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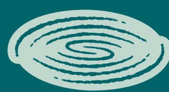
Report No.

Report of an Unannounced Inspection of the Induction and Orientation Unit and the Special Handling Unit at Casuarina Prison



Office of The Inspector
of Custodial Services
Western Australia

ISSN 1445-3134

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The Inspector's Overview

BACKGROUND, CONTEXT, KEY ISSUES, PHILOSOPHY AND FINDINGS

On 22nd November 2000, the Attorney General and Minister for Justice, the Hon. Peter Foss QC MLC, directed me in writing to investigate matters raised with him in relation to the operation of the Induction and Orientation Unit of Casuarina Prison. The "normal" or most common operation of the inspection powers set out in Part XA of the *Prisons Act* 1981[1] is that the decision to conduct a prison inspection will be made by the Inspector of Custodial Services. However, the legislation[2] also permits the Minister to "direct the Inspector to inspect a prison or to review a prison service or an aspect of a prison service and report on a specified matter of significance", and it was this power that was invoked.

The Induction and Orientation Unit (IOU) adjoins and is managed in conjunction with the Special Handling Unit (SHU). Together they are the most closed areas of the prison, housing various categories of prisoners who for one reason or another are segregated from the general prisoner population. In my earlier discussions with the Minister, it had seemed that the alleged problems had arisen no less in the SHU than the IOU. In any case, it was my view that the matters raised in the direction could not be addressed meaningfully without being placed in the fuller context of the general operations of the two Units.[3] I conveyed this view to Mr Foss via his Chief of Staff, and with his approval interpreted his direction in this way. The relevant documentation, including the answers to the Minister's specific questions, is found in Appendix 1 of this Report.

THE INSPECTION TEAM

At the time the Minister's direction was received, my Office was still in the process of recruiting staff. The Director of Operations, Mr Bob Stacey, and myself were the only Office personnel with subject matter experience and knowledge.[4] It was necessary to put together an ad hoc team. We recruited three additional persons for this purpose, thus constituting an inspection team of five people.

Mr Rod Wise is the General Manager of Barwon Prison in Victoria. Barwon is the location of that State's main Special Handling Unit (there is also a smaller facility at Port Phillip Prison), so Mr Wise was particularly well equipped to bring expertise to this task. At my request, Mr John Griffin, the CEO of the Public Sector Correctional Enterprise (CORE) of Victoria, readily made him available to assist. I wish to put on the record my appreciation of Mr Griffin's generosity, as well as my acknowledgement at the professional skill and know-how that Mr Wise brought to the task.

Mr Kerran Campbell is a leading world authority on prison security systems. He has worked widely in Australia, and was involved in the original security design of Casuarina itself. His recent work includes participation in prison planning and other security work in Singapore, Dubai, Sri Lanka, Malaysia and South Africa. My Office was indeed fortunate that he was able to make himself available to assist in this inspection. Mr Campbell's vision and insight were invaluable.

Ms Lynn Atkinson was a consultant criminologist and researcher, with wide experience of closed institutional arrangements, programs and Indigenous issues. She had recently been appointed Manager

1 Part XA was enacted into the principal statute by the *Prisons Amendment Act* 1999.
2 *Prisons Act* 1981, s. 109L(2).
3 Indeed, the practice within the prison is now to refer to these Units generically as the "Multi-purpose Unit". In Chapter 1 the question of the correct terminology to describe the various areas within these Units is discussed further.
4 Mr Stacey had in fact been the Superintendent of Casuarina for a year until 1995.

Research and Publications of this Office, but had not at the time commenced employment. Part of the methodology of the inspection was to be the distribution and analysis of survey questionnaires to both prisoners and officers, and Ms Atkinson took particular responsibility for that aspect with notable success.

I would also put on the record my appreciation of assistance given to me during the planning stage for this inspection by the State Ombudsman (Mr Murray Allen) and the Officer-in-charge of the Prison Unit of the W.A. Police Service (Detective Senior Sergeant Rick Scupham) in supplying certain information that I considered was relevant to the inspection.

