has taken a proactive approach to ensuring that bedroom accommodation in the youth justice precincts are of a high standard and takes into account the safety needs of young detainees and the Royal Commission’s recommendations.

296. While the standards required of the department do little to provide guidance on the removal of obvious hanging points, the department was able to successfully identify risks with its accommodation and make necessary improvements.


60 Design Guidelines for Juvenile Justice Facilities in Australia and New Zealand 1996 which was created using the Australasian Juvenile Justice Administrators Standards for Juvenile Custodial Facilities.
Recommendation
I recommend that the Department of Human Services:

Recommendation 18
Develop safety guidelines specific for youth justice precincts which aim to eliminate obvious hanging points and provide a safe physical environment for detainees.

Department of Human Services response:
The department agrees that it is timely to review the extent to which the Australasian Juvenile Justice Administrators’ (AJJA) guidelines adequately address current best practice in design and safety for youth justice centres. A review could consider whether there are other standards in existence which could be applied to Victorian Youth Justice centres or whether there is a need for new guidelines to be developed.
Victorian prisons

Key issues

My investigation identified that:

- Corrections Victoria poorly managed a $50 million project to eliminate hanging points, including removing $11 million in project funding without adequate assessment of the impact on cell safety

- 38 per cent of all prison cells still have hanging points and fail to comply with Corrections Victoria’s Cell and Fire Safety Guidelines and the recommendations of the Royal Commission into Aboriginal Deaths in Custody in relation to safe cells

- there have been six prisoners in the past six years (several of whom had mental health issues) who committed suicide by hanging, nearly all in cells which did not comply with the cell and fire safety guidelines

- Corrections Victoria failed to comply with the recommendations of the State Coroner in relation to improving cell safety and the accommodation of prisoners with mental health issues

- Corrections Victoria continues to place prisoners with a history of suicide/self-harm or mental health issues in cells with hanging points

- the many obvious hanging points in more than one third of all prison cells raise concerns whether Corrections Victoria is meeting its duty of care to prisoners and complying with the Charter of Human Rights and Responsibilities

- Corrections Victoria has no immediate plans to eliminate hanging points from 1,236 cells accommodating 1,650 prisoners.

297. The Australian Institute of Criminology (AIC), in its most recent report\textsuperscript{61}, found that the second highest cause of death in custody in Australia between 2008-09 and 2010-11 resulted from hangings\textsuperscript{62}. Fittings such as cell doors, ceiling vents, cell bars, shower fixtures and bunk beds were commonly used as hanging points, with bed sheets being the most common material used to create the ligature.

298. In 2003, a survey\textsuperscript{63} of 500 prisoners conducted by the OCSR found that the prevalence of mental health illness among prisoners was three to five times greater than in the community. The survey also identified that 50 per cent of prisoners surveyed had experienced thoughts of committing suicide, with 60 per cent of this group actually attempting suicide. Additionally, 25 per cent reported that their thoughts about suicide had increased or greatly increased once they were imprisoned.

\textsuperscript{61} Australian Institute of Criminology, Deaths in custody in Australia to 30 June 2011: Monitoring Reports 2012.

\textsuperscript{62} The most common cause of death resulted from natural causes.

299. As mentioned earlier in my report, 55 per cent of the Victorian prison population have an identified suicide/self-harm risk rating, while 42 per cent have an identified psychiatric risk rating.

The Building Design Review Project

300. The Building Design Review Project (the project) was established by Corrections Victoria in response to the State Coroner’s findings in April 2000, in which the Department of Justice and Group 4 Correction Services Pty Ltd\textsuperscript{64}, were found to have contributed to four suspected suicides at Port Phillip Prison, by failing to minimise hanging points in the design and construction of its cells.

301. The Coroner recommended that the Department of Justice establish guidelines to eliminate obvious hanging points in mainstream prison cells and hospital wards.

302. The Building Design Review Project resulted in the development of Correction Victoria’s Cell and Fire Safety Guidelines for prison cell and content design, which included eliminating obvious hanging points\textsuperscript{65}.

303. In practical terms, the project involved the refurbishment of a number of prison cells to make them compliant with the guidelines. In some cases this involved completely emptying the cell and removing all sharp edges and replacing fittings, such as sink taps, with special tapered fittings to prevent a ligature being attached.

304. In order to understand the extent of the work undertaken as part of this project, my investigators requested detailed information from Corrections Victoria, including preliminary risk assessments and audits conducted by a private consultant engaged by Corrections Victoria.

305. In response to my office’s requests for information in relation to the project, Corrections Victoria advised that it was unable to locate a significant number of the original documents requested including key risk audits of prison cells conducted by a private consultant, which identified prison cells to be given priority as part of the project works. When my investigators sought further information and clarification from Corrections Victoria about the details of the project, the Manager, Operations Directorate responded by stating:

\textit{CV [Corrections Victoria] has no additional information to provide with regard to the timeline of the initial BDRP [the Building Design Review Project] project works, or the number/location of cells and expenditure relating to BDRP works per financial year ...}

306. From the limited information provided to my office, I am able to provide a history of the project as follows:

\begin{itemize}
\item In 2001-02, Corrections Victoria established the project after receiving $50 million in Victorian government funding allocated from the state budget. The aim of the project was to deliver upgrades to existing cells in Victorian prisons.
\end{itemize}

\textsuperscript{64} The private operator of Port Phillip Prison, now known as G4S Australia Pty Ltd.
\textsuperscript{65} The guidelines also focus on fire prevention and safety within prison cell accommodation.
• Between 2002 and 2004, Corrections Victoria undertook a preliminary risk assessment of existing cells at both maximum and medium security prisons and identified ‘cell and fire safety works well in excess of the $50 million funding allocation’.

• In the 2005-06 financial year, $11 million of project funding was reallocated by Corrections Victoria to finance security upgrades at the Melbourne Assessment Prison and Barwon Prison, reducing the total project funding to $39 million.

• Between 2007 and 2008, project upgrades were completed to two accommodation units at Port Phillip Prison. The estimated costs of delivering the project upgrades increased dramatically between 2005 and 2008. For example at Port Phillip Prison, project costs to refurbish cells in the Charlotte Unit and St Paul’s Psycho-social Unit increased by approximately $394,800 and $290,900 respectively.

• By July 2010, the project funds were fully expended and a total of 364 maximum and medium security cells across the prison system were refurbished and made compliant with the cell and fire safety guidelines.

• In March 2010, Corrections Victoria estimated it would cost a further $200 million to refurbish all remaining prison cells to make them compliant with the cell and fire safety guidelines.

307. My investigation identified that as at 18 October 2013, 1,236 prison cells, which equates to 38 per cent of all cells across the prison system, still do not comply with the cell and fire safety guidelines.

Risk assessment of cells

308. The risk assessment process undertaken as part of the project aimed to assess and score prison cells in maximum and medium security prisons to determine which cells required upgrading. The score related to the potential for prisoners to inflict serious self-harm through inadequate cell design. Prison cells that scored above 70 were considered a high priority for upgrading.

309. Cells considered most likely to accommodate high risk prisoners were given priority. This included management, protection, intellectually disabled, acute and psycho-social units in all maximum security prisons. However, information provided by Corrections Victoria shows only some of these units being assessed and assigned a risk score.

310. When comparing information provided by Corrections Victoria, there are also differences in the cells that were identified as a priority, having received a score above 70, to the cells that were actually upgraded. For example, Diosma Unit, a 64 cell mainstream unit at Barwon Prison, scored 57 out of 70 and yet was upgraded to comply with the guidelines. Similarly, the Spring Unit, a 12 cell management unit at the Melbourne Assessment Prison, which did not receive a risk score, was also upgraded.

311. Some reasoning is provided in a document\textsuperscript{67} written by Mr Wise, Deputy Commissioner, Corrections Victoria. Mr Wise stated that although the risk assessment was conducted, there were difficulties in delivering the project upgrades to certain units, such as the mainstream units at the Melbourne Assessment Prison and Port Phillip Prison, due to the fact that those units were in high demand and prisoners were unable to be relocated to appropriate units in other prisons.

\textbf{$11$ million reprioritisation of project funding}

312. In 2005-06, the Victorian government Expenditure Review Committee\textsuperscript{68} approved Corrections Victoria’s request for the reprioritisation of $11 million of funding originally intended for the Building Design Review Project.

313. The funding was reallocated to upgrade the perimeter security of the Melbourne Assessment Prison and Barwon Prison, following the arrest of suspected terrorists. This reduced the project budget for prison cell upgrades to $39 million.

314. My investigation identified information that suggests that Corrections Victoria failed to adequately assess the impact that the $11 million reallocation of project funding would have on the remaining upgrades to prison cells.

315. In a Department of Justice briefing note to the Secretary of the department, dated 31 March 2010, reference is made to this decision. The briefing note states:

\begin{quote}
It appears that no assessment of the impact on implementation of remaining [project] works was undertaken when the reallocation was applied for and approved …
\end{quote}

316. My investigation also identified an email exchange between finance staff at Corrections Victoria dated 24 March 2010, in which questions were raised as to whether an adequate risk assessment was conducted prior to the funding being reprioritised, as a number of key documents relating to the reprioritisation were unable to be located. The email from the Manager, Finance and Business Services states:

\begin{quote}
In regards to your query about the reprioritisation of BDRP [Building Design Review Project] funds under the Major crimes initiative, I have conducted a search of my records, electronic and hard copy and found a few bits and pieces but not possibly everything you require.
\end{quote}

317. At interview, Mr Wise was asked about the $11 million reprioritisation of project funds. He said:

\begin{quote}
$11$ million dollars of that [$50 million project funding] was taken away in order to do greater priority work at the time [referring to the security upgrades at Melbourne Assessment Prison and Barwon Prison] and that was all endorsed by those who needed to endorse that.
\end{quote}

\textsuperscript{67} Corrections Victoria, Cell & Building Safety Redesign, Supplementary Report, 22 July 2008.

\textsuperscript{68} Expenditure Review Committee, a sub-committee of the Victorian Cabinet which considers financial matters for the state budget.
318. Following the $11 million reprioritisation of project funding, between November 2008 and August 2010 six prisoner deaths occurred at the Melbourne Assessment Prison. In four of these cases, the prisoner used bed linen to hang themselves from a solid fixture, such as a shower screen, within their prison cell. Several of these deaths occurred in prison cells with obvious hanging points which did not comply with the cell and fire safety guidelines and which may have been made compliant if funding had not been diverted.

**Obvious hanging points**

319. My investigators visited each prison in order to view first-hand the state of prison cells and other accommodation being used to accommodate prisoners. During these visits, my officers identified and photographed a number of obvious hanging points within prison cells, with the potential for prisoners to attempt suicide or self-harm.

320. The many obvious hanging points identified at several prisons raise concerns as to whether Corrections Victoria is meeting its duty of care to prisoners held in these prison cells. It is also questionable as to whether Corrections Victoria, by placing prisoners in cells with obvious hanging points, is complying with the Charter of Human Rights and Responsibilities in relation to ensuring a prisoner’s right to life.

**Exposed heating pipes at Port Phillip Prison**

321. Exposed heating pipes are present in a number of cells throughout Port Phillip Prison. The heating pipes are a design feature of the prison dating back to its construction in 1996.

322. The following photograph shows the exposed heating pipes in cells at Port Phillip Prison. The pipes, which have been previously used by a prisoner to commit suicide by attaching a ligature (a sheet) and placing it over a solid shower wall to create a hanging point, are also present in a number of units throughout the prison, including those accommodating vulnerable prisoners, such as Penhyn, the prison’s youth unit.
Photograph 3: The exposed heating pipes in cells at Port Phillip Prison have been previously used by a prisoner to commit suicide by attaching a ligature (Port Phillip Prison, Scarborough South Unit, 26 July 2013).

323. The following case study highlights the lack of action taken by Corrections Victoria in relation to the heating pipes.

Case study 11: Failure to act in response to the Coroner’s recommendations

In March 2008, Prisoner K, a 29 year old prisoner, accommodated in the Scarborough South Unit, a reception unit at Port Phillip Prison, was found dead, hanging in the shower. Prisoner K tied a sheet to the exposed heating pipe and passed it up and over the shower wall in his cell to create a hanging point.

At the time of his death, Prisoner K had a ‘S3’ rating, indicating that he was at ‘potential risk of suicide/self-harm’. Prisoner K had self-harmed a month earlier at the Melbourne Assessment Prison by cutting his neck.

In September 2012, the State Coroner held an inquest into the death of Prisoner K and recommended that, unless structural changes are made to remove the hanging points created by the heating pipes, prisoners that are assessed to be ‘at risk’ are not to be placed into cells with obvious hanging points.

In response to the Coroner’s recommendation, the Acting Secretary of the Department of Justice advised that the department was unable to implement the recommendation due to the high costs of renovating the existing cells to make them compliant with the guidelines and stated:

There are substantial costs involved in renovating the prison cells to meet current cell and fire safety standards and cell renovation works of the scale recommended would significantly disrupt the operations of the Port Phillip Prison and the daily movement of prisoners within Victoria’s prison system.
324. In response to this issue, the Department of Justice stated:

The department is not required to comply with findings by the State Coroner. Following the issuing of findings by the State Coroner, the department has three months to provide a written response to any recommendations made. The department’s response can include acceptance, partial acceptance or rejection of any recommendation.

325. At interview, the General Manager of Port Phillip Prison was asked what action the prison had taken in relation to making the heating pipes safe. He said:

We were requested [by Corrections Victoria] to get a design cost and an installation plan for the cover of the remaining pipes across Port Phillip that are currently exposed and which we have provided that cost to Corrections Victoria.

326. The General Manager said that the total cost of covering the exposed heating pipes to make them safe was estimated at $1.4 million. He also said that Port Phillip Prison is waiting to hear from Corrections Victoria in relation to this funding submission.

327. At interview, the Deputy General Manager of Port Phillip Prison was also asked about the exposed heating pipes. He said:

I have done an assessment [of covering the heating pipes] and the General Manager has sent that assessment in to the Contracts Management Branch of Corrections Victoria because really the onus is actually on them [Corrections Victoria] because it is their infrastructure. Any expenditure they would have to fund it.

From an operator’s point of view seeing that [exposed heating pipes] is certainly not acceptable.

328. When asked at interview about the cost of covering the heating pipes, Mr Wise said that he was not able to provide any further details about this matter, given that there may have been recent discussions with the Victorian government about this issue.

329. When asked about the action being taken by Corrections Victoria to cover the heating pipes, Ms Shuard said:

... I am not aware ... I think ... they [Port Phillip Prison management] have done some assessment at Port Phillip ...

330. At the time of completing this report, no action had been taken to make the exposed heating pipes safe at Port Phillip Prison. In a letter dated 19 December 2013, the Secretary of the Department of Justice stated:
... a detailed risk assessment has also been completed of the Port Phillip Prison cells containing exposed heating pipes, photographs of which you [the Victorian Ombudsman] provided to me in your ... correspondence. The assessment detailed the various potential ligature points in the original cells and that the covering of the pipes, while removing one potential risk, would not remove the risk overall. The complete redevelopment of the accommodation is not possible at this time therefore the department will continue to manage any potential risks until that work can be undertaken.

331. At interview, the General Manager of Port Phillip Prison was also asked about the accommodation of prisoners identified at potential risk of suicide or self-harm at the prison. He said:

... we aim to whenever possible, hold them in cells that are BDRP [Building Design Review Project] compliant ...

332. The General Manager said that Port Phillip Prison has limited placement options in dealing with prisoners with a suicide/self-harm risk rating due to the fact that the majority of cells do not comply with the cell and fire safety guidelines.

333. As at 18 October 2013, 547 prison cells accommodating 696 prisoners at Port Phillip Prison did not comply with the cell and fire safety guidelines. The General Manager of Port Phillip Prison was asked at interview whether these figures are of concern to him. He said:

Absolutely. Any general manager would say that in a perfect world that all the cells would be BDRP [Building Design Review Project] compliant because it ... greatly removes the risk of a prisoner taking his life.

**Exposed plumbing in prison cells**

334. The exposed plumbing of a toilet or sink within prison cells can provide prisoners with the opportunity to attach a ligature, such as a cord, and hang themselves. Several prisoners have committed suicide in this manner.

335. The following photograph taken at Port Phillip Prison shows the hanging points created by the exposed plumbing of the toilet and sink, as well as the hanging point created by the sink taps that are not recessed into cell walls. My investigators observed the same type of hanging points in several prisons they visited, including the Melbourne Assessment Prison, Loddon Prison, Barwon Prison, and the Fulham Correctional Centre.
Photograph 4: The exposed sink tap was used by a prisoner at Port Phillip Prison in February 2013 to commit suicide by attaching a ligature (Port Phillip Prison, Scarborough South Unit, 26 July 2013).

336. The following case study illustrates how exposed plumbing in a prison cell can be used by a prisoner to take their life.

**Case study 12: Apparent suicide of a prisoner with mental health issues in a cell with hanging points**

In February 2013, Prisoner L, a 36 year old prisoner, was found dead hanging from the sink tap in his Scarborough South Unit cell at Port Phillip Prison. Prisoner L had what appeared to be a shoelace and plastic bag wrapped around his neck, which was tied to the sink tap.

At the time of his death, Prisoner L had a ‘S4’ rating, indicating that he had a previous history of risk of suicide/self-harm and a ‘P3’ rating, indicating that he had a stable psychiatric condition requiring continuing treatment or monitoring.

Prisoner L had been placed in a cell which did not comply with the cell and fire safety guidelines. The State Coroner is yet to determine the cause of Prisoner L’s death.

337. At interview, Mr Wise was asked about the placement of prisoners with a previous history of suicide or self-harm, such as Prisoner L, in prison cells with obvious hanging points such as exposed plumbing. He said:

    ... it’s a single case ... I don’t think you can extrapolate too strongly from a single case ...

338. Mr Wise was also asked whether he considered Prisoner L’s case highlights the risk that cells need to be upgraded to ensure that prisoners are not placed in environments with obvious hanging points. He said:
Well no it doesn’t necessarily … I’d prefer to have all cells BDRP [Building Design Review Project] compliant. There’s no doubt about that but it’s not an unreasonable risk to be taking [referring to placing prisoners in non-compliant cells with obvious hanging points] ...

339. Prisoner L’s death is not an isolated event as the following case study demonstrates.

**Case study 13: Death of a prisoner assessed at potential risk of suicide**

In March 2010, Prisoner M’s cellmate used the cell intercom to report having found Prisoner M, a 41 year old prisoner, hanging dead from the shower screen in their William Unit cell at the Melbourne Assessment Prison.

When prison staff responded, they saw that Prisoner M had used a pillow case to tie around his neck to create a ligature. At the time of his death, Prisoner M had a ‘S3’ rating, indicating that he was a ‘potential risk of suicide/self-harm’. Prisoner M had been in custody for a week prior to his death.

340. The following photograph taken at the Melbourne Assessment Prison shows a shower curtain rod, exposed taps and shower curtain, which could all be used to self-harm and attempt suicide.

**Photograph 5: The exposed taps, the shower curtain rod and shower curtain can be used by prisoners to commit suicide by attaching a ligature (Melbourne Assessment Prison, King Unit, 23 July 2013).**
Following the apparent suicide of six prisoners at the Melbourne Assessment Prison between November 2008 and August 2010, in 2010-11 the Department of Justice reprioritised $8.6 million from its budget to fund upgrades to prison cells in two mainstream units and two medical observation cells at the Melbourne Assessment Prison to make them compliant with the cell and fire safety guidelines.

However, it was not until the death of a prisoner in August 2010, which was the third for that year in similar circumstances to the previous two, that the Department of Justice endorsed the commencement of prison cell upgrades at the Melbourne Assessment Prison to make them compliant with the cell and fire safety guidelines.

During the course of my investigation, I obtained a Corrections Victoria document\(^69\) which refers to the inadequate cell design at the Melbourne Assessment Prison and the risk to prisoners accommodated in these cells. The document states:

> ... recent incidents of suicide at the MAP [Melbourne Assessment Prison] have highlighted the deficiencies in current cell design and fit out which were not part of the previous BDRP [Building Design Review Project] program.
>
> ... If these cells are not upgraded there is a greater risk of suicide and self-harm by prisoners, which cannot be fully managed by operational means.

In response to this issue, the Department of Justice has recently stated:

> ... from February 2001 to November 2008, there were no suicide deaths at the MAP [Melbourne Assessment Prison].

I note that in the past six years, there were six prisoners (several of whom had mental health issues) who committed suicide at the Melbourne Assessment Prison. Nearly all deaths were by hanging and most occurred in cells which did not comply with the cell and fire safety guidelines.

While 82 prison cells were upgraded at the Melbourne Assessment Prison in 2011 to make them compliant with the cell and fire safety guidelines, as at 18 October 2013 there remain 84 prison cells in mainstream prison units across the Melbourne Assessment Prison which do not comply with the guidelines.

**Bunk bed ladders in prison cells**

Earlier in my report I made reference to the obvious risks associated with a bunk bed ladder being used as a hanging point for a prisoner to commit suicide. The following case study highlights my concerns.

---

**Case study 14: Bunk bed ladder used as a hanging point to commit suicide**

In May 2010, Prisoner N, a 28 year old prisoner, was found dead hanging from the rungs of the bunk bed ladder in his cell at the Melbourne Assessment Prison. Prisoner N used a bed sheet to hang himself.

---

It was Prisoner N’s first time in prison. Prisoner N spent 20 days at the Melbourne Assessment Prison before his death, having been transferred from the Metropolitan Remand Centre, where all cells are compliant with the cell and fire safety guidelines.

At the time of his death, Prisoner N had a ‘S3’ rating, indicating that he was a ‘potential risk of suicide/self-harm’.

348. During the course of my investigation, I identified an email dated 23 April 2010 written by a Prison Supervisor at Barwon Prison to the Acting General Manager, raising concern that the cells in the Cassia Unit at Barwon Prison are also not compliant with the cell and fire safety guidelines.

349. The email written by the Prison Supervisor, states:

To inform you that Cassia Reception Unit has not been BDRP [Building Design Review Project] or Cell Fire Safety re-fitted. CV [Corrections Victoria] re-allocated the money. That is why Cassia unit still has double bunks and many available ‘hanging points’.

The issue was raised when Cassia unit re-opened 11th July 2008.

350. The Acting General Manager responded to this email on 27 April 2010 stating:

Thanks …
Will take it on board.

351. As the following photograph shows, the bunk bed ladder in the Cassia Unit continues to provide an obvious hanging point.

Photograph 6: A similar bunk bed ladder has previously been used by a prisoner at another prison to commit suicide by attaching a ligature (Barwon Prison, 15 July 2013).
352. No action has been taken by Corrections Victoria to make the cells in the Cassia Unit at Barwon Prison compliant with the cell and fire safety guidelines.

Refurbished cells

353. There have been several revisions to Corrections Victoria’s Cell and Fire Safety Guidelines since its implementation in 2004 which aim to improve the level of safety in prison cells.

354. My investigation identified that prison cells renovated to comply with the cell and fire safety guidelines in place at the time, have not been re-assessed by Corrections Victoria to determine whether they continue to comply with the current cell and fire safety guidelines.

355. For example, the Charlotte Unit at Port Phillip Prison was refurbished between 2007 and 2008. The current guidelines require all cell lighting to be recessed and sitting flush with the ceiling for safety reasons. However, the light fittings in the Charlotte Unit do not comply with this requirement.

356. The following photograph taken at Loddon Prison shows a light fitting which has not been recessed.

Photograph 7: Light fitting is not recessed meaning that a prisoner could break the fitting and use the plastic shards to commit suicide or self-harm (Loddon Prison, Management Unit, 30 July 2013).

357. The failure to recess cell lighting was identified as a safety risk at several prisons, including the Acute Assessment Unit at the Melbourne Assessment Prison, a unit accommodating mentally unwell patients.

358. Corrections Victoria does not undertake any reviews to determine whether previously renovated cells comply with the current cell and fire safety guidelines.
359. The only reviews of cell accommodation that are conducted are undertaken by the Contract Management Branch of Corrections Victoria in relation to the privately operated prisons, Port Phillip Prison and the Fulham Correctional Centre. These inspections aim to identify hazards in cells, cottage-style accommodation and prison grounds. The inspection does not specifically include identification of obvious hanging points.

**Cottage-style accommodation**

360. While the cell and fire safety guidelines provide detailed specifications for prison cell safety, there are no equivalent guidelines in place for cottage-style accommodation within prisons.

361. There are 1,540 beds in cottage-style accommodation across the prison system, some of which are located in maximum and medium security prisons. At Loddon and Dhurringile Prisons, prisoners with an intellectual disability are sometimes held in cottage-style accommodation.

362. During visits to each prison, my investigators identified obvious hanging points in a number of the cottages. For example, exposed plumbing in the bathrooms, as well as shower heads and cords. All of these objects could be used by a prisoner to self-harm or attempt suicide.

363. My investigation identified concerns with several risks contained within cottage-style accommodation. For example, knives and appliances are not secured, posing a risk to prisoner and staff safety, more so in the maximum security prisons, as the objects could be used to inflict serious injuries to prisoners or prison staff.

364. The following case study highlights the potential dangers in cottage-style accommodation.

**Case study 15: Risk of self-harm in cottage-style accommodation**

In February 2013, Prisoner O, accommodated in cottage-style accommodation at the Marngoneet Correctional Centre, self-harmed by slashing his left wrist. Prison staff were alerted to this incident by other prisoners in the cottage.

Prisoner O was taken to the medical unit of the prison where he was transferred by ambulance to the nearest hospital for urgent treatment.

365. The Manager, Operations Directorate, Corrections Victoria provided the following reasoning to explain why there are no guidelines for cottage-style accommodation:

> ... construction or redevelopment [of cottage-style accommodation] occurs based on principles that reflect standard domestic and community living arrangements, where it would be impossible and unnecessary to have similar specifications as found in cellular accommodation.

366. In relation to establishing specific building and content standards for cottage-style accommodation, the Department of Justice stated that:
... [it] does not accept that specific guidelines are required. The purpose of placing prisoners in such cottages is to provide them with an environment more akin to residential living as part of their pre-release transition.

367. In light of the recent introduction of other types of prisoner accommodation, such as the use modified shipping containers, I will continue to monitor the requirement for specific building and content standards for non-cellular prison accommodation.

**Cell safety for the future**

368. My investigation established that Corrections Victoria does not have any current plans for upgrading the 1,236 cells which do not comply with the cell and fire safety guidelines. In response to my office’s request for information about future upgrades to prison cells, The Manager, Operations Directorate, Corrections Victoria stated:

> ... there is no ongoing budget for BDRP [Building Design Review Project] works in the annual Corrections Victoria (CV) budget. There is, however, an allocation set for capital works, which CV considers each year with funding directed on a priority basis relating to the good order, security and safety of the prison system – this may include BDRP upgrades. As with many Departments [sic] or organisations, the list of potential capital works is greater than the available budget.

369. My investigators also requested information from Corrections Victoria about the costs associated with making a prison cell compliant with the cell and fire safety guidelines. The Manager, Operations Directorate, stated that retrofitting existing cells is a complex process with costs estimated at approximately $129,000 per cell.

370. However, when requested to provide a breakdown of the costs, The Manager, Operations Directorate advised that Corrections Victoria was unable to provide an accurate costing, stating:

> It is difficult to provide an accurate cost for a BDRP [Building Design Review Project] retrofit for cells across the entire system ...

> ... the indicative [their emphasis] costs of up to $129,000 per cell are based on the most recent BDRP proposal for retrofits at the Melbourne Assessment Prison [which was in 2010].

371. At interview, Ms Shuard said that the cost of making cells compliant with the guidelines is expensive, and it may be more cost effective in some instances to knock down an old prison unit and rebuild it to make it compliant with the guidelines, than what it costs to upgrade older cells.

**Conclusions**

372. I consider that the Building Design Review Project was poorly managed by Corrections Victoria from start to finish. While the risk assessment process identified high priority cell upgrades across the prison system, such as cells in management and reception units in maximum security prisons, many such cells were never upgraded. It is also unclear why other cells, such as the Diosma Unit at Barwon Prison, which did not receive a high risk score, were upgraded.
373. Corrections Victoria was unable to provide key documentation in relation to the project, such as the initial risk assessments conducted by private consultants, to explain the rationale for the priority given to cell upgrades. Corrections Victoria could not provide such basic information as a breakdown for each financial year in relation to how many cells were made compliant with the guidelines and how much funding this required.

374. The project identified at an early stage that $50 million would not be sufficient to refurbish all existing prison cells to comply with the cell and fire safety guidelines. However, additional funding was not requested by Corrections Victoria.

375. To the contrary, $11 million in funding was removed from the project. Corrections Victoria failed to conduct an adequate assessment to determine the impact that the reprioritisation of $11 million in funding would have on the remaining upgrades to cells.

376. Had an appropriate risk assessment been conducted, and the $11 million funding not been reallocated, Corrections Victoria would have had sufficient funding to upgrade a further 85 cells. This could have been used to fund upgrades to high priority cells at Port Phillip Prison or the Melbourne Assessment Prison.

377. Tragically, between November 2008 and August 2010, six prisoners committed suicide at the Melbourne Assessment Prison, nearly all by hanging in cells which did not comply with the cell and fire safety guidelines.

378. Approximately 1230 prison cells, or 38 per cent of all cells across the prison system, still do not comply with cell and fire safety guidelines. Port Phillip Prison, a maximum security prison, has only 204 out of 752 cells that comply with the cell and fire safety guidelines.

379. With prison overcrowding and the increasing numbers of prisoners with either a suicide/self-harm risk rating, or a psychiatric risk rating, it is unacceptable that prisoners continue to be accommodated in prison cells with obvious hanging points. The presence of obvious hanging points in cells has the potential to influence the impulsive action of a prisoner at a time of emotional trauma to attempt suicide or actually commit suicide.

380. The Department of Justice’s failure to take action in relation to the Coroner’s recommendations regarding the exposed heating pipes at Port Phillip Prison is of concern, particularly as the exposed heating pipes continue to be present in a number of units throughout Port Phillip Prison, where vulnerable prisoners are accommodated. The exposed heating pipes are present in 73 per cent of all cells at Port Phillip Prison.

381. Corrections Victoria has also failed to take adequate action in relation to the potential risks of exposed plumbing and bunk bed ladders in prison cells. This is despite the concerns of some prison staff and the deaths of several prisoners in the past six years who used such fixtures to hang themselves.
382. I consider the lack of action taken by Corrections Victoria to eliminate obvious hanging points from prison cells is a breach of the Charter of Human Rights and Responsibilities. Corrections Victoria is also failing to comply with the Royal Commission’s recommendations in relation to eliminating hanging points.

383. In my view, Corrections Victoria should seek to identify practical, time and cost effective solutions aimed at reducing obvious hanging points and making cells safer. For example, covering up the heating pipes and exposed plumbing, and replacing bunk bed ladders with safer alternatives. Without improvements taking place, I am concerned that there may be more prisoner deaths which could have been prevented.

384. Corrections Victoria is also failing to ensure that cells refurbished to comply with earlier versions of the cell and fire safety guidelines are reviewed to ensure compliance with the current guidelines. This can have serious consequences as highlighted in the case of a prisoner who smashed the un-recessed light fitting in his cell and used the shards to slash his wrist.

385. In response to my concerns regarding the safety of prisoner accommodation, the Department of Justice stated:

... the department continues a rolling program of maintenance and upgrades to improve the safety of prison infrastructure within its budget constraints, including increasing the number of BDRP [Building Design Review Project] compliant cells. It is not operationally practical or necessary to make all cells BDRP compliant.

In the meantime, Corrections Victoria have a number of risk management approaches in place to ensure that those with a current risk of suicide or self harm are not placed in cells with hanging points. Unfortunately there have been some occasions where even a BDRP compliant cell has not prevented a prisoner intent on harming themselves from doing so. These incidents are carefully investigated and reviewed and responses are put in place promptly to ensure similar events do not occur.

Recommendations

I recommend that the Department of Justice:

Recommendation 19

Engage an independent consultant to:

• conduct an immediate review of all prison cells to identify cells which do not comply with the current cell and fire safety guidelines;
• develop practical, cost effective and time effective solutions aimed at reducing obvious hanging points and making cells safer; and
• conduct quarterly reviews of all public and private prisons, which focus on identifying obvious hanging points, safety of accommodation and conditions of accommodation.
Recommendation 20
Engage an independent consultant to oversee and manage the implementation of identified cell safety works.

*Department of Justice response:*
... [these] recommendations will require significant resources to implement and further consideration in the context of broader budgetary requirements.

Recommendation 21
Develop and implement a system in which documents relating to a major project are properly recorded and accurately documented.

*Department of Justice response:*
... [the department] will meet the intent of ... [this] recommendation[s].
The Thomas Embling Hospital

Key issues
My investigation identified that:

- there are a number of obvious hanging points in accommodation for mentally unwell patients throughout the hospital highlighted by the hanging death of a patient in June 2013
- the hospital has only recently taken steps to identify and address the many obvious hanging points throughout the hospital
- the lack of closed circuit television coverage in patient units throughout the hospital compromises the safety and security of the hospital for both its patients and staff.

386. At the time of its construction in 2000, the hospital complied with relevant building standards for psychiatric hospitals, including anti-ligature measures. These measures have been regularly updated over time, such as the introduction of anti-ligature taps and showerheads.

387. However, until recently the hospital did not have a system in place whereby accommodation was audited or reviewed from a patient safety perspective.

388. When my investigators visited the hospital on 15 August 2013, they identified several obvious hanging points throughout the hospital. Five units at the hospital are identical and therefore have the same obvious hanging points, including shower hoses, towel rails, and exposed plumbing. The remaining two units are rehabilitation units.

389. My investigation identified a hazard inspection report dated March 2012, in which Forensicare staff identified potential hazards in the Atherton Unit. The report stated that the shower head and hose in the main bathroom70 of the Atherton unit, were deemed a ‘high suicide point’, as were the hand rails, in that they could be used as potential hanging points. It also stated that the bathroom was in the process of being renovated and ‘removal of suicide points underway’.

390. At interview, Mr Tom Dalton, the Chief Executive Officer, Forensicare said that while the main bathroom in the Atherton Unit was renovated to remove potential hanging points, no similar action was taken to renovate other bathrooms throughout the hospital, with the same obvious hanging points.

391. The following photographs are of the disabled bathroom in the Argyle Unit, a male unit accommodating acutely mentally unwell patients. The photographs show obvious hanging points created by the hand rails and shower head hose.