THE PROTOCOLS

The nature of the inspection of a "prison within a prison" is that it should be unannounced.[5] A common allegation about such places is that there is widespread intimidation of prisoners by staff.[6] Without wanting to seem melodramatic, an unscheduled arrival at the Units puts the inspection team in a much stronger position to make a spot check of such allegations. Accordingly, an unannounced mode of inspection was determined.

The team assembled in Orton Road, east of the entrance to the prison, and entered the prison at 0645 on Monday 11th December. It was evident from various surrounding circumstances that our arrival had not been anticipated. However, gate staff members were familiar with the instructions previously issued by the General Manager Prison Services relating to inspections, and entrance first to the prison and then to the Units was achieved smoothly. This meant that the team was in the Units before unlock and before staff changeover. The importance of this timing is self-evident.

I would like to record at this point that the Casuarina staff – from Superintendent through to Unit officers – were impeccably professional and cooperative throughout the whole of our visit. Our need for a work-room was met by the surrender of the prison's own Conference Room; the Assistant Superintendent Incident Management was taken off her other duties to act as our liaison officer and efficiently facilitated our every request for documentation, movement to other parts of the prison and access to personnel; management personnel made time available from other duties as requested and in particular for the de-brief session. One can say with confidence that our reception at this, our first, inspection was propitious for the development of a good working relationship between the Ministry of Justice and this Office.

THE METHODOLOGY

Direct observation of prison operations in the two Units was a key aspect of our methodology. We also held extensive discussions with prisoners and staff, both individually and in groups. Discussions were also held with related personnel whose work is not principally carried out in those Units but who nevertheless

5 The *Prisons Act* 1981, s. 109J(2), authorises both announced and unannounced inspections.

6 Just prior to our inspection, the Deaths in Custody Watch Committee Inc. WA had made a widely publicised complaint to the United Nations Committee against Torture alleging systematic brutality in the Western Australia prison system. Many of the allegations related to Casuarina and some of these specifically referred to the Special Handling Unit. Although most of these allegations related to a somewhat earlier period, it seemed prudent, in developing the protocols of our inspection, to take cognisance of the existence of these kinds of allegation.

have sufficient contact to have formed worthwhile impressions of their functioning – for example, the Nurse-manager, the Library Officer, the Prosecutions Officer and the Prisoner Support Officer. We extensively perused relevant documentation, as well as ascertaining information gaps. Other areas of the prison were visited whose operation impinges upon or is affected by the operation of the Units, particularly Unit 1. Most senior managers were interviewed. Finally, as mentioned, written survey questionnaires were distributed to and completed by both staff and prisoners.

Subsequently, the team put together a series of notes that formed the basis of a verbal de-brief to senior management (including the General Manager Prison Services, who attended specially on the afternoon of Day 2 for this purpose). A preliminary report was submitted to the Minister on 19th December and discussed by him and the Inspector the following day. The Minister made that report available to the Director-General of the Ministry of Justice in early January. The present Report was then sent to the Ministry in draft form on 9th February 2001, with a request for comments. These were received on 2nd March.

These comments have been dealt with in the final report as follows. Any factual errors that were brought to our attention have been corrected in the text. Changes to processes introduced by the Ministry since our inspection have been noted either in the text or as footnotes. Disagreements as to interpretations have been considered, but mostly not adopted. Often these disagreements arose out of the fact that the Ministry was inclined to dismiss out of hand any prisoner testimony with which it did not agree. This simplistic approach to fact-finding is a luxury that a properly functioning Inspectorate cannot afford. Difficult as it is, recognising that we will be subjected to special pleading and attempted manipulation as we go about our task, we have endeavoured to assess what we have been told in the light of the surrounding contextual information.