---

70 Located in common areas of each unit.
Photographs 8 and 9: The exposed taps, rails and shower hose can be used by patients to commit suicide by attaching a ligature (The Thomas Embling Hospital, Argyle Unit, 15 August 2013).

392. The following case study illustrates the risks that obvious hanging points pose in units where acutely unwell patients are accommodated.
Case study 16: Shower hose used in the apparent suicide of a patient

In June 2013, Patient P, a 24 year old patient at the Thomas Embling Hospital, was found dead hanging by the shower hose in the disabled bathroom of the Argyle Unit. Patient P had spent two months at the hospital before his death.

A review of Patient P’s death by the hospital found that while the disabled bathroom was required to remain locked at all times other when a staff member was supervising a patient to use the bathroom, Patient P was somehow able to gain access to the bathroom which contained numerous hanging points.

Since Patient P’s death, the disabled bathrooms have been taken off-line. The Coroner is yet to determine the cause of death for Patient P.

393. Following the commencement of my investigation, Forensicare established a policy in relation to addressing the risk of ligature points throughout the hospital. The policy states:

   Thomas Embling Hospital aims to provide a safe and therapeutic environment which is as free as possible of ligature and anchor points.

394. At interview, the Executive Director, Inpatient Operations, Forensicare was asked about the establishment of the hospital’s ligature policy and the audit process for identifying ligature points. She said:

   I think it’s a problem that we haven’t done reviews …
   … we didn’t do regular audits of ligature points … we’ve certainly done it now [referring to audits] …

395. In July and October 2013, an internal ligature risk audit was conducted in all bedroom accommodation and patient areas using the guidelines set out in the policy. The audit, based on an accredited United Kingdom assessment tool, identified high risk issues such as shower hoses, which were replaced with safer alternatives.

396. Although the risk audit identified many ‘high risk’ ligature points throughout the hospital, my investigation identified several other ligature points, particularly in patient bedrooms, which had been overlooked. For example, the following photograph taken in the Daintree Rehabilitation Unit, shows many obvious hanging points such as exposed plumbing, a towel rail, tap and sink spout. The partition between the toilet and sink provides the opportunity for a patient who is at risk of suicide to tie a sheet or cord to the exposed plumbing, place it over the partition to create a ligature, and attempt to hang themselves. The ligature audit undertaken by the hospital failed to identify the toilet seat, exposed plumbing and the towel rail as ligature points.

72 By an audit team consisting of the hospitals Operations Manager, Maintenance Manager and Clinical Nurse Consultant.
Photograph 10: The exposed plumbing, tap and sink spout, and towel rail can be used by patients to commit suicide by attaching a ligature (The Thomas Embling Hospital, Daintree Unit, 15 August 2013).

397. At interview, the Executive Director, Inpatient Operations, Forensicare said that because the Daintree Unit is a rehabilitation unit, its requirements in terms of layout and content are different to that of an acute or sub-acute unit for mentally unwell patients. The Executive Director also said that patients that are accommodated in the Daintree Unit have day leave from the hospital, therefore they are not confined to their bedrooms on a daily basis.

Conclusions

398. Given the mentally unwell state of patients accommodated at the hospital, it is unfortunate that the hospital has only recently taken steps to identify and address the many obvious hanging points throughout the hospital. This oversight is highlighted by the recent hanging death of a patient.

399. While the hospital’s ligature policy and audit process sets out positive steps that aim to eliminate obvious hanging points, I am of the view that more work needs to be done. My investigation identified a number of obvious hanging points, particularly in patient bedrooms, which the ligature risk audit overlooked.

Recommendation

I recommend that Forensicare:

Recommendation 22

Engage an independent consultant to review safety standards which focus on eliminating potential hanging points in all patient units throughout the hospital.
Department of Health response:
The Department of Health supports the removal of ligature points at Thomas Embling Hospital where assessed as posing risk, particularly in private and less observable spaces, such as ensuites, bathrooms and toilet areas.

... The engagement of an independent consultant could be a useful alternate approach to assessing ligature risks. However, it is recommended that such an approach supplements rather than supersedes internal Forensicare auditing and assessment practices in relation to ligatures.

Monitoring systems
400. While it is important to have a safe physical environment, free of obvious hanging points, it is equally important to have proper monitoring systems in place.
401. In several of my previous reports73 I discussed the importance of adequate closed circuit television (CCTV) coverage in prisons and youth justice precincts. I found that out-dated CCTV and/or a lack of CCTV had resulted in incidents being un-detected, affecting the security of these facilities and the safety of detainees and staff.
402. It is equally important to have adequate staffing levels to ensure that the behaviours of vulnerable detainees are identified and appropriately managed.

Closed circuit television monitoring
403. CCTV coverage is in place to varying degrees in Victorian prisons, the youth justice precincts, and police cells, and to a limited extent at the Thomas Embling Hospital.

Youth justice
404. Following my 2010 report74 which made recommendations to the Department of Human Services in relation to improving CCTV coverage, the department took positive steps to install audio and visual CCTV throughout the entire Melbourne Youth Justice Precinct.
405. At interview, the Manager Infrastructure Projects and Security Units, Department of Human Services said that the use of audio and visual CCTV monitoring at the Melbourne Youth Justice Precinct had proven invaluable.
406. The Manager Infrastructure Projects and Security Units also said that the department received $1.5 million funding to improve CCTV at the Malmsbury Youth Justice Precinct. The CCTV installed at Malmsbury includes both audio and visual capabilities.

73 Victorian Ombudsman, Investigation into conditions at the Melbourne Youth Justice Precinct, October 2010.
74 Victorian Ombudsman, Investigation into the death of Mr Carl Williams at HM Barwon Prison – investigation into Corrections Victoria, April 2012.
407. There are 348 CCTV cameras at the Parkville Youth Justice Precinct and 167 CCTV cameras at the Malmsbury Youth Justice Precinct that are used for prevention and detection of misbehaviour and improving safety at the precincts. Except in a few instances where it is used for monitoring at risk young people, CCTV is not installed in young people’s bedrooms.

The Thomas Embling Hospital

408. The hospital’s CCTV coverage is currently limited to outdoor areas, the gym, the swimming pool and perimeter fencing. My office has previously raised concerns with Forensicare regarding the lack of CCTV coverage in patient units throughout the hospital.

409. In June 2013 I wrote to the Chief Executive Officer of Forensicare regarding this issue. In response, Mr Dalton in his letter dated 6 August 2013 stated:

We have undertaken a literature review but have only been able to find limited research on the use and effectiveness of CCTV. What information is available suggested that CCTV does not assist in preventing incidents from occurring but may be of some assistance in review of incidents. Given the lack of a strong evidence basis for the use of CCTV in preventing incidents the organisation does not at this stage believe there is benefit in introducing such a security measure.

410. The following case studies illustrate the importance of CCTV in a closed environment. While the CCTV is not intended to prevent incidents from occurring or to replace staff observations and interactions with patients, it may assist staff by providing an extra form of monitoring and insight into an incident, which can later be reviewed to improve practices.

Case study 17: Lack of CCTV coverage

In November 2009, Patient Q, a 49 year old male, stabbed and killed two patients in the Jardine Unit at the Thomas Embling Hospital. Patient Q was found in another patient’s unit (which they did not share) by hospital staff in the act of stabbing a fellow patient. It was not until an hour after police attended the hospital that a further patient was discovered deceased in his bedroom having also been stabbed by Patient Q.

411. Forensicare conducted its own internal review of the incident involving Patient Q and made 20 recommendations, including that patient bedroom doors be fitted with locks with a staff override facility, and that patients be encouraged to lock their doors at night. However, none of the hospital’s recommendations related to the introduction of CCTV at the hospital. The Chief Psychiatrist of Victoria also conducted a review of this incident however did not make any recommendations in relation to additional CCTV coverage at the hospital.

412. In a similar instance:
Case study 18: Lack of CCTV coverage

In December 2012, Patient R, a 30 year old male sentenced prisoner with a maximum security rating due to his violent behaviour, was found by hospital staff attempting to strangle another patient in a bedroom in the Argyle Unit. Approximately 30 minutes later, hospital staff found another patient, a 27 year old male, deceased in his Argyle Unit bedroom.

Before being transferred to the hospital, Patient R was in a high security prison unit for 12 months, with minimal contact with other prisoners.

413. The Chief Psychiatrist of Victoria conducted a review of the incident involving Patient R and commented that the bedroom design and absence of patient call/duress systems, combined with the current practice of patients being able to enter other patients’ bedrooms and the limited observations conducted by staff, increased the risk of violence occurring.

414. The Chief Psychiatrist made several recommendations including that the hospital review clinical and security monitoring arrangements of patient corridors and bedrooms and consider additional surveillance options such as the installation of CCTV.

415. Forensicare also conducted a review of the incident involving Patient R and while recommendations were made, again none related to the consideration of CCTV coverage.

416. When asked about the installation of CCTV at the hospital, at interview the Executive Director, Inpatient Operations, Forensicare said:
   ... I don’t have the same concerns that some clinical staff have ...
   ... I think if you’re clear about it [CCTV] being there, and you make patients aware that there is CCTV ...
   ... I don’t know that it is damaging [to patients] ...
   ... the benefit I see is post the event ... that it [CCTV] has some benefit in being able to piece together what happened ...

417. The Executive Director also said that in the absence of CCTV, hospital staff still did not know everything that happened about the incident involving Patient R.

418. The Executive Director said that following the Chief Psychiatrist’s recommendation that the hospital consider installing CCTV, it was looked at again, however installing CCTV was ‘quite an expensive thing to do’. The Executive Director said that a final decision is yet to be made by the hospital about the installation of CCTV.

419. At interview, Mr Dalton was asked about the installation of CCTV at the hospital. He said:
   ... personally I sit on the fence with this [the issue of CCTV] ...

420. Mr Dalton said that the focus of the hospital is engaging with patients rather than observing patients on a monitor.
Conclusions

421. The use of CCTV in the youth justice precincts has provided better security and safety for detainees, staff and the community, as well as assisting staff in their management and observation of young detainees.

422. The lack of CCTV coverage in patient units throughout the Thomas Embling Hospital has in my view compromised the safety and security of the hospital for both its patients and staff. I consider that while staff interaction with patients is important, CCTV will provide staff with extra oversight and assist staff when responding to a critical incident by providing immediate footage.

423. In response to this issue, Mr Dalton stated:

   ... I fully support your observation ... that CCTV may assist in providing an extra form of monitoring or investigation of an event.

   ... the issue of installation of CCTV on units is actively being considered by management and Council of the organisation [Forensicare].

Recommendation

I recommend that Forensicare:

Recommendation 23

Install CCTV coverage in all common areas throughout the hospital, including bedroom corridors, program areas and recreational areas, as a matter of priority.

Department of Health response:

The Department of Health supports a measured further application of CCTV at Thomas Embling Hospital. It is not the position of the Department that CCTV is proven to significantly assist with immediate safety and security incidents as they occur in mental health settings, but can be of some assistance following critical incidents in regards to improving relational, procedural and physical security and safety measures. The judicious expansion of CCTV at the hospital should be balanced against patient/staff privacy and dignity, cost impacts on service delivery and therapeutic implications.
Transitional support services

Key issues

The deaths of recently released prisoners are a hidden toll which are far greater in number than the number of deaths in custody in Australia each year.

My investigation identified that:

- intensive transitional support services in the community are limited to 695 prisoners per year (6,609 prisoners were released from Victorian prisons into the community during 2012-13)
- finding suitable housing for ex-prisoners in the community is a significant issue
- despite the large number of prisoners with a psychiatric condition, the community integration program for prisoners with mental health issues is limited to 100 prisoners per year and operates at only two prisons.

424. Assisting prisoners to re-enter the community following a term of imprisonment reduces the likelihood of re-offending and improves the chances that they will make a meaningful contribution to our society. For some prisoners, the help they receive to re-enter the community can mean the difference between life and death.

425. The first few weeks immediately following release is a time of high risk for many individuals. Without adequate support, some ex-prisoners may return to a life of crime and/or risk taking behaviours, such as the abuse of drugs and/or alcohol, with potentially life-threatening consequences to their health. Other ex-prisoners with mental health issues may struggle to adjust to life in the community without appropriate support.

426. A 2011 research study undertaken to estimate the number of deaths among recently released prisoners, estimated that between 68 and 138 people released from prison in Australia in 2007-08, died within four weeks of release. Between 449 and 472 ex-prisoners were also estimated to have died within one year of their release from prison. The study was based on data collected from ex-prisoners in Western Australia and New South Wales.

427. The study recommended the establishment of a national system for monitoring ex-prisoner deaths following release from prison and for correctional authorities to continue their duty of care to ex-prisoners after leaving custody.

75 Mr Stuart A Kinner, Mr David B Preen, Mr Azar Kariminia, Mr Tony Butler, Ms Jessica Y Andrews, Mr Mark Stoové and Mr Matthew Law, Counting the cost: estimating the number of deaths among recently released prisoners in Australia, Medical Journal Australia 2011 195 (2), 64-68.
428. A separate research study conducted into unnatural deaths involving people released from Victorian prisons between 1990 and 1999, found that Victorian ex-prisoners are 10 times more likely to die unnatural deaths than are members of the general population. The study concluded that ex-prisoners are more likely to die as a result of suicide, homicide or an accident.\(^{76}\)

429. During the course of my investigation, several witnesses raised concerns about the number of deaths which have occurred within the first few weeks of people leaving prison, and the adequacy of the transitional support services provided to prisoners by Corrections Victoria.

430. My investigators interviewed Associate Professor Stuart Kinner, an academic who has conducted extensive research into the deaths of recently released prisoners in Australia. At interview, Associate Professor Kinner said that the number of ex-prisoner deaths following release from custody is a far greater problem than the number of deaths in custody. He also said that this is a problem that no-one is willing to take responsibility for.

431. At interview, the Chief Executive Officer of the Victorian Aboriginal Legal Service said that he was aware of the deaths of ex-prisoners who had died within a few weeks of their release from prison. For example, he said that a person of aboriginal heritage was released from a Victorian prison one day, and then found dead the next. The Chief Executive Officer said that he had concerns about the lack of aboriginal support services provided to this person upon their release into the community.

432. A prison chaplain at interview also raised concerns about the number of female ex-prisoners who have died within a few weeks of being released into the community. She said:

> There would be on average ... between six and ten [funeral] memorials per year for women [ex-prisoners] who die within weeks of release.

433. Where the death of a parolee occurs within three months of leaving prison, the Office of Correctional Services Review (OCSR) is required to prepare a report for the State Coroner in relation to the management of that person while in the custody of Corrections Victoria. At the request of the Coroner, the OCSR can also prepare a report into the death of any person who has either been in the custody of Corrections Victoria or under the supervision of Corrections Victoria as part of a community corrections order made by the courts or the Adult Parole Board.

434. At interview, Mr Jonathan Kaplan, Director of the OCSR was asked whether the OCSR had conducted any research into the deaths of recently released prisoners. He said that he could not recall any specific research that the OCSR had conducted into this issue.

435. Mr Kaplan subsequently provided my office with an OCSR report titled, *Trends in Community Correctional Services Offender Deaths in Victoria, 2004-05 to 2008-09*. Mr Kaplan stated that in error this report had been overlooked by the OSCR at the time of my office’s request for information.

436. The OCSR’s report\(^7\) examined trends in the deaths of 404 offenders on various court orders, some of which involved or followed a custodial sentence such as parole orders, in the period between 1 July 2004 and 30 June 2009. The OCSR found that suicide and drug use accounted for approximately half of these deaths. Nearly 40 per cent of the deaths examined occurred within 20 weeks of an offender commencing a community corrections order.

**Victorian prisons**

437. For people leaving prison, Corrections Victoria provides a range of support services, information and programs to assist with their transition into society. The aim of these programs is to reduce re-offending and to assist ex-prisoners with their re-integration into the community.

438. In 2012-13, 6,609 prisoners were released from Victorian prisons into the community. Pre-release planning generally commences six months prior to release, although for some prisoners with complex needs this may commence 12 months before their release date.

**Transitional Assistance Program**

439. The Transitional Assistance Program is a pre-release program offered by Corrections Victoria to all sentenced prisoners coming to the end of their sentence. A Remand Release Assistance program is also provided to prisoners who may be discharged directly following a court appearance. Assistance is also provided to approximately 1,250 ex-prisoners on parole.

440. The Transitional Assistance Program focuses on issues relevant to a person about to leave prison. It includes an assessment of the prisoner’s transitional needs and a series of information sessions and referrals to community service providers.

441. In relation to the medical needs of prisoners re-entering the community, medical staff are required to develop medical discharge plans. This includes forwarding a discharge summary to the prisoner’s general practitioner, or to other health providers, with relevant medical reports and records, as well as arranging any future medical appointments.

442. Upon their release, people who have been receiving prescribed medication while in prison are generally provided with seven days of medication to take with them. Prisoners receiving prescribed Opioid Substitution Therapy medication, for example methadone and buprenorphine, which is used to treat opioid dependencies such as heroin addiction, are eligible to receive one month’s free supply of the medication dispensed by pharmacies in the community.

---

443. Associate Professor Kinner was asked at interview about the effectiveness of the Transitional Assistance Program in preparing prisoners for release into the community. He said:

There is no evidence that … [the Transitional Assistance Program] makes any difference.

... The evidence suggests what works is to have a personalised program to help people to connect to services in the community that meet their needs, and that must occur post-release or ideally commence pre-release and continue post-release. And that again is just common sense because the problems occur when the people are in the community. So any program that occurs exclusively in custody is just in the wrong place.

444. The following case study illustrates what can happen if people leaving custody are not provided with adequate transitional support services to assist with their re-entry into the community.

**Case study 19: Inadequate transitional support services**

In February 2014, the Victorian Court of Appeal handed down its decision in the case of an ex-prisoner with serious mental illness, who within one month of being released from prison on parole in April 2011, attacked a police officer with a knife.

The Court considered the failure of correctional authorities to provide the ex-prisoner with adequate transitional support services, including mental health supports, to be a significant factor in his re-offending. In granting a reduction in the prisoner’s sentence, the President of the Court of Appeal stated:

The crucial feature, in my view, is that the appellant’s relapse into mental illness – and into offending behaviour – can be traced directly to the inexplicable failure of the correctional authorities, at the time of his release on parole, to make the necessary arrangements for his transition back into the community.

... No provision had been made for appropriate accommodation; he did not have a referral to an Area Mental Health Service; there had been no pre-release visit from Centrelink; and he was not given personal identification documents, which he needed in order to obtain assistance and treatment.

... Both the appellant and the community were entitled to expect that the authorities would take all reasonable steps to ensure that, following his release, he was in a position to maintain stability in his mental health. That he was unable to do so meant that this offending was, in an important sense, involuntary. It also had the consequence that a brave policemen was unnecessarily exposed to grave danger.

445. In 2010-11, 37 per cent of Victorian prisoners released into the community re-offended within two years of their release and were returned to prison.

---

78 Aggelidis v The Queen [2014] VSCA 6 (7 February 2014).
Intensive transitional support programs

446. For prisoners leaving prison who are assessed as having complex transitional needs, Corrections Victoria funds intensive transitional support programs providing pre and post-release case management services. Support workers provide individuals with assistance in transitional needs, including employment, education, training and drug and alcohol issues.

447. The voluntary programs commence six months prior to a prisoner’s release and can continue for up to 12 months in the community. The programs include:

- Konnect – a support program for indigenous people leaving prison
- Link Out – a program for men offering pre and post-release case management support
- The Women’s Integrated Support Program – a program for women offering pre and post-release case management support.

448. Corrections Victoria funds a maximum of 695\(^{80}\) intensive transitional support programs per year for prisoners re-entering the community. The programs range from a community reorientation program for ex-prisoners who receive three hours of direct contact with support workers for a maximum of one month post-release, through to high intensity programs for ex-prisoners providing a maximum of 30 hours of direct contact with support workers for a period of 12 months post-release.

449. During my investigation, my investigators were approached by two senior officers from a provider of intensive transitional support services to ex-prisoners raising concerns about the availability and delivery of support services to ex-prisoners. The officers said that overall, the transitional support services available to people leaving prison are inadequate. They also said that for those people fortunate enough to receive transitional support services in the community, there are not enough direct contact hours available with their support workers.

450. The officers said that the model for providing transitional support services to prisoners had dramatically changed in the past year. They said that in the past they would attend the prison three to six months prior to the release of a prisoner and seek to build a relationship with the prisoner, so as to understand their individual needs and to develop a customised program. However, under Corrections Victoria’s current service delivery model, they said that this option was no longer available.

451. The officers also said that the delivery of support services to prisoners in regional areas is problematic as the assigned support worker is centrally based and often unfamiliar with the support services available in the local area.

452. In response to these issues, the Department of Justice stated that the service delivery model for intensive transitional support programs has not changed.

---

453. In addition to the intensive transitional support services, Corrections Victoria funds some grants to community service organisations to deliver programs for prisoners, offenders and their families. The programs include culturally specific support programs as well as programs designed to assist with training, transportation and crisis housing.

454. A supported housing program and housing brokerage service is provided by Corrections Victoria to assist prisoners identified at risk of homelessness in finding and securing suitable and stable accommodation in the community. Eligibility to this program, however, is restricted to people participating in the intensive transitional assistance program.

455. The housing program has access to transitional housing placements through registered housing agencies. In the three year period between 2009-10 and 2011-12, 214 prisoners received housing assistance as part of this program, while 91 prisoners received financial assistance through the housing brokerage service.

456. During my investigation, several witnesses commented on the lack of supported housing alternatives available to ex-prisoners and the difficulties in finding ex-prisoners suitable accommodation. At interview, a prison chaplain said that the lack of suitable housing alternatives meant that many ex-prisoners were placed in inappropriate accommodation, such as boarding houses, where drug and alcohol issues were often prevalent.

457. At interview, Mr Wise said that Corrections Victoria has continued to encounter difficulties in finding suitable accommodation for many ex-prisoners.

Community Integration Program

458. For prisoners with an acute mental illness who are re-entering the community, the Community Integration Program, funded by the Department of Justice, provides for an assessment of the person’s needs and intensive post-release outreach support services to ensure that they are linked in with local area mental health services and other support.

459. The program is generally limited to 12 weeks of assistance per person, with six to eight weeks outreach support in the community. However, the program is only available to a maximum of 100 people per year and operates at two prisons – the Melbourne Assessment Prison and the Dame Phyllis Frost Centre.

460. Male prisoners receiving mental health treatment at St Paul’s psychosocial ward at Port Phillip Prison do not have access to the Community Integration Program on their release into the community. The program is also not available to prisoners with mental health problems at regional prisons.
461. Ms Larissa Strong, Director of Justice Health\textsuperscript{81} was asked at interview whether Justice Health had any plans to increase funding for the Community Integration Program. She said that an evaluation of the program is first required to understand the outcomes of the program before making any decisions about whether to expand the program to more people and other prisons. Ms Strong also said that the specifications for the new men’s prison being built at Ravenhall included a contingency for extending the Community Integration Program. That prison is not due to be opened until 2017.

Conclusions

462. The death of recently released prisoners are a hidden toll, which according to one study, are far greater in number than the annual number of deaths in custody in Australia each year. Post-release deaths also raise concerns about the duty of care owed to people after they leave prison. It requires a multi-disciplinary approach from government and community agencies to ensure that ex-prisoners are provided with adequate housing, health, employment and education opportunities in the community so as to minimise the risks of death upon their release and limit the chances of re-offending.

463. While 6,609 prisoners were released from Victorian prisons into the community in 2012-13, intensive transitional support is available to a maximum of 695 prisoners per year. It is also concerning that the community integration program for prisoners with mental health issues is limited to 100 prisoners and operates at only two prisons. The availability of suitable housing alternatives for ex-prisoners is also a major concern.

464. With the Victorian prison system overcrowded and greater numbers of prisoners presenting with complex problems such as mental health issues, it is important that there are sufficient community support programs available to assist ex-prisoners in re-entering the community; that the programs allow for adequate time with support workers; and that the programs are delivered in an efficient and cost effective manner.

465. I consider that the community re-integration programs provided to prisoners and ex-prisoners by Corrections Victoria require detailed evaluation to determine their adequacy and effectiveness.

Recommendations

I recommend that the Department of Justice:

Recommendation 24

Arrange for an independent research study to be conducted to identify the number and nature of deaths which occur within four weeks of a person leaving prison, and within one year of a person leaving prison.

\textsuperscript{81} A business unit of the Department of Justice responsible for the delivery of health services in Victorian prisons.
Department of Justice response:

... [this] recommendation ... will require significant resources to implement and further consideration in the context of broader budgetary requirements.

Recommendation 25

Review the adequacy and effectiveness of transitional support programs provided to people leaving prison, including their service delivery, with a view to determine the need to expand the range of programs and services and provide greater in-community support.

Recommendation 26

Review the adequacy and effectiveness of the Community Integration Program to people leaving prison with mental health issues, including its service delivery, with a view to determine the need to expand the range of programs and services and provide greater in-community support.

Department of Justice response:

... [the department] will meet the intent of these recommendations.
Access to appropriate health care

Key issues

Despite my office having raised concerns with the Department of Justice in 2011 regarding the grossly inadequate number of psychiatric beds for prisoners with mental health issues, the department has failed to increase the number of mental health beds in the Victorian prison system.

With overcrowding and the shortage of psychiatric beds, prisoners with mental health issues are at increased risk of self-harm and even death. The lack of psychiatric beds at the Thomas Embling Hospital means that only prisoners who are exceptionally mentally unwell are admitted for treatment.

Corrections Victoria is failing to identify and safely manage prisoners with an intellectual disability or an acquired brain injury, placing them at risk of harm in the prison system.

The current prisoner health model has significant shortcomings with the potential to adversely affect the health of prisoners. The shortcomings include:

• inadequate inpatient facilities
• the lack of medical services available at some regional prisons
• difficulties with prisoners attending specialist appointments due to limited transport arrangements
• the requirement for prisoners to attend Port Phillip Prison to receive certain types of specialist medical treatment
• the inability of prisoners to choose their own doctor in certain circumstances, or to access the Medicare or Pharmaceutical Benefits schemes.

Prisoners have far greater health needs than the general population, with high levels of mental health disorders, illicit substance use, chronic disease, communicable disease and disability\(^82\). The prevalence of mental health issues among Victorian prisoners is three to five times greater than that in the community\(^83\).

In my 2011 report to Parliament on access to prisoner health care\(^84\) I highlighted the inadequate physical and mental health services available to prisoners within the Victorian prison system, including:

• the grossly inadequate psychiatric beds available to prisoners with mental health issues
• lengthy waiting periods for prisoners to access specialist health services

---

83 Justice Health, Health Policy, 2011.
84 Victorian Ombudsman, Investigation into prisoner access to health care, August 2011.
468. I recommended fundamental changes to improve the functioning of the prison health system, some of which are yet to be fully implemented by the Department of Justice.

469. Failing to provide appropriate access to health care services can have adverse effects on the health and wellbeing of prisoners. Ill health can cause prisoners to regress in the prison environment and exhibit frustration through acts of violence, self-harm and suicide.

470. Given the high number of prisoners released into the community each year, the health of prisoners can also have significant effects on the wider community. For example, the spreading of infectious diseases. Therefore, it is important that prisoners are provided with a reasonable standard of health care.

471. Overcrowding in the prison system has placed further pressure on the limited health services available to prisoners.

Medical assessments

472. Custodial operators have a duty of care to ensure that comprehensive medical assessments are undertaken on all persons entering custody. If a detainee is incorrectly medically assessed or there is delay in their assessment, this can lead to adverse health consequences for detainees.

Victorian prisons

473. All prisoners are required to be assessed by a health professional (usually a nurse) within 24 hours of entering the prison system or entering a new prison after being transferred. While medical assessments are generally being undertaken within the 24-hour timeframe, the increasing prisoner numbers are making it difficult for some medical staff to conduct comprehensive medical assessments.

474. During my investigation, nursing staff at the Melbourne Assessment Prison raised concerns about the limited time they have to medically assess prisoners, who often present with complex health problems. At interview, the Health Services Manager at the Melbourne Assessment Prison said that in August 2013 there were 608 medical receptions; meaning that primary health care staff medically assessed 22 prisoners per day, six days a week, with an average of 13 minutes spent on each prisoner.

475. In response to this issue, the Department of Justice stated:

It is also important to note that the average single general practitioner consultation time in the public health sector is 14.6 minutes (as estimated by the Royal Australian College of General Practitioners based on data from the ‘Bettering the Evaluation and Care of Health 2008-09’ report).
476. Primary health care staff at the Melbourne Assessment Prison also raised concerns about their ability to obtain fast, up-to-date and accurate medical information regarding prisoners upon their entry into the prison system. Prison health records are mainly paper based meaning that health care staff are required to manually obtain a prisoner’s past medical information by contacting health providers via telephone and receiving faxed medical information in a short timeframe.

477. The quality of some of the equipment used by medical staff in the medical assessment process is also an issue. A primary health care nurse at the Melbourne Assessment Prison said that the fax machines used to fax medical information to general practitioners are old and this means that documents are often illegible.

478. In my 2011 report on prisoner health, I identified the need for timely and accurate medical information about prisoners and recommended that Justice Health ensure the prompt implementation of an electronic health records system. Although Justice Health has progressed with the implementation of this project, it is not expected to be completed until later this year.

**Screening prisoners for acquired brain injury and intellectual disability**

479. A 2012 report into the health of Australian prisoners identified that 43 per cent of prison entrants report that they have received a blow to the head resulting in loss of consciousness; one of the high risk factors which attribute to traumatic brain injuries. Similarly, a study into Acquired Brain Injury (ABI) in Victorian prisons found that there is a high prevalence of ABI in the Victorian correctional system, with 42 per cent of males and 33 per cent of females found to have evidence of an ABI and a possible intellectual disability.

480. The failure to detect an impairment such as an ABI in a timely manner can lead to prisoners not receiving adequate or appropriate treatment in prison which in turn can have a detrimental effect on their mental health. This can lead to an increased risk of self-harm.

481. With the high prevalence of ABI and intellectual disability in the prison system, a robust, measurable assessment process to identify such prisoners is important.

482. In 2010, Corrections Victoria developed a screening tool for use by prison staff, to identify whether a prisoner has an ABI. My investigation identified that there is no prescribed use for the screening tool and that Corrections Victoria has not collected any data from staff about its use.

483. While training has been provided to 125 prison staff regarding the use of the ABI screening tool, there are no policies or procedures guiding staff about how to consistently apply the tool.

---

87 A Traumatic Brain Injury is an injury to the brain caused by an external force such as a violent blow or jolt to the head.
484. During my investigation, various witnesses including general managers, prison officers, medical and mental health clinicians were asked about the use of the ABI screening tool. Most said that they were unaware of the use of a screening tool to identify prisoners with an ABI.

485. As at March 2013, there were 144 prisoners registered\(^{89}\) as having an intellectual disability in the prison system. The prison system has three specialist units catering for people with intellectual disabilities with a total of 47 beds. Port Phillip Prison has a 35-bed unit, Loddon and Dhurringile Prisons each have a single six-bed unit. This means that 97 intellectually disabled prisoners were without specific support for their disability.

486. At interview, the Deputy General Manager of Port Phillip Prison said that while Port Phillip Prison has capacity to hold 35 intellectually disabled prisoners in a specialist unit, there were approximately 90-95 other intellectually disabled prisoners accommodated throughout the prison. He said that some of these prisoners ‘struggle to survive’ in the prison mainstream.

487. At interview, Mr Tom Dalton, Chief Executive Officer, Forensicare spoke about the limited placement options for prisoners with intellectual disability. Mr Dalton said that at times intellectually disabled prisoners are placed in acute mental health units because the prison system has no other safe placement options for them.

488. The following case study is an example of the limited placement options in the prison system for prisoners with an ABI or an intellectual disability.

\begin{center}
\textbf{Case study 20: Placement of a prisoner with an intellectual disability}
\end{center}

In September 2013, the mother of Prisoner S approached my office concerned about the placement of her son in the prison system. Her son, a first time offender was sentenced to a lengthy prison term as a result of culpable driving. As a result of the motor vehicle accident, Prisoner S suffered a traumatic brain injury which severely impaired his cognitive ability leaving his mother to manage his affairs.

Prisoner S’s mother was concerned that the prison had not placed her son in a unit that adequately caters for prisoners with special needs. My investigators made enquiries with the prison and found that the prison was aware of Prisoner S’s condition but had no formal record of his condition, despite a copy of a neuropsychologist’s report being provided to the presiding judge at the time of sentencing.

The prison also advised that Prisoner S was unable to be placed in a specialist unit due to lack of bed availability. Prisoner S was subsequently transferred to a more suitable prison after receiving his sentence.

489. Despite the high incidence of intellectual disability across the prison system, training on intellectual disability is limited to prison officers who work within the specialist units catering for intellectual disability. Although Corrections Victoria has created a position for an ABI Clinician, this position has remained vacant for several months.

\(^{89}\) The registration of a prisoner with an intellectual disability is based on the person being registered with the Department of Human Services and is not determined by Corrections Victoria.
Conclusions

490. It is important that clinical staff have adequate time to assess a prisoner to ensure an appropriate health plan is in place. Time constraints increase the risk of primary health care staff insufficiently recording medical information which can lead to adverse health outcomes for prisoners.

491. The absence of up-to-date equipment can delay prisons receiving timely information, which increases the risks of effectively managing a prisoner’s health and may result in actions of self-harm and even death.

492. Corrections Victoria has a responsibility to identify and safely manage prisoners with disabilities such as an ABI or an intellectual disability. More should be done to ensure the early detection and appropriate management of such prisoners.

493. Failing to screen and appropriately place such prisoners can potentially cause individuals to be subjected to stand-overs and abuse, which in turn can have adverse effects on a prisoner’s mental health leading to incidents of self-harm and suicide.

Recommendations

I recommend that the Department of Justice:

Recommendation 27

Undertake a review of the time allocated to nursing staff to assess prisoners upon reception.

Recommendation 28

Ensure the implementation of the electronic health records system by March 2014.

Department of Justice response:

... [the department] will meet the intent of these recommendations.

Recommendation 29

Review the state of the office equipment used by nursing staff with a view to updating any old or out-dated equipment.

Department of Justice response:

... [this recommendation] ... will be raised with GEOCare who are contractually responsible for the office equipment used by nursing staff.

Recommendation 30

Establish procedures in each prison in relation to the use of the acquired brain injury screening tool.
Recommendation 31
Employ an Acquired Brain Injury Clinician to manage the screening of prisoners.

Recommendation 32
Develop and facilitate training on intellectual disability and acquired brain injury for all prison officers.