SEGREGATION

The ability to segregate prisoners from the mainstream has always been a necessary tool for managing prison systems. Segregation may be for punishment, for the safety of staff, because of their vulnerability or because of the disruption or danger that they otherwise cause. It may involve solitary confinement or may simply be segregation within a similar group. Whatever form it takes, the treatment of prisoners who are segregated from mainstream accommodation and services is a vital indicator of the health of a prison. From the prisoner perspective, if the experience of being taken "down the back" is seen as little more than the arbitrary and oppressive exercise of authority by line management, great tensions may build up over time. For example, one of the immediate triggers for the riots of 25th December 1998 at Casuarina itself was the decision of officers to take a prisoner to the Special Handling Unit.[7]

From the officer perspective, segregation areas represent the location where they can expect to encounter the most intractable or dangerous prisoners – where, accordingly, the "custodial" aspects of their training and experience are most likely to be invoked. Yet the place of such a Unit in the continuum of control and treatment must be clear and focused – a purposeful backdrop to the overall objectives of the prison regime, not merely a place of containment. Routine utilisation of what should be an exceptional regime must be avoided. Confusion and uncertainty, if they exist, will reflux into the overall regime.

[7] See Smith, Indermaur and Boddis, *Report of the Inquiry into the Incident at Casuarina Prison on 25th December 1998* (Perth: Ministry of Justice, March 1999), paragraphs 5.2.6.4.- 5.2.6.5.

Questions arise about the psychological effects of prolonged periods of segregation. Just as separation from the general community is stressful for prisoners, so separation from the mainstream prison community must be expected to impose extra stress.

Research evidence is mixed. A recent Canadian study found that "the hypothesis that the mental health and psychological functioning of segregated inmates would deteriorate over a period of 60 days in segregation was not supported" (Zinger and Wichmann 1999[8]). This study met rigorous methodological criteria, but was confined to relatively short-stay prisoners. On the other hand, a meta-analysis reviewing a number of earlier papers concluded that, on balance, segregation caused an overall detrimental effect on the mental health of personality disordered detainees (other than schizophrenics) and that this could lead to extreme acting out behaviours and the development of severe mental illness (Grassian and Friedman 1986[9]). More recent research (Kupers 1999[10]) has indicated that "the forced idleness and isolation in these [segregation] units cause many previously stable men and women to exhibit signs of serious mental illness".

It is doubtful whether the psychological issues can ever be definitively resolved. People differ; the exact mode of segregation varies; the cultural context impacts in diverse ways. However, even if it could be shown that segregation caused no psychological damage, the humanitarian issue would remain. It was this, in part, which drove the recent case brought in Queensland by the notorious escapee, Brendan Abbott (*Abbott v. Chief Executive, Department of Corrective Services*, SC No. 9096 of 2000, unreported), and although the legal outcome supported the continuation of Abbott's prolonged segregation, it is the duty of an Inspectorate, in contrast to a judicial body, to probe more deeply than the applicable statute would seem to require.[11]

International instruments also address this question. Whilst these do not possess the force of law in the Australian States[12], they nevertheless do represent an aspirational standard. For example, the *Standard Guidelines for Corrections in Australia and New Zealand* (1996), which are the domestic version of the United Nations *Standard Minimum Rules for the Treatment of Prisoners*, proceed from the assumption that separate confinement may well have a deleterious effect on physical or mental health: see Guidelines 5.33. - 5.34.

In summary, the operation of separate confinement, close supervision or segregation units is a first order issue in penal administration.

THE FINDINGS

The detailed findings are set out in the Report. Many of them are applicable to the IOU as well as the SHU. There are some reassuring matters, notably the absence of any evidence of systematic use of

[8] *The Psychological Effects of 60 Days in Administrative Segregation.* Research Branch, Correctional Services Canada. March 1999.

[9] *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement.* 8 International Journal of Law and Psychiatry pp. 49-65.

[10] "Prison Madness: The Mental Health Crisis behind Bars". Josey-Bass Publishers, San Francisco. 1999: p. 53.