Recommendation 33
Recruit prison officers with diverse backgrounds such as disability, social work, mental health and aged care.

Recommendation 34
Consider making provision for a specialist unit for prisoners with intellectual disabilities in the new men’s prison at Ravenhall.

Department of Justice response:
... [the department] will meet the intent of these recommendations.

Victoria Police cells

494. All detainees entering police custody are medically assessed within 24 hours. The Melbourne Custody Centre is staffed with a nurse 24 hours per day. Detainees also have access to the custodial health advice line, which allows detainees to speak with a nurse about their medical concerns and a nurse will then triage their request.

495. The Custodial Health Service runs medical clinics at the Melbourne Custody Centre and the metropolitan police stations daily to medically assess detainees. If doctors cannot attend the police cells, a nurse will attend and assess detainees and decide if the attendance of a doctor is required. As this service does not extend to rural police stations, detainees are seen by a local general practitioner after hours in these locations.

496. My investigation identified concerns about the medical coverage available to detainees held in rural police cells. As more detainees are being held for longer periods of time in rural locations, this is placing greater demands on local general practitioners in responding to the medical needs of detainees.

497. At interview, an Inspector from the Victoria Police Prisoner Management Unit said that Victoria Police had experienced difficulties in obtaining adequate medical coverage in some rural areas to promptly assess detainees, including those detainees presenting with mental health issues.
Conclusions

498. The inability of some regional police stations to access medical professionals promptly means, at times, detainees are required to be transferred to local hospitals or to Melbourne for treatment. This is a resource intensive, expensive and lengthy process which can result in adverse health outcomes to detainees.

Recommendation

I recommend that Victoria Police:

Recommendation 35

Review the provision of service for both general medical services and mental health services provided to detainees in regional police cells.

Victoria Police response:

Supported.

Mental health care

499. The prevalence of mental health disorders among Victorian prisoners is three to five times greater than that in the community\(^{90}\). Studies have suggested that prisoners who are released from prison with a reasonable state of mental wellbeing and who are free from addiction have a better chance of being rehabilitated back into the community\(^{91}\).

Victorian prisons

500. The number of prisoners with a psychiatric risk rating in Victoria’s prison system has increased from 32 per cent of the prison population in 2008-09 to 42 per cent in 2012-2013.

501. Male prisoners requiring intensive mental health treatment are able to access services via the:

- 16-bed inpatient unit at the Acute Assessment Unit at the Melbourne Assessment Prison, or;
- 32-bed psychiatric ward at Port Phillip Prison.

502. Female prisoners are able to access intensive mental health services via the Marrmak Unit, a 20-bed inpatient service at the Dame Phyllis Frost Centre.

503. If involuntary mental health treatment is required, male and female prisoners can be admitted to the Thomas Embling Hospital; a 116-bed secure forensic mental health service.

\(^{90}\) Justice Health, Health Policy, 2011

\(^{91}\) Justice Health, Health Policy, 2011.
504. My investigation identified that all male mental health services in the prison system are running at maximum capacity and have extensive waiting lists. The high demand on mental health services means that prisoners with the highest psychiatric risk ratings at the Melbourne Assessment Prison are increasingly being managed in mainstream units by outpatient psychiatric services while waiting for a bed to become available at the Acute Assessment Unit.

505. At interview, Mr Dalton expressed concern about the ability of Forensicare to deliver good quality care for mentally unwell patients in the prison system. He said:

... the reality of delivering the type of mental health interventions we do in MAP [the Melbourne Assessment Prison] means that as the population or the throughput increases ... we have been balancing essentially a finite clinical resource into doing more clinical activity.

... if you only have ... three or four nurses ... running outpatient appointments, they are seeing more people which means they are seeing more people for less time and that is a real issue.

506. The Assistant Director Clinical Services, the Acute Assessment Unit at the Melbourne Assessment Prison said at interview:

... by and large we are not in a position to provide a reasonable level of care for people who do not have more severe forms of mental illness ...

507. Due to the increase in prisoner numbers and the scarcity of beds in the mental health units, placement options for prisoners with mental health issues are limited. At times prisoners are placed in regional prisons where access to mental health services are less than adequate.

508. For example, Loddon Prison, which currently has 412 prisoners, has only 16 psychiatric nursing hours per week and six consultant psychiatrist hours per month to cater for prisoners with mental health issues.

509. As many first time offenders have low security risk ratings, they are often placed at regional prisons. For prisoners who are struggling to cope with the realities of prison life, being placed at a prison with minimal mental health services can have an adverse effect on their mental wellbeing.

510. The following case highlights the appropriateness of the placement and care of a mentally unwell prisoner in a regional prison.

**Case study 21: Placement of a mentally unwell prisoner at a regional prison**

My officers interviewed a first time offender, Prisoner T who expressed concerns about the management of his mental health issues while in custody at Loddon Prison. Prisoner T had been identified as having both psychiatric and self-harm concerns upon reception into the prison system. During his time on remand, he made numerous threats to self-harm and despite this, a decision was made to place him to Loddon Prison.
While at the prison, Prisoner T was caught fashioning a noose by his cell mate; who was able to convince him not to attempt to take his life. Prisoner T raised issues around the quality of care by medical staff, saying that both medical and custodial staff questioned the severity of his mental state and the prison environment made it difficult for him to cope as he was not receiving adequate care. He said that the prison observation cells used for persons at risk of self-harm exacerbated his condition and that he believed he would have received more appropriate care from a forensic mental health hospital such as the Thomas Embling Hospital.

In August 2013, Prisoner T was released from prison.

511. In response to this issue, the Department of Justice stated:

The department does not believe that there is any evidence to support the claim that the provision of mental health services at regional prisons is less than adequate.

... Justice Health has requested Forensicare to submit a proposal to increase psychiatric services at regional prisons.

512. In 2012-13, there were 2,237 prisoners with a psychiatric risk rating and just 68 mental health beds available in the prison system to cater for this need.

513. Data obtained from Justice Health shows that in 2011-12 on average prisoners received 3.7 consultations with a psychiatric nurse per year. Justice Health’s analysis of this data suggests that four to six per cent of the prison population pose a significant degree of psychiatric risk while 40 per cent pose a residual risk and require ongoing monitoring.

514. In response to the increasing numbers of prisoners with mental health issues, Corrections Victoria has proposed the establishment of a new 75-bed mental health unit accommodating mentally unwell prisoners as part of the new prison being built at Ravenhall by 2017.

515. At interview, Mr Dalton was asked whether the new 75 mental health beds will be adequate to service the projected demand for mental health services in the prison system. He said:

... by the time Ravenhall opens in the absence of some significant shift in public policy in relation to the imprisonment of offenders, the apprehension of parolees, the denial of parole to an increasing number of prisoners; by the time Ravenhall opens that number of mental health beds for a prison system that is expected to expand by almost half of its current size will be woefully inadequate ...

Staff training

516. The Victorian prison system has limited capacity to transfer prisoners with mental health needs to specialist mental health units leaving many mentally unwell prisoners to remain in the mainstream system. Consequently, prison officers are often placed in the position of being responsible for the daily care of some mentally unwell prisoners.
In my 2011 prisoner health report, I recommended that suicide and self-harm training provided to new prison officers should be improved to allow staff to identify mental health behaviour and the importance of reporting this to medical professionals.

Since 2011, Corrections Victoria has contracted Forensicare to deliver a one-day training program about dealing with suicide and self-harm to new prison officers. The training package has been endorsed by the Deputy Commissioner and the Director of Justice Health.

My investigation identified concerns about the extent of suicide and self-harm training provided to prison staff. At interview, a prison officer said that he was not equipped to deal with prisoners with complex mental health issues. The prison officer also said that training he received many years ago was ‘a joke’ and that he had not received any refresher training since the initial training.

At interview, the Program Manager at the Marrmak Unit at the Dame Phyllis Frost Centre also raised concerns about the adequacy of the training provided to prison staff. He said:

… I think there is a huge gap ... in my view ... any member of staff whether you’re a cleaner ... as long as you have contact with mental health patients you have to have a global understanding of the illness and the risks ...

… you need to make sure those individuals [prison officers] are aware of the different types of mental illnesses ...

Conclusions

Approximately 42 per cent of the prison population have a psychiatric risk rating, indicating mental health issues. As prisoner numbers continue to rise, it is important that the provision of mental health care is adequate to cater for the increasing need. If sufficient mental health interventions are not provided, the mental health of prisoners will deteriorate resulting in adverse effects on them.

Some mentally unwell prisoners are left to manage without adequate support in the prison mainstream. These prisoners can easily become victims of stand-overs, violence and sexual abuse which can lead to at-risk behaviours such as self-harm and suicide.

The inability of prisoners to access adequate mental health services places a significant burden on prison officers to manage and monitor the mental health needs of prisoners. In order for prison officers to safely manage mentally unwell prisoners, additional mental health training needs to be provided to all staff. This should include ensuring that prison officers receive adequate refresher training.

While Corrections Victoria has committed to increasing the number of psychiatric beds by 2017, in my view it needs to consider an interim measure to adequately care for prisoners with mental health issues. This may include adapting the existing prison environment by staffing certain units with forensic mental health professionals.
525. In response to my concerns regarding the adequacy of mental health services available to prisoners, the Department of Justice stated:

Additional mental health services are being provided by Forensicare in some prisons, with more planned to commence in the future.

... in male prisons in 2012, the ratio of mental health clinicians to prisoners was 1.6 times higher than the equivalent ratio in the community. Further, the ratio of acute (hospital) mental health beds to potential client population in prisons was 17 times higher than in the community. The ratio of psycho-social residential beds was also higher by a factor of 28, reflecting the much higher prevalence of mental illness within the prisoner population.

... There was on average a ratio of 1.3 acute mental health beds per 100 prisoners in 2012-13. It is anticipated that when the prison at Ravenhall becomes operational in 2017-18, the ratio will actually increase to 1.7 acute mental health beds per 100 prisoners.

Recommendations

I recommend that the Department of Justice:

Recommendation 36

Review the provision of mental health services provided across the prison system with a view to increasing both psychiatric nursing and psychiatric consult hours to prisoners to address the current shortfall.

Recommendation 37

Review the effectiveness of suicide and self-harm training provided to prison officers, including providing specialist mental health training for prison officers working in specialist prison units.

Department of Justice response:

... [the department] will meet the intent of these recommendations.

Victoria Police cells

526. Ideally detainees should spend minimal time in police custody as the accommodation is not conducive to long term incarceration, particularly for those with mental health issues.

527. In 2006, I recommended that detainees who are assessed as suffering from a serious medical condition not be held in police custody overnight93. Victoria Police accepted this recommendation. Despite Victoria Police's commitment, the impact of overcrowding has made this difficult to achieve.

---

528. The Melbourne Custody Centre has 24-hour nursing coverage, making it a central point for dealing with detainees with difficult behaviours and complex mental health issues. Generally, detainees with significant mental health issues are transferred to the Melbourne Assessment Prison as quickly as possible. However, as a result of the increasing numbers of prisoners, this is not always possible.

529. At interview, the Custodial Medical Officer for Victoria Police raised concerns about the holding of mentally unwell detainees in police cells for several days. He cited the example of an acutely mentally unwell detainee being held at a local police station for up to six days because of the lack of beds available at the Melbourne Assessment Prison.

530. The following case study highlights that the Melbourne Custody Centre is not an ideal place for highly distressed, mentally unwell prisoners.

**Case study 22: Repeated self-harm in police custody**

In August 2012, Prisoner U contacted my office on two occasions while being held at the Melbourne Custody Centre expressing concerns about his mental state and threatening self-harm if he was not seen by a psychiatrist or transferred to the Melbourne Assessment Prison.

My office raised concerns with the Melbourne Custody Centre on each occasion. Despite this, Prisoner U self-harmed. Prisoner U was at the Melbourne Custody Centre for eight days, three days post the self-harm incident before being moved to the Melbourne Assessment Prison where his mental health needs could be addressed. Records indicate that Prisoner U had a psychiatric condition and a history of self-harm prior to these incidents.

531. Custodial health staff primarily rely on a paper-based medical records system. This system is archaic and can delay the medical assessment process. Upon transferring a prisoner into police custody, the Melbourne Assessment Prison is required to provide Victoria Police with medication, drug charts and a discharge summary. As a result of the high number of prisoners transferring into police custody, in particular transferring to the Melbourne Custody Centre, this does not always occur.

532. Several witnesses said that custodial health staff are often required to follow up documents such as prisoner drug charts to ascertain what medication a prisoner requires.

533. In mid-2013, Justice Health changed the manner in which medication is dispensed to prisoners. However, custodial health staff said that they were not informed of these changes. In one case, this resulted in a prisoner who was being held in police custody running out of medication.

534. Despite the fact that the Melbourne Assessment Prison and the Melbourne Custody Centre are often involved in treating the same people, communication is less than ideal.
Conclusions

535. The lack of prison beds has caused detainees to spend longer periods of time in police custody, even when the detainee presents with complex mental health needs that cannot be adequately catered for in police custody. At times, people in police custody are made to wait in excess of 14 days before being transferred into the prison system for mental health care.

536. Denying detainees the right to access appropriate mental health treatment raises concerns whether the detainee’s right to be treated humanely when deprived of liberty under the Charter of Human Rights and Responsibilities is being upheld.

537. Detainees with mental health issues are transferred between the Melbourne Assessment Prison and the Melbourne Custody Centre on a daily basis, yet both agencies work in isolation. This hinders the ability of Victoria Police to appropriately manage the medical needs of detainees and ultimately increases the risk of compromising their physical and mental health. The sharing of appropriate medical records is important in the management of a detainee’s mental health.

538. In response, the Department of Justice stated:

Justice Health works with Victoria Police on prisoner health issues in a number of ways:

- A Victoria Police representative has been a member of the Justice Health Joint Management Committee (to which Justice Health report) since its inception in 2007, along with representatives from corrections and the courts.
- Victoria Police are represented on the project board for Justice Health’s Electronic Health Record System project, JCare. JCare will have the potential to also be used for persons in police custody. However, due to the need to understand how the product will interface with their technical environment and develop an understanding of costs, Victoria Police are monitoring the pilot implementation within the correctional context.
- Regular monthly meetings are held between the Justice Health Manager of Clinical Governance and the Victoria Police Chief Custodial Health Officer
- Health staff at the Melbourne Custody Centre are invited to attend all Justice Health Provider Forums.

539. The implementation of an electronic health records system would assist custodial health staff in the clarity and security of health records and the speed at which medical staff are able to access clinical information.

540. From a consistency and cost perspective, I consider that there is some merit in having a single agency, such as Justice Health, with oversight responsibilities for the provision of medical services in police cells and prisons.
Recommendations
I recommend that Victoria Police:

**Recommendation 38**
Consider implementing an electronic health records system.

*Victoria Police response:*
Needs to be further explored as to the feasibility. The recommendation is subject to costs, logistics and interoperability.

I recommend that Victoria Police and the Department of Justice:

**Recommendation 39**
Consider Justice Health extending its oversight to include Victoria Police’s Custodial Health Service.

*Victoria Police response:*
Victoria police will explore [this recommendation] further in conjunction with the Department of Justice.

*Department of Justice response:*
... [this] recommendation ... will require significant resources to implement and further consideration in the context of broader budgetary requirements.

I recommend that the Department of Justice:

**Recommendation 40**
Liaise with Victoria Police to ensure that all prisoners with a P1 psychiatric risk rating are returned to the Melbourne Assessment Prison after appearing at court.

*Department of Justice response:*
P1s are prioritised for transfer back into prison.
... 
... [the department] will meet the intent of ... [this] recommendation[s].
The Thomas Embling Hospital

541. Most patients enter the Thomas Embling Hospital from the criminal justice system or are ordered by the courts to be detained for psychiatric treatment.\(^94\)

542. The hospital’s 116-bed capacity was originally based on information available in the early 1990’s regarding the requirement for forensic mental health beds, and relied on the Department of Justice’s forecast that the prisoner population would peak at 2,500 before descending. As at January 2014, the prison population had reached 5,857.

543. As early as 2003, Forensicare identified that the demand for psychiatric beds had exceeded availability and that without additional secure bed capacity, prisoners with untreated serious mental illness have the increased risk of:

- violence to staff;
- self-harm and suicide;
- reoffending post release; and
- exacerbation of their illness by the prison environment.\(^95\)

544. In 2005, Forensicare raised concerns with the Department of Human Services, culminating in a funding submission for a 120-bed secure hospital at the Austin Hospital. The Victorian government allocated funding for this project as there was strong support from various stakeholders for the establishment of this additional facility, with an emphasis on the project providing a significant increase in community protection.\(^96\) Significant planning went into the project for approximately three years prior to the then government deciding to no longer pursue it.

545. In 2007, the Thomas Embling Hospital identified that it had underestimated its bed need by 50 per cent.\(^97\) Seven years on, there are no additional mental health beds; the prison population has grown by 26 per cent and 42 per cent of the current prison population hold a psychiatric risk rating.

546. In 2012, Forensicare again raised its concerns with the Department of Health in relation to bed capacity at the hospital. The department responded by agreeing to engage a consultant to develop a service plan for the configuration of forensic mental health services both in prison and in the community. In 2013, a steering committee was formed with various members, including Forensicare and Justice Health. However, to date no tangible outcomes have been achieved regarding an increase in psychiatric beds.

\(^96\) Forensicare, Scoping study - Service Delivery Requirements for forensic patients regarding the planning and development and operation of the ‘Victorian Intensive Intervention Hospital’, undated.
547. In response, the Department of Justice stated:

The objective of this project is to develop a recommended service configuration for Victoria’s forensic mental health services, underpinned by a clinically effective and cost effective model of care, to appropriately respond to future service demand, enabling timely access to assessment and treatment, and supporting the rehabilitation and recovery of patients in safe and therapeutic environments.

To date, the contractor has been engaged and has performed a situational analysis, a model of care appraisal and a jurisdictional scan. The contractor is currently performing a demand analysis and drafting an options paper with scenario modelling, due to [sic] for stakeholder consultation in March 2014.

548. The inability of acutely mentally unwell prisoners to gain access to treatment at the Thomas Embling Hospital can have serious consequences for some prisoners.

549. Pursuant with the Mental Health Act 1986, following a certificate from a psychiatrist confirming that a prisoner appears to be mentally ill and requires treatment, the Secretary of the Department of Justice can issue an order for a prisoner be transferred to an approved mental health facility, such as the Thomas Embling Hospital, for involuntary treatment.

550. At interview, the Assistant Director Clinical Services, Acute Assessment Unit at the Melbourne Assessment Prison spoke about the high threshold for certifying prisoners for involuntary mental health treatment due to the lack of beds available at the Thomas Embling Hospital. He said:

There is the question of course of … the threshold at which you make the decision to certify [a prisoner]. One could certify much larger numbers of people than we do, because there is no point if there is no possibility of a bed [at Thomas Embling Hospital].

551. As at August 2013, there were nine certified patients in the Acute Assessment Unit awaiting transfer to the Thomas Embling Hospital. With the prison population increasing rapidly it is expected that the number of certified patients awaiting transfer to the Thomas Embling Hospital for urgent treatment will continue to grow.

552. The Executive Director, Inpatient Operations, Forensicare said at interview that in the current environment the Thomas Embling Hospital is under a significant amount of pressure to expedite the return of prisoners receiving treatment at the hospital to prison. Consequently, prisoners may not receive the optimal level of treatment required, needing to return to the hospital for further treatment.

553. The Executive Director also said that prisoners are presenting more unwell due to the longer waiting times to be admitted to the hospital. An example was provided of a prisoner who was required to be extracted from his prison cell to be transferred to the Thomas Embling Hospital. It was believed that his condition was exacerbated due to extended waiting periods. Upon arrival at the hospital, the prisoner appeared traumatised and this had a significant impact on how the hospital managed his care.

98 Section 16.
554. The mental health services within the prison system are only able to provide voluntary treatment to prisoners as the Thomas Embling Hospital is the sole facility that can treat prisoners who have been certified and require involuntary treatment. Having one secure facility with limited beds restricts a large number of prisoners from accessing this service.

Conclusions

555. For over a decade concerns about the capacity of the Thomas Embling Hospital have been repeatedly raised and to date no additional forensic mental health services have been made available for prisoners. The inability to provide sufficient mental health services to acutely unwell prisoners can be detrimental to their mental health, leading to instances of self-harm and even death.

556. Only prisoners who are the sickest of the sick are able to access mental health treatment at the Thomas Embling Hospital, leaving the prison system to manage a large number of acutely unwell prisoners. Prisoners who are fortunate enough to be admitted to the Thomas Embling Hospital are provided with a limited window of opportunity to receive appropriate treatment due to extensive waiting lists.

557. In order for the Thomas Embling Hospital to effectively manage the mental health of prisoners it needs to expand its services to provide additional beds to adequately care for acutely unwell prisoners.

Recommendation

I recommend that the Department of Health in conjunction with the Department of Justice:

Recommendation 41

Increase the number of mental health beds at the Thomas Embling Hospital as a priority, or establish a new secure psychiatric facility.

Department of Health response:

In the context of an expanding prison population and prison system growth, the Department of Health is undertaking a forensic mental health service plan. The planning process considers the whole of the Victorian forensic mental health service system (both bed-based and community based) and involves both the Department of Health and the Department of Justice. The service plan is expected to be completed mid-year when consideration of recommendations can be made by the Victorian Government. The Ombudsman’s recommendation will form part of this consideration.

Department of Justice response:

… [this] recommendation … will require significant resources to implement and further consideration in the context of broader budgetary requirements.
Health care services

Victorian prisons

558. The Australian Medical Association\(^9^9\) has stated that ‘prisoners and detainees have the same right to access equity and quality of health care as the general population’. The right to the equivalence of care is also outlined in the United Nations Declaration on basic principles for the treatment of prisoners\(^1^0^0\).

559. Physical health care services in Victorian prisons are under pressure as a consequence of overcrowding with the potential for adverse prisoner health outcomes.

560. The prison system has only two inpatient facilities\(^1^0^1\) to cater for the increasing prison population. In 2012, Corrections Victoria sought to relieve the increasing demand on inpatient beds by constructing an inpatient unit at the Hopkins Correctional Centre. However, the unit will not be opened until late 2014.

561. Several witnesses interviewed said that with overcrowding they are concerned about the quality of medical care prisoners are receiving. Mr Charandev Singh, a paralegal who works with prisoners and their families said at interview:

... access [to health services] is diminishing and the quality of care and the continuity of care is diminishing. There is extraordinary pressures [on prisoner health services] ...

562. Mr Singh provided the example of a prisoner at Port Phillip Prison who waited one month to see a doctor for a serious case of scabies.

563. Extensive waiting lists can have adverse health effects on prisoners. The following case study is one such example.

### Case study 23: Lengthy waiting times to see a specialist

Prisoner V at Loddon Prison was diagnosed with a number of medical conditions, including uncontrolled diabetes and hypertension. He injured his foot and was told that the wait time to see a podiatrist was extensive due to the limited provision of this service (one appointment available per month).

A nurse treating Prisoner V said that the injury to his foot could easily be exacerbated to form clots and at worst may require amputation.

**Health services in regional prisons**

564. My investigation identified concerns regarding the provision of medical services in some regional prisons. Medical officers attend regional prisons between three and 20 hours per week. For example, at Loddon Prison, which currently has 412 prisoners, a medical officer is only available 20 hours per week. These hours are spread over three days.

---


\(^1^0^0\) United Nations Secretariat, 1990 Basic principles for the treatment of prisoners.

\(^1^0^1\) A 20-bed medical facility at Port Phillip Prison’s St John’s ward and a 10-bed secure ward at the St Augustine’s ward within St Vincent’s Hospital.
565. Consequently, a doctor is not available at Loddon Prison four out of seven days per week. However, an on-call medical practitioner is available to nursing staff in the event of a medical emergency or as required.

**Prisoner refusal to attend medical treatment**

566. In my 2011 prisoner health report\(^\text{102}\), I reported on the refusal of some prisoners to attend Port Phillip Prison to receive specialised medical treatment. The reasons for a prisoner refusing to attend Port Phillip Prison can include:

- fear of maximum security prisoners at Port Phillip Prison
- not wanting to return to a maximum security prison after being accommodated at a lower security prison
- concern about losing their current cell placement, prison employment and work programs.

567. A prisoner has the right to refuse medical treatment by signing a waiver releasing the health service provider of responsibility for the provision of medical treatment. My investigators reviewed a sample of waivers signed by prisoners refusing medical treatment. For example, at Loddon Prison between 2011 and 2013, prisoners signed waivers refusing medical treatment that required transfer on 178 occasions.

568. At interview, a nurse from a regional prison said that the effects of a prisoner refusing treatment could potentially lead to a prisoner’s death. The following case study highlights this concern.

---

**Case study 24: Prisoner refusal to receive necessary medical treatment**

Prisoner W at a regional prison attended the medical centre complaining of chest pains and was transferred to the local hospital for treatment. Prisoner W was found to have suffered a heart attack and after treatment returned to the regional prison. Prisoner W was then scheduled to attend a specialist cardiac appointment at Port Phillip Prison which he refused due to fears for his safety. Prisoner W signed a medical waiver to this effect.

A nurse advised my investigators that she had grave fears that Prisoner W would not survive without this necessary treatment. At the time of my investigation, Prisoner W was continuing to refuse to attend Port Phillip Prison.

---

**Cancellation of specialist appointments**

569. In July 2012, Justice Health conducted a review of the cancellation of specialist appointments for prisoners and found that in the period April 2011 until May 2012, there were 1,110 external appointments attended at St Vincent’s Hospital and that 370 appointments were cancelled. The cancellations increased by 150 per cent from the previous financial year.

570. In 2012-13, 5,329 specialist appointments were made and 589 (11 per cent) of those appointments were cancelled by either the health services provider at the current or receiving prison, the external health care provider or Corrections Victoria.

571. In some cases, prisoners are required to transfer from regional prisons to attend Port Phillip Prison, only to have their specialist appointments cancelled.

**Choice of doctor**

572. Under the *Corrections Act 1986* 103, prisoners have the right to access reasonable medical treatment necessary for the preservation of health; including the right to access a private registered medical practitioner at the prisoner’s expense and with the approval of the Principal Medical Officer.

573. My investigation identified that between 2006 and 2013, Justice Health approved 184 applications for a prisoner to see a private practitioner and denied 49 applications. In 21 of the 49 cases, prisoners had their application denied on the grounds that the equivalent medical service could be provided by the prison’s health service provider.

574. Referring the prisoner to the prison health service is also denying them the opportunity to obtain a second medical opinion.

575. In response to this issue, the Department of Justice stated:

> Our most recent records do not support the contention that applications are being denied on the grounds that equivalent medical services can be provided by the prison health service. For example, for prisoner applications for the period 2012-13, 82 per cent of prisoner requests were approved, with the remaining requests declined because either:

> o The prisoner was suspected of seeking access to drugs not deemed clinically required by the prison health service provider

> o The treatment requested was not medically required or appropriate for the prisoner’s medical condition

> o The prisoner did not provide a medical reason for their request or were not identified as having a health-related issue.

**Access to Medicare**

576. A barrier to improved health outcomes for prisoners is the inability of prisoners to access Medicare or the Pharmaceutical Benefits Scheme (PBS) while in custody.

577. The Australian Medical Association (AMA) has stated 104 that prisoners should retain their entitlement to Medicare and the PBS while in prison. Other countries such as England and Scotland have recognised the need to provide prisoners with access to national health services to improve health outcomes.

---

103 Section 47 (f).
578. I identified the issue of prisoner access to Medicare in my 2006 report\textsuperscript{105}. I noted a recommendation from a report into the management and operations of Victoria’s private prisons\textsuperscript{106} which suggested that the Minister of Corrections seek agreement from the appropriate Ministers in other States and Territories for a joint approach to the Commonwealth Minister for Health to provide Medicare cover for prisoners. While my report was published over eight years ago, this important issue is yet to progress.

579. In response, the Department of Justice stated:

> ... the issue of access to Medicare for prisoners has been the subject of discussions between the Commonwealth and State and Territory Governments for many years. State and Territory Governments, as well as various medical and public health organisations, have made representations to the Commonwealth about giving prisoners access to Medicare.

> Most recently, in 2013 the issue was raised by State and Territory Justice and Health Ministers through interjurisdictional forums, which included the Commonwealth. The Victorian Minister for Corrections also wrote to the Commonwealth Minister for Justice on the issue on 13 October 2013. The Commonwealth Minister for Justice has since forwarded this correspondence to the Commonwealth Minister for Health.

Conclusions

580. The current prisoner health model has significant shortcomings with the potential to adversely affect the health of prisoners. The shortcomings include:

- inadequate inpatient facilities
- the lack of medical services available at some regional prisons
- difficulties with prisoners attending specialist appointments due to limited transport arrangements
- the requirement for prisoners to attend Port Phillip Prison to receive certain types of specialist medical treatment
- the inability of prisoners to choose their own doctor in certain circumstances, or to access the Medicare or PBS schemes.

581. I consider there needs to be significant change to the prisoner health care model to ensure that prisoners receive access to appropriate health care. The Department of Justice has an opportunity to improve the provision of services in 2017 when the contract for secondary and tertiary services at Port Phillip Prison is due to expire.

582. In response, the Department of Justice stated:

> As prisoner numbers have increased, health services have been reviewed and commensurately enhanced.


... [the department] most recently reviewed the levels of prison health services in September 2013. This led to a 13% increase in funding for general practitioners and a 14% increase in funding for nursing services. Access to specialist appointments is in line with routine public health waiting list management.

... the Health Service Model project that commenced in mid 2013 ... will comprehensively review the prison health model.

Recommendations

I recommend that the Department of Justice:

Recommendation 42

Review the prison health model to:

- reduce the wait times for prisoners to access specialist appointments
- increase nursing and general practitioner services at regional prisons
- improve transport arrangements for prisoners to medical treatment and specialist appointments
- reduce the number of prisoners required to attend Port Phillip Prison for medical treatment.

Recommendation 43

Review the process in which a prisoner can access their own private practitioner to ensure that, where security is not compromised, a prisoner is able to access private medical treatment at their own expense.

Recommendation 44

Raise the issue of prisoner access to Medicare with other States and Territories with the aim of bringing the issue to the attention of the Commonwealth.

Department of Justice response:

... [the department] will meet the intent of these recommendations.
Accountability and transparency

Key issues

My investigation identified that the Office of Correctional Services Review (OCSR) which is responsible for monitoring and reviewing the performance of Victorian prisons, Community Correctional Services and other correctional services:

- lacks independence from Corrections Victoria
- lacks transparency
- has repeatedly failed to take appropriate action in relation to systemic issues affecting the Victorian prison system, including prisoner deaths.

As the OCSR does not publicly report the outcomes of its investigations, the public and Parliament have no way of knowing whether appropriate remedial action has been taken by prison authorities.

583. While there is little doubt that ensuring the security of closed environments is an important consideration, this should not come at the expense of accountability and transparency. Managers of custodial facilities are generally quick to cite security as the reason why information about the activities of custodial facilities cannot be publicly reported.

584. However, making custodial environments more open, transparent and accountable helps to ensure that people in custody are treated with dignity and respect and it provides the community with confidence about the treatment of people in custody.

Monitoring and review

585. Unlike other states of Australia, such as Western Australia and New South Wales, and in other countries such as England, Victoria does not have an independent prisons inspectorate responsible for overseeing prisons.

586. In Victoria, the Office of Correctional Services Review (OCSR) located within the Department of Justice, is responsible for reviewing and monitoring Victorian prisons. The OCSR was established in August 2007 following my investigation of its predecessor, the Corrections Inspectorate, which identified significant concerns in relation to the Inspectorate’s ability to perform its functions in an independent and impartial manner. In that investigation I identified the need for a transparent and accountable corrections inspectorate.
587. The OCSR conducts investigations into serious incidents in the corrections system and reviews of correctional operations and services, including unannounced prison inspections. The OCSR is also responsible for preparing reports to the State Coroner for each prisoner death which occurs in the Victorian prison system and monitoring the coronial inquests and any recommendations which may arise. The reports provided to the Coroner include recommendations made by the OCSR to Corrections Victoria and Corrections Victoria’s responses to the recommendations.

588. The OCSR is part of the Department of Justice’s Community Operations and Strategy Division and reports to the Secretary of the Department of Justice. More recently, the OCSR is overseen by the Corrections Monitoring and Review Steering Committee, which is chaired by the Secretary of the Department of Justice and comprised of two independent members.

589. In the youth justice system, there is also no independent inspector of the youth justice precincts. In the event of a death in the youth justice precincts occurring, a review would be undertaken by a separate unit within the Department of Human Services — the Office of Professional Practice, Community and Executive Services. Major incidents involving detainees are also subject to internal review by the Department of Human Services.

590. Critical incidents and deaths which occur in police cells are subject to independent scrutiny and oversight by the Independent Broad-based Anti-corruption Commission (IBAC). Deaths in police custody are investigated, on behalf of the Coroner, by the Homicide Squad, overseen by Victoria Police’s Professional Standards Command Unit. The IBAC can independently review and monitor such investigations for any emerging issues which may require public reporting.

591. In relation to the Thomas Embling Hospital, under the provisions of the Mental Health Act 1986, the hospital is required to notify the Chief Psychiatrist of Victoria of any patient death that is a reportable death within the meaning of the Coroner’s Act 1985.

592. The Chief Psychiatrist has the power to register an interest with the Coroner regarding the findings arising from any coronial inquest or enquiry. The Chief Psychiatrist can consider the Coroner’s findings and report on any emerging themes or concerns.

593. The Chief Psychiatrist publishes regular summaries of coronial findings for the mental health sector. The findings draw attention to ongoing quality improvements in the mental health sector, including the implementation of recommendations to improve local practices, policies and procedures.

594. The Chief Psychiatrist is empowered to conduct investigations concerning treatment-related issues. For example, in 2011-12 the Chief Psychiatrist undertook an investigation of inpatient deaths for the period 2008-10\(^{107}\), which resulted in a number of recommendations for improving systems and clinical practice in mental health services.

---

A review of the implementation of recommendations arising from this report is currently being undertaken by the Chief Psychiatrist. Consistent with a recommendation contained in his first report, the Chief Psychiatrist has initiated a second Inpatient Death Review 2011-2013.

### Lack of independence

The OCSR’s lack of independence has been a matter of public concern, including by my office, for a number of years. In February 2008, Professor Richard Harding, the then Western Australian Inspector of Custodial Services, had the following to say about the lack of an independent prisons inspectorate in Victoria:

> It is well short of what a democratic society is entitled to and we come back to human rights issues. In the end, these can only be traversed by external accountability.