[11] The Supreme Court of Queensland stated: "[T]he court is essentially concerned with whether or not correct procedures were followed in arriving at the decisions in question. This court has no jurisdiction to review the actual merits of the decision if it was properly arrived at in accordance with the statutory provisions."

[12] In the Abbott case, counsel referred in passing to international covenants "but no attempt was sought to base the relief claimed on such considerations".

excessive force towards prisoners. However, the matters giving cause for concern were more numerous – in particular, the lack of case management, the consequence that some prisoners seemed to remain in the Units for longer periods than were either necessary or useful, the prevailing value systems of staff and the poor standard of record keeping. Underlying the problems that we have identified are confused objectives and organisational sclerosis, rather than managerial indifference or operational ill will.

These matters emanate primarily, though not exclusively, from Head Office. We became aware, for example, of the fact that a comprehensive review of the SHU (but not the other parts of this area) had been carried out in 1996. The recommendations were not only sensible and positive but also were widely endorsed across the spectrum of prison management. Yet no action was taken towards implementation. A further review had taken place in mid-2000, reporting in September. Some tentative moves had been made towards taking up some of its recommendations, but in the light of previous experience one could not be entirely confident that the momentum would be maintained.[13]

The Ministry of Justice, then, does seem in the past to have succumbed to its own inertia, and in this sense our inspection was timely. The dangers of drift and inaction in correctional practice go far beyond this particular example. If there is a single unifying theme, it is that in correctional policy and practice there is no such thing as a steady state. Things get worse if they are not deliberately managed so as to make them better.

For management, officers and prisoners, however, the significance of this inspection lies principally in the changes that should follow upon our recommendations. The Ministry's formal response has indicated that important changes either have been made since the inspection or are in the pipeline. The Ministry's Action Plan is appended as Appendix 3.[14] We shall conduct a follow-up inspection before the end of 2001 to ascertain to what extent these changes have been implemented, whether they have been beneficial and whether those recommendations that the Ministry has already decided not to accept should have been implemented.

Professor Richard Harding
Inspector of Custodial Services

8th March 2001.

[13] In its comments, the Ministry of Justice claimed that "full implementation of the policy and procedures of the Kelly Report commenced on 2nd March 2001", i.e. after the completion of our inspection and receipt of our Interim and Draft Reports.
[14] The full text of the Ministry's response is available from this Office upon request.

Chapter 1

THE PRISONERS

CATEGORIES AND NUMBERS

1.1 To understand the prisoner mix adequately, it is necessary to examine the functional plan of the area, attached herewith.[15] Some knowledge of the history of the Units is also useful.

1.2 As can be seen, the Reception area leads into five apparently distinct areas. They are, sequentially, as follows:

- The IOU area for high protection prisoners (which on the plan we call Area 1);
- The IOU multi-function area, used for prisoners who required close confinement but who had not yet been placed on punishment or ordered to undergo close supervision or whose status did not otherwise readily fit (Area 2);
- Prisoners in the IOU ordered to undergo solitary confinement pursuant to disciplinary orders (Area 3);
- High security prisoners in the SHU undergoing Levels 1 or 2 regimes[16] under Casuarina Prison Standing Orders 2B and 2C (Area 4); and
- Long term SHU residents on a Level 3 regime (Area 5).

1.3 At the time of our inspection, 27 prisoners in all were housed in the two Units, as follows: nine in Area 1[17]; two in Area 2; three in Area 3; four in Area 4; and nine in Area 5.

1.4 For clarity, we have used our own terminology of Areas 1 to 5 because the terminology used within the prison and at Head Office is inconsistent. On the outside wall, the whole IOU/SHU area is labelled the "Discipline Unit". Some local management personnel refer to Areas 3 and 4 as the Discipline Unit. Yet others describe the whole area as being "multi-purpose".[18] Some others refer without differentiation to the SHU as an all-encompassing name for the whole area. It should also be noted that the same staff roster covers Areas 1 – 5, further eroding any attempt at strict differentiation.[19]

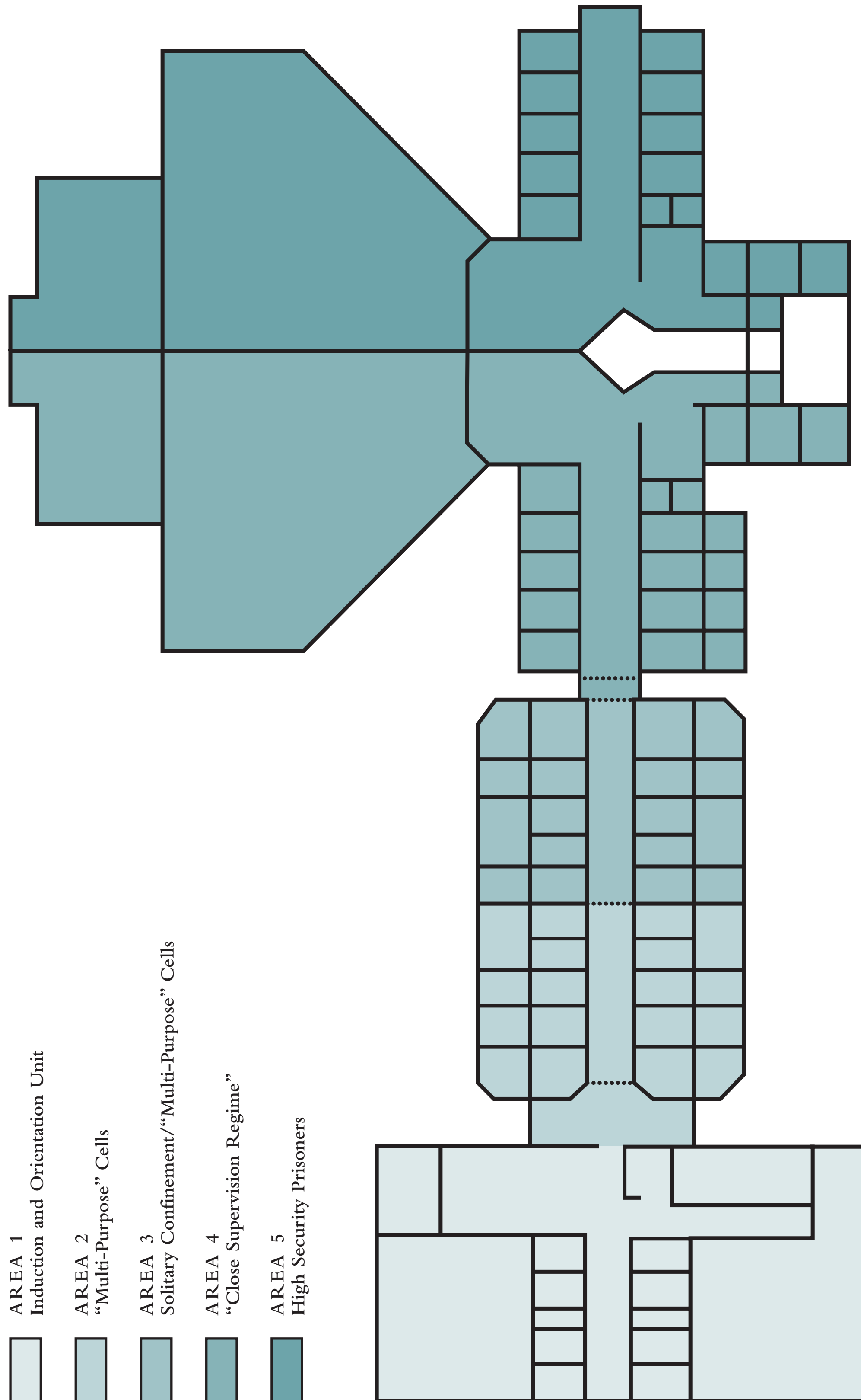
[15] The Ministry of Justice was not able to produce a functional or schematic plan of the area for us, and the one used here was specifically drawn within this Office after the inspection had been completed. The Ministry has subsequently informed us that a functional plan is now available for all prisons, including Casuarina.

[16] Level 1 is the most harsh (no association, only one hour out of the cell, two or three officers at unlock, most movements under restraint); Level 2 permits some association in a common exercise yard; Level 3 involves free association within the SHU and normal prison unlock hours, as well as access to a wide range of personal property.

[17] There were only eight cells in this category, so one prisoner spent the nights in a cell in Area 3. The selection criterion was apparently that, in contrast to the remainder of this group, he was a non-smoker.

[18] The term "multi-purpose" raises issues about the historical development of special purpose prison accommodation and regimes. The *Prisons Act* and the *Prisons Regulations* either explicitly (Act, ss. 43 and 82; Regulations, 68 and 72) or implicitly (Act, s. 36; Regulations, 54C) require special purpose cells to be approved or provided as being appropriate for the specified purpose. Over time most of the special purpose accommodation has come to be cross-designated as being fit for all special purposes (punishment, separation pending investigations, s. 43, close supervision, management and even medical observation). Accordingly, these various categories of accommodation have come to be referred to routinely within the prison as being "multi-purpose", even though neither the Act nor the Regulations uses that phrase in any context.

[19] Subsequently, the Head Office of the Ministry indicated that its own use of terminology was as follows: the IOU for Area 1; the Unit 8 Multipurpose Unit for Areas 2 and 3; and the Unit 9 Special Handling Unit for Areas 4 and 5. On the ground, it is nowhere near as neatly differentiated as this; the lack of precision we encountered was widespread.


AREA 1
Induction and Orientation Unit
AREA 2
"Multi-Purpose" Cells
AREA 3
Solitary Confinement/"Multi-Purpose" Cells
AREA 4
"Close Supervision Regime"
AREA 5
High Security Prisoners
CASUARINA PRISON

1.5 Our feeling after the inspection was that this terminological confusion may not have been simply a neutral or insignificant matter but could well have reflected something of the confused operational objectives that we identified. Historically, despite its name the IOU has never – from Day 1 of the opening of Casuarina Prison – been used for induction and orientation. It was immediately found that the throughput of incoming prisoners was such that a backlog of new prisoners would build up if the Unit were used for this purpose. Thus the much larger Unit 5 became the effective Induction and Orientation Unit, a practice that has continued for over ten years.

1.6 A further point characterising the confusion of penal arrangements within the prison is that not all prisoners undergoing punishment were found in Area 3 or elsewhere in the SHU/IOU. There were also five punishment/close supervision prisoners in Unit 1 of the main prison. They were held in cells on the secure side of a moveable barrier. This arrangement has ripple effects upon the management of both 'A' and 'C' wings of that Unit, complicating the arrangements for keeping protection prisoners and "heavy" mainstream prisoners away from each other. In other words, decisions as to admission and retention of prisoners in the IOU and SHU area impinge upon prisoner management issues in other parts of the prison. This is an important point, for there is a tendency for these Units to be seen, in terms of management issues, as being self-contained. They are not. A further consequence is the extra stress and demoralisation that, we were emphatically told, is felt by officers working in those parts of Unit 1.

CIRCUMSTANCES OF ADMISSION

1.7 In the case of the Area 1 high protection prisoners, the circumstances were straightforward, relating to the nature of their offences (usually sex or paedophilia) or their previous employment (prison officer, policeman). There was one slightly odd case, however, that involved a prisoner whom the prison authorities considered, on the basis of intelligence received, might be the subject of an externally initiated escape attempt. There was nothing to suggest that he could not otherwise be managed effectively within the mainstream, nor was there any indication as to when his segregation would end.

1.8 With regard to the prisoners held in Area 5 - the "soft" side of the SHU – they had "graduated" through Levels 1 and 2 of the special handling regime