> If you have an external inspectorate, all of these things – justice and fairness and decency to the individual – and the way the prisons are spending their money become visible to the public.

In several of my recent reports to Parliament, I have raised concerns about the OCSR’s lack of independence from Corrections Victoria and the need for an independent prisons inspectorate. In my 2012 report titled, *The death of Mr Carl Williams at HM Barwon Prison – investigation into Corrections Victoria*, I highlighted concerns regarding the OCSR’s inability to perform its role effectively and the conflicted role of the Secretary of the Department of Justice having both legal custody of prisoners and being responsible for monitoring the performance of correctional services in Victoria.

At interview, the Executive Director of the Human Rights Law Centre raised concerns about the oversight and monitoring of prisons in Victoria. He said:

> We have criticised the lack of independence of the Office of Correctional Services Review ... as being institutionalised in the department they are responsible for reviewing.

The Chief Executive Officer of the Victorian Aboriginal Legal Service also commented about the OCSR’s lack of independence at interview. He said:

> We have concerns about the Office of Correctional Services Review.

> How do they independently review correctional issues when they are in fact part of the system.

When questioned about the OCSR’s lack of independence, Mr Jonathan Kaplan, Director of the OCSR said that while OCSR is part of the Department of Justice, it is located in a different reporting branch to Corrections Victoria. He also said that there is a steering committee overseeing the OCSR with independent representation, and that the OCSR provides objective advice to the Secretary of the Department of Justice.

---


601. Mr Kaplan also stated:

> While independence and transparency are reasonable objectives for an independent oversight body, I do not agree that these objectives accurately reflect the role of the OCSR. The OCSR is not a fully independent oversight body. The Secretary, Department of Justice, is responsible under section 7(1) of the Corrections Act 1986 for monitoring the performance in the provision of all correctional services to achieve the safe custody and welfare of prisoners and offenders. The OCSR operates as an internal review unit to assist the Secretary in acquitting this statutory responsibility. The OCSR provides advice to the Secretary on the administrative performance of Corrections Victoria, the prison system and Community Correctional Services and identifies opportunity for improvement.

> ... The OCSR was never intended to provide fully independent oversight [of correctional services in Victoria].

**Investigation outcomes**

602. Following an investigation, the OCSR has the ability to make recommendations to Corrections Victoria in relation to the management of the Victorian prison system. This can include recommendations aimed at improving administrative processes and procedures within prisons.

603. However, Corrections Victoria is under no obligation to accept the recommendations of the OCSR. At interview, Mr Kaplan said that between 80 and 90 per cent of the OCSR’s recommendations in the 2012-13 financial year were accepted by Corrections Victoria.

604. In my December 2013 report, *Investigation into children transferred from the youth justice system to the adult prison system*, I concluded that Corrections Victoria had influenced the OCSR’s investigation. The OCSR amended several of its recommendations and modified some key wording in its report after receiving feedback from Corrections Victoria. Corrections Victoria also refused to accept three recommendations made by the OCSR.

605. In relation to the OCSR’s consultation with Corrections Victoria, Mr Kaplan stated:

> … OCSR does consult with Corrections Victoria on its draft recommendations. Consultation is not to reach a consensus on issues but to understand and reflect on Corrections Victoria’s perspective on OCSR findings.

> … Consultation on draft recommendations does not affect the OCSR’s ability to operate objectively and separately from Corrections Victoria.

606. In my December 2013 report\(^{110}\), I recommended that the Minister for Corrections give consideration to making the OCSR separate and independent from the Department of Justice. The Minister agreed to give this recommendation due consideration.

---

\(^{110}\) Victorian Ombudsman, *Investigation into children transferred from the youth justice system to the adult prison system*, December 2013.
607. My current investigation identified several cases where Corrections Victoria refused to accept the OCSR’s recommendations. At interview, Mr Wise, Deputy Commissioner, Corrections Victoria, said that there are occasions where either the OCSR’s recommendations are not practical to implement, or Corrections Victoria disagrees with the recommendations.

608. My investigation also identified cases where the OCSR, despite having identified significant concerns during its investigations, did not make any recommendations to Corrections Victoria in order to address the underlying issues.

609. For example, in 2012 the OCSR conducted a review of the safety of bunk beds in prisons. The review noted that bunk beds at Barwon Prison, the Dame Phyllis Frost Centre and a number of bunk beds at the Melbourne Assessment Prison were fitted with runged ladders which presented obvious ligature points. In May 2010 a prisoner at the Melbourne Assessment Prison used the top rung of a bunk bed ladder as a ligature point to tie a bed sheet and commit suicide by hanging.

610. In spite of the OCSR having investigated the 2010 hanging death of the prisoner at the Melbourne Assessment Prison, and noting in its review of bunk bed safety the potential for bunk bed ladders to be used as a ligature point, it made no recommendations to Corrections Victoria in relation to either removing the bunk bed ladders from existing prison cells, or replacing them with a safer alternative.

611. In response to this issue, Mr Kaplan stated:

> At the time of the 2010 hanging death of a prisoner at the Melbourne Assessment Prison and the OCSR’s review of bunk bed safety, Corrections Victoria was already taking action to reduce ligature points in cells.

> The OCSR did not allow the safety risks associated with bunk beds to go unaddressed.

**Lack of transparency**

612. The OCSR does not publicly report the outcome of its investigations. While the Department of Justice 2013 Annual Report provided a two-page overview of the work of the OCSR, it did not provide any details of its investigation outcomes or changes to administrative process and procedures as a result of its investigations. With the exception of limited information about the role of the OSCR on the Department of Justice’s website, no other information about the work of the OSCR is publicly available.

613. In response, Mr Kaplan stated:

> ... the [Department of Justice 2012-13] Annual Report includes a section titled ‘Impact of review, enquiries and investigations’. This section provides examples of improvements made in 2012-2013 as a result of OCSR work, including investigations. While I acknowledge this section of the report is brief, it publicly presents an overview of notable changes achieved by the OCSR in the year.

---

614. At interview, the Executive Director of the Human Rights Law Centre said that there is very little understanding by the general public about the work performed by the OCSR as its reports are rarely made public.

615. Mr Kaplan said at interview that the OCSR does not publish its reports into prisoner deaths, primarily for privacy reasons relating to the family members of the deceased. Mr Kaplan also said that as the OCSR has no ability to compel witnesses to give evidence, the public reporting of its investigations could potentially discourage witnesses from cooperating with OCSR investigations. I do not accept this viewpoint.

616. The following case study highlights the concerns of one family about the OCSR's lack of independence in conducting investigations into prisoner deaths.

Case study 25: Lack of independence and transparency

My investigators interviewed the family members of Prisoner X who died in prison in 2005. The family members raised concerns about the lack of independence in relation to the work of the OCSR and its predecessor, the Corrections Inspectorate. The family members said that the lead investigator conducting the investigation admitted to having a friendship with the general manager of the prison being investigated. The family members said that the investigation report was very much slanted in favour of the prison and that the report had not been provided to them until the day of the Coroner's inquest, more than 12 months after the death. The family members also said that they had no idea as to whether the recommendations arising from the investigation had been implemented by the prison, as there is no transparency in relation to the OCSR investigation and its outcomes.

617. In response to case study 25, the Department of Justice stated:

... [the case study] is not supported by any evidence provided to support the assertion that the investigation had been compromised by departmental staff.

618. In the United Kingdom, the Prisons and Probations Ombudsman for England and Wales is responsible for conducting independent investigations into the deaths of prisoners. Following completion of a coronial inquest into a prisoner death, the Prisons and Probation Ombudsman publishes his investigation reports, including his conclusions and recommendations, on his website. The reports are de-identified to remove the names of all individuals and agencies. As the Prisons and Probations Ombudsman stated in his 2012-13 Annual report:

A key part of the new vision for my office is to identify and disseminate lessons from investigations. Our primary job is to investigate individual cases, but if we are to contribute more generally to improving safety and fairness, we must encourage services to learn the lessons that can avoid the next complaint and help avoid the next preventable death. To this end, the past year has seen the creation of a significant agenda of learning lessons materials.
As well as conducting thematic reviews, the Prisons and Probations Ombudsman publishes a series of ‘learning lessons’ bulletins via its website to highlight the actions taken by prisons in response to his investigations. For example, in February 2013 the Prisons and Probations Ombudsman published a learning lessons bulletin examining the use of restraints by prisons for seriously ill and dying prisoners.

At interview, Mr Kaplan was asked why the OCSR does not adopt a similar approach in relation to publishing the outcomes of its investigations. He said there are ‘pros and cons’ in relation to publishing the outcomes of investigations into the death of prisoners, with the right to privacy being a significant issue for some family members of the deceased.

Mr Kaplan also stated:

The OCSR reports to the Coroner to feed into and support this existing public accountability mechanism. Under the Coroners Act 2008, the Coroner has a statutory responsibility to give consideration to keeping family members informed of the details of an investigation, and to balance protecting a living or deceased person’s personal information with the public interest in release of that information.

OCSR reports may contain a significant quantity of personal and sensitive information about a deceased person. The OCSR does not release its prisoner and offender death reports in view of the Coroner’s leading role in determining the information released in relation to a person’s death. I consider that this demonstrates appropriate consideration to the role of the Coroner by avoiding intervening in a judicial process. It also recognises that the Coroner gives due consideration to the requests and interests of family members of the deceased and other parties through the inquest.

...Coronial investigations and hearings provide the principal mechanism to inform the public as to whether appropriate action has been taken following a death.

At interview, Mr Wise was asked about the publication of the OCSR’s investigation findings. He said:

... there are usually matters that pertain to the security of a prison that are in those reports and sometimes ... if those get in the wrong hands then that’s not helpful to the operation of the prison system. It could also alert prisoners to where there are vulnerabilities in the system and how they could exploit them ...

I do not accept the reasoning provided by Mr Kaplan and Mr Wise for the OCSR not publishing the outcomes of its investigations. The Prisons and Probations Ombudsman for England and Wales is able to accommodate these issues in his published reports without compromising security or privacy. Nor have I encountered such difficulties in my reports to Parliament on prison issues.

624. During my investigation, several people also raised concerns about the decision of the Department of Justice to no longer publish detailed statistical information on the Victorian prison population. Corrections Victoria advised my office that this decision was taken on the basis that ‘reporting statistical data via the department’s website was a duplication of resources, as detailed comparative data is already published quarterly by the Australian Bureau of Statistics, annually by the Productivity Commission and in the Department of Justice’s Annual Report’.

**Independent visitors**

625. The Independent Prison Visitor scheme was established in 1986 to provide the Minister for Corrections with independent and objective advice in relation to the operation of Victorian prison system. There are 40 volunteers who regularly visit prisons to observe and report on any issues or concerns.

626. In 2012-13, the independent prison visitors completed over 300 reports, covering a range of matters including prisoner property, accommodation and general conditions. At the commencement and completion of each visit, independent prison visitors debrief with the prison general manager about any issues or concerns.

627. The OCSR is responsible for administering the Independent Prison Visitor scheme and analysing the information provided by the independent visitors. Mr Kaplan commented on the work of the Independent Prison Visitors at interview. He said:

> It [the Independent Prison Visitor Scheme] has two really useful purposes. One is for the Minister to have that [independent] view and also it is an ability for us [OCSR] to have a fact check and test in terms of what things we are seeing in our work from a different perspective.

628. My investigators interviewed an independent visitor about their experiences working for the scheme. The independent visitor said that while their reports were analysed by the OCSR and then provided to the Minister for Corrections, she had not received any feedback about any of the issues she raised in her reports.

629. There is no publicly reported information available about the information provided by the independent visitors to the Minister for Corrections or the actions taken in response to raising these issues.

630. The lack of transparency surrounding the work of the Independent Prison Visitor Scheme is of concern given the critical role performed by the volunteer visitors providing the Minister of Corrections with independent advice. I have raised such concerns in the past\(^{113}\).

631. In response to this issue, Mr Kaplan stated:

> I can advise that there are identified processes for IPVs [independent prison visitors] to receive feedback on the outcome of matters raised.

632. As a result of a recommendation made by me in my 2010 investigation into the Melbourne Youth Justice Precinct\textsuperscript{114}, a similar Independent Visitors Program for the youth justice precincts has been in operation since 2012. The Commission for Children and Young People administers the Independent Visitors Program for the youth justice precincts.

633. Independent visitors attend the youth justice precincts on a monthly basis to meet with detainees and discuss any issues or concerns. Within seven days of each visit, the independent visitors are required to provide a written report to the Commissioner for Children and Young People. Reports are also provided to the Secretary of the Department of Human Services and the Minister for Community Services.

Conclusions

634. The Victorian community should have confidence that the prison system is subject to independent, robust and transparent oversight. By any measure, the OCSR does not achieve any of these objectives.

635. I consider that the OCSR is subject to influence by Corrections Victoria and that despite identifying significant concerns, such as the ligature points in relation to the bunk bed ladders, the OCSR has failed to take appropriate action to address many underlying issues.

636. The OCSR does not publicly report the outcomes of its investigations. As a result, the public and Parliament have no way of knowing whether appropriate remedial action has been taken by prison authorities.

637. It is important that an independent custodial inspectorate has the ability to report publicly on its investigations and outcomes. While mindful of the security and privacy implications, these issues can be accommodated as the Prisons and Probations Ombudsman for England and Wales has shown.

638. In response to my concerns regarding the OCSR, Mr Kaplan stated:

\begin{quote}
In general, I acknowledge room for improvement in regard to some pieces of work. Since becoming Director [of OCSR] on 14 April 2013, I have formed the view that the OCSR could be better structured to allow it to operate more effectively and efficiently.

A new proposed structure is currently subject to consultation with staff and the Community and Public Sector Union under clause 10 of the Victorian Public Services Agreement 2012. This new structure will strengthen the OCSR’s ability to deliver on its mandate.

A business case for a case management system is also close to finalisation. A key benefit will be an integrated electronic system to record and track the work of the OCSR in a more systematic way. This will support good case management, supervision and records management - all areas where opportunities for improvement have been identified.

Other changes include:

- completion of a Certificate IV qualification in Government (Investigations) by five staff in July 2013 to strengthen investigative competency, with three more staff currently undertaking or scheduled to complete the course
\end{quote}

\textsuperscript{114} Victorian Ombudsman, Investigation into conditions at the Melbourne Youth Justice Precinct, October 2010.
• implementation of a weekly oversight meeting attended by senior OCSR staff to give consideration to all individual investigations and reviews afoot to track issues and activity and determine any immediate actions required
• development of an enhanced governance model, the OCSR Advisory Committee, to provide increased independent oversight of the work of the OCSR and the discharge of its monitoring mandate.

639. The Department of Justice also stated:
The OCSR can not be directly compared with other organisations such as the Prisons and Probations Ombudsman for England and Wales, as the organisations have different mandates, intent and delivery methods.

640. The Department of Justice’s recent decision to cease publication of statistical information on the profile of the Victorian prison system is contrary to expected standards of accountability and transparency required of government departments. It also undermines public confidence in relation to Corrections Victoria’s management of the Victorian prison system.

641. I consider that the youth justice precincts would also benefit from an independent custodial inspectorate.

642. The volunteers that attend prisons and youth justice precincts as part of the independent visitors program perform a valuable role. However, I consider that the visitor program would benefit from greater transparency in relation to what happens with any issues or concerns raised by the independent visitors with the relevant Minister.

Recommendations
I recommend that the Minister for Corrections and the Minister for Community Services:

Recommendation 45
Give consideration to establishing an independent custodial inspectorate reporting to Parliament with monitoring and oversight responsibilities for Victorian prisons and youth justice precincts, including:

• inspecting Victorian prisons and youth justice precincts
• carrying out thematic reviews of system-wide prison and youth justice precinct services
• conducting reviews of deaths in prisons and youth justice precincts
• conducting reviews of a specific aspect of prisons and youth justice precincts (e.g. mental health care), or a specific experience of individuals or groups in custody (e.g. indigenous detainees)
• managing the Independent Visitors Scheme for prisons and youth justice precincts
• publicly reporting on the outcomes of inspections, visits, reviews and investigations.
Department of Justice response:
... [the department] will be providing further advice in relation to [this recommendation] for ... [the Minister’s] further consideration.

Department of Human Services response:
... the Minister will accept your recommendation.

I recommend that the Department of Justice:

Recommendation 46
Publish detailed statistical information on the Victorian prison system each year.

Department of Justice response:
Statistical information is available via the [department’s] Annual Report and the Productivity Commission Report on Government Services. Further consideration will be given to how to promote the availability of these publications.
Summary of recommendations

I recommend that the Department of Justice:

**Recommendation 1**
Conduct an independent review to determine whether the planned building works to expand the capacity of existing prisons and to construct a new men’s prison will adequately address growth in the prisoner population as a result of changes to sentencing and parole laws and increased law enforcement in the next three to five years.

**Recommendation 2**
Develop and implement comprehensive strategies for dealing with the effects of prison overcrowding, including violence reduction, harm minimisation, protection of vulnerable prisoners and access to services.

**Recommendation 3**
Promptly implement short-term strategies for housing prisoners deemed at minimum security, such as prisoner work camps and the establishment of new temporary correctional facilities using portable buildings.

**Recommendation 4**
Conduct regular reviews of the cleanliness and hygiene of prisoner accommodation and take appropriate action to rectify identified issues.

**Recommendation 5**
Ensure that all prisoners receive the required one hour out of cell per day.

**Recommendation 6**
Ensure that prisoners assessed as requiring protection are not placed in management units on loss of privileges.

**Recommendation 7**
In conjunction with Victoria Police, develop and implement immediate strategies to reduce the number of prisoners and the length of stay in police cells.

**Recommendation 8**
Ensure that prisoners attending court, wherever possible, are returned to prison within 72 hours of their court appearance.

**Recommendation 9**
Refurbish the County Court holding cells to allow for overnight accommodation of detainees and make the cells available to Victoria Police to assist with the holding of detainees.
Recommendation 10

Provide Victoria Police with access to the PIMS database for detainees held at the Melbourne Custody Centre.

I recommend that Victoria Police:

Recommendation 11

Ensure that detainees are not held at the Melbourne Custody Centre for longer than five consecutive days.

Recommendation 12

Arrange for the provision of clean clothes to all detainees within 48 hours in police custody.

I recommend that the Department of Justice:

Recommendation 13

Review the management of prisoners identified at risk of suicide or self-harm with the aim of providing a more therapeutic approach to their management.

Recommendation 14

Review the management of prisoners identified at risk of suicide or self-harm with the aim of providing a more therapeutic approach to their management.

Recommendation 15

Review policies and procedures in relation to the provision of dangerous items, such as razor blades and plastic bags, to prisoners with a suicide or self-harm or psychiatric risk rating.

Recommendation 16

Establish guidelines for the consistent reporting of incidents of attempted suicide and self-harm for all prisons and ensure that prison staff are made aware of the guidelines.

Recommendation 17

Conduct regular reviews of systemic issues and proactively implement changes to its policies – focussing on mitigating risk to prisoners at risk of suicide or self-harm.

I recommend that the Department of Human Services:

Recommendation 18

Develop safety guidelines specific for youth justice precincts which aim to eliminate obvious hanging points and provide a safe physical environment for detainees.
I recommend that the Department of Justice:

**Recommendation 19**
Engage an independent consultant to:
- conduct an immediate review of all prison cells to identify cells which do not comply with the current cell and fire safety guidelines;
- develop practical, cost effective and time effective solutions aimed at reducing obvious hanging points and making cells safer; and
- conduct quarterly reviews of all public and private prisons, which focus on identifying obvious hanging points, safety of accommodation and conditions of accommodation.

**Recommendation 20**
Engage an independent consultant to oversee and manage the implementation of identified cell safety works.

**Recommendation 21**
Develop and implement a system in which documents relating to a major project are properly recorded and accurately documented.

I recommend that Forensicare:

**Recommendation 22**
Engage an independent consultant to review safety standards which focus on eliminating potential hanging points in all patient units throughout the hospital.

**Recommendation 23**
Install CCTV coverage in all common areas throughout the hospital, including bedroom corridors, program areas and recreational areas, as a matter of priority.

I recommend that the Department of Justice:

**Recommendation 24**
Arrange for an independent research study to be conducted to identify the number and nature of deaths which occur within four weeks of a person leaving prison, and within one year of a person leaving prison.

**Recommendation 25**
Review the adequacy and effectiveness of transitional support programs provided to people leaving prison, including their service delivery, with a view to determine the need to expand the range of programs and services and provide greater in-community support.
Recommendation 26
Review the adequacy and effectiveness of the Community Integration Program to people leaving prison with mental health issues, including its service delivery, with a view to determine the need to expand the range of programs and services and provide greater in-community support.

Recommendation 27
Undertake a review of the time allocated to nursing staff to assess prisoners upon reception.

Recommendation 28
Ensure the implementation of the electronic health records system by March 2014.

Recommendation 29
Review the state of the office equipment used by nursing staff with a view to updating any old or out-dated equipment.

Recommendation 30
Establish procedures in each prison in relation to the use of the acquired brain injury screening tool.

Recommendation 31
Employ an Acquired Brain Injury Clinician to manage the screening of prisoners.

Recommendation 32
Develop and facilitate training on intellectual disability and acquired brain injury for all prison officers.

Recommendation 33
Recruit prison officers with diverse backgrounds such as disability, social work, mental health and aged care.

Recommendation 34
Consider making provision for a specialist unit for prisoners with intellectual disabilities in the new men’s prison at Ravenhall.

I recommend that Victoria Police:

Recommendation 35
Review the provision of service for both general medical services and mental health services provided to detainees in regional police cells.
I recommend that the Department of Justice:

**Recommendation 36**
Review the provision of mental health services provided across the prison system with a view to increasing both psychiatric nursing and psychiatric consult hours to prisoners to address the current shortfall.

**Recommendation 37**
Review the effectiveness of suicide and self-harm training provided to prison officers, including providing specialist mental health training for prison officers working in specialist prison units.

I recommend that Victoria Police:

**Recommendation 38**
Consider implementing an electronic health records system.

I recommend that Victoria Police and the Department of Justice:

**Recommendation 39**
Consider Justice Health extending its oversight to include Victoria Police’s Custodial Health Service.

I recommend that the Department of Justice:

**Recommendation 40**
Liaise with Victoria Police to ensure that all prisoners with a P1 psychiatric risk rating are returned to the Melbourne Assessment Prison after appearing at court.

I recommend that the Department of Health in conjunction with the Department of Justice:

**Recommendation 41**
Increase the number of mental health beds at the Thomas Embling Hospital as a priority, or establish a new secure psychiatric facility.

I recommend that the Department of Justice:

**Recommendation 42**
Review the prison health model to:
- reduce the wait times for prisoners to access specialist appointments
- increase nursing and general practitioner services at regional prisons
• improve transport arrangements for prisoners to medical treatment and specialist appointments
• reduce the number of prisoners required to attend Port Phillip Prison for medical treatment.

Recommendation 43

Review the process in which a prisoner can access their own private practitioner to ensure that, where security is not compromised, a prisoner is able to access private medical treatment at their own expense.

Recommendation 44

Raise the issue of prisoner access to Medicare with other States and Territories with the aim of bringing the issue to the attention of the Commonwealth.

I recommend that the Minister for Corrections and the Minister for Community Services:

Recommendation 45

Give consideration to establishing an independent custodial inspectorate reporting to Parliament with monitoring and oversight responsibilities for Victorian prisons and youth justice precincts, including:

• inspecting Victorian prisons and youth justice precincts
• carrying out thematic reviews of system-wide prison and youth justice precinct services
• conducting reviews of deaths in prisons and youth justice precincts
• conducting reviews of a specific aspect of prisons and youth justice precincts (e.g. mental health care), or a specific experience of individuals or groups in custody (e.g. indigenous detainees)
• managing the Independent Visitors Scheme for prisons and youth justice precincts
• publicly reporting on the outcomes of inspections, visits, reviews and investigations.

I recommend that the Department of Justice:

Recommendation 46

Publish detailed statistical information on the Victorian prison system each year.
Appendix 1: Photographs of Victorian prisons showing hanging points


Photograph 13: Dame Phyllis Frost Centre, 9 July 2013.
Appendix 2: Victorian custodial facilities

Victorian prisons

643. Corrections Victoria is responsible for managing Victoria’s adult corrections system, 60 community correctional facilities, as well as oversight responsibilities for the two privately operated prisons.

644. In Victoria, there are 11 publicly operated prisons; two privately operated prisons – Port Phillip Prison and the Fulham Correctional Centre; and one transitional correctional centre – the Judy Lazarus Transition Centre. Below is a current list of Victorian prisons:

- Barwon Prison
- Beechworth Correctional Centre
- Dame Phyllis Frost Centre (Women’s Prison)
- Dhurringile Prison
- Fulham Correctional Centre
- Hopkins Correctional Centre
- Judy Lazarus Transition Centre
- Langi Kal Kal Prison
- Loddon Prison
- Marngoneet Correctional Centre
- Melbourne Assessment Prison
- Metropolitan Remand Centre
- Port Phillip Prison
- Tarrengower Prison (Women’s Prison).

Victoria Police cells

645. Victoria Police is responsible for the management of police cells, which are used to hold people in police custody on a temporary basis. The reasons for their detention may include:

- individuals who have been charged with an offence and are awaiting transfer to prison
- sentenced and remanded prisoners who are in transit before and after court appearances
- individuals who appear drunk, drug affected or unwell.

646. Detainees cannot be held in police cells beyond 14 consecutive days, except at the Mildura Police Station, which is designated to hold detainees for a maximum of 30 days.

The Melbourne Custody Centre

647. The Melbourne Custody Centre is the main reception facility in Melbourne for people who have been arrested by police. It is an underground facility located beneath the Melbourne Magistrates’ Court and can accommodate 67 detainees (30 June 2013).
648. The centre is privately operated on behalf of Victoria Police by G4S Australia Pty Ltd, which is classified as a sub-contractor within the meaning of section 3(1) of the *Corrections Act 1986* in its capacity as a manager of police goal under a sub-contract agreement.

**Police cells**

649. Victoria Police operates a number of police cells at police stations throughout Victoria. Often referred to as ‘police watch-houses’, the cells are intended for short term stays of detention. Many of the police cells are co-located together with, or in close proximity to, the local Magistrates’ Court.

**Youth justice**

650. Victoria has two youth justice precincts accommodating young offenders, under the management of the Department of Human Services.

**Parkville Youth Justice Precinct**

651. The Parkville Youth Justice Precinct, located in the inner northern Melbourne suburb of Parkville, accommodates 123 young offenders, including:

- 10-14 year old males – remanded and sentenced by a Victorian Court
- 15-18 year old young men who have been sentenced or remanded by a Victorian Court
- 10-17 year old females – remanded and sentenced by a Victorian Court
- 18-21 year old women sentenced to a Youth Justice Precinct Order by the Adult Court in Victoria.

**Malsbury Youth Justice Precinct**

652. Located at Malsbury, approximately 100 kilometres north of Melbourne, the Malsbury Youth Justice Precinct accommodates young men aged between 18 and 21 years of age who have been sentenced to a Youth Justice Centre Order by the Adult Courts in Victoria. The Precinct can accommodate up to 90 young men in a mix of low and high security residential units.

**The Thomas Embling Hospital**

653. The Thomas Embling Hospital is a secure 116-bed mental health facility located in Fairfield, Melbourne, providing clinical treatment for patients with serious mental illness who have been admitted for treatment under the *Mental Health Act 1896*. The majority of patients come from the criminal justice system, having either been transferred from the custodial system or the subject of a court order requiring them to be detained for psychiatric assessment and/or care and treatment.

654. The Victorian Institute of Forensic Mental Health, known as Forensicare, is responsible for providing adult mental health services at the Thomas Embling Hospital, as well as the Acute Assessment Unit at the Melbourne Assessment Prison and the Marrmak Unit at the Dame Phyllis Frost Centre.
Ombudsman’s Reports 2004-14

2014
Ombudsman Act 1973 Ombudsman’s recommendations – Third report on their implementation February 2014
Ombudsman Act 1973 Investigation into a complaint about the conduct of Authorised Officers on V/Line February 2014

2013
Ombudsman Act 1973 Investigation into children transferred from the youth justice system to the adult prison system December 2013
Ombudsman Act 1973 A section 25(2) report concerning the constitutional validity of aspects of Victoria’s new integrity legislation October 2013
Ombudsman Act 1973 Own motion investigation into unenforced warrants August 2013
Whistleblowers Protection Act 2001 Investigation into allegations of improper conduct by a Magistrates’ Court registrar May 2013

2012
Own motion investigation into the governance and administration of the Victorian Building Commission December 2012
A section 25(2) report to Parliament on the proposed integrity system and its impact on the functions of the Ombudsman December 2012
Whistleblowers Protection Act 2001 Investigation into allegations concerning rail safety in the Melbourne Underground Rail Loop October 2012
Whistleblowers Protection Act 2001 Investigation into allegations of improper conduct by CenITex officers October 2012
Whistleblowers Protection Act 2001 Investigation into allegations of improper conduct involving Victoria Police October 2012
Whistleblowers Protection Act 2001 Investigation into allegations against Mr Geoff Shaw MP October 2012
Investigation into the temporary closure of Alfred Health adult lung transplant program October 2012
Investigation into an alleged corrupt association October 2012
Whistleblowers Protection Act 2001 Investigation into allegations of detrimental action involving Victoria Police June 2012
Own motion investigation into Greyhound Racing Victoria June 2012
The death of Mr Carl Williams at HM Barwon Prison – investigation into Corrections Victoria April 2012
Whistleblowers Protection Act 2001 Conflict of interest, poor governance and bullying at the City of Glen Eira Council March 2012
Investigation into the storage and management of ward records by the Department of Human Services March 2012

2011
Investigation into the Foodbowl Modernisation Project and related matters November 2011
Investigation into ICT-enabled projects November 2011
Investigation into how universities deal with international students October 2011
Investigation regarding the Department of Human Services Child Protection program (Loddon Mallee Region) October 2011
Investigation into the Office of Police Integrity’s handling of a complaint October 2011
SafeStreets Documents – Investigations into Victoria Police’s Handling of Freedom of Information request September 2011
Investigation into prisoner access to health care August 2011
Investigation into an allegation about Victoria Police crime statistics June 2011
Corrupt conduct by public officers in procurement June 2011
Investigation into record keeping failures by WorkSafe agents May 2011
Whistleblowers Protection Act 2001 Investigation into the improper release of autopsy information by a Victorian Institute of Forensic Medicine employee May 2011
Ombudsman investigation – Assault of a Disability Services client by Department of Human Services staff March 2011
The Brotherhood – Risks associated with secretive organisations March 2011
Ombudsman investigation into the probity of The Hotel Windsor redevelopment February 2011
Whistleblowers Protection Act 2001 Investigation into the failure of agencies to manage registered sex offenders February 2011
Whistleblowers Protection Act 2001 Investigation into allegations of improper conduct by a councillor at the Hume City Council February 2011

2009
Investigation into the issuing of infringement notices to public transport users and related matters December 2009
Ombudsman’s recommendations second report on their implementation October 2010
Whistleblowers Protection Act 2001 Investigation into conditions at the Melbourne Youth Justice Precinct October 2010

Whistleblowers Protection Act 2001 Investigation into an allegation of improper conduct within RMIT’s School of Engineering (TAFE) – Aerospace July 2010
Ombudsman investigation into the probity of the Kew Residential Services and St Kilda Triangle developments June 2010
Own motion investigation into Child Protection - out of home care May 2010
Report of an investigation into Local Government Victoria’s response to the Inspectors of Municipal Administration’s report on the City of Ballarat April 2010
Whistleblowers Protection Act 2001 Investigation into the disclosure of information by a councillor of the City of Casey March 2010
Ombudsman’s recommendations – Report on their implementation February 2010

2009
Investigation into the handling of drug exhibits at the Victoria Police Forensic Services Centre December 2009
Own motion investigation into the Department of Human Services – Child Protection Program November 2009
Own motion investigation into the tendering and contracting of information and technology services within Victoria Police November 2009
Brookland Greens Estate – Investigation into methane gas leaks October 2009
A report of investigations into the City of Port Phillip August 2009
An investigation into the Transport Accident Commission’s and the Victorian WorkCover Authority’s administrative processes for medical practitioner billing July 2009
Whistleblowers Protection Act 2001 Conflict of interest and abuse of power by a building inspector at Brimbank City Council June 2009
Whistleblowers Protection Act 2001
Investigation into the alleged improper conduct of councillors at Brimbank City Council
May 2009
Investigation into corporate governance at Moorabool Shire Council
April 2009
Crime statistics and police numbers
March 2009

2008
Whistleblowers Protection Act 2001 Report of an investigation into issues at Bayside Health
October 2008
Probit controls in public hospitals for the procurement of non-clinical goods and services
August 2008
Investigation into contraband entering a prison and related issues
June 2008
Conflict of interest in local government
March 2008
Conflict of interest in the public sector
March 2008

2007
Investigation into VicRoads’ driver licensing arrangements
December 2007
Investigation into the disclosure of electronic communications addressed to the Member for Evelyn and related matters
November 2007
Investigation into the use of excessive force at the Melbourne Custody Centre
November 2007
Investigation into the Office of Housing’s tender process for the cleaning and gardening maintenance contract – CNG 2007
October 2007
Investigation into a disclosure about WorkSafe’s and Victoria Police’s handling of a bullying and harassment complaint
April 2007
Own motion investigation into the policies and procedures of the planning department at the City of Greater Geelong
February 2007

2006
Conditions for persons in custody
July 2006
Review of the Freedom of Information Act 1982
June 2006
Investigation into parking infringement notices issued by Melbourne City Council
April 2006
Improving responses to allegations involving sexual assault
March 2006

2005
Investigation into the handling, storage and transfer of prisoner property in Victorian prisons
December 2005
Whistleblowers Protection Act 2001
Ombudsman’s guidelines
October 2005
Own motion investigation into VicRoads registration practices
June 2005
Complaint handling guide for the Victorian Public Sector 2005
May 2005
Review of the Freedom of Information Act 1982
Discussion paper
May 2005
Review of complaint handling in Victorian universities
May 2005
Investigation into the conduct of council officers in the administration of the Shire of Melton
March 2005
Discussion paper on improving responses to sexual abuse allegations
February 2005

2004
Essendon Rental Housing Co-operative (ERHC)
December 2004
Complaint about the Medical Practitioners Board of Victoria
December 2004
Ceja task force drug related corruption – second interim report of Ombudsman Victoria
June 2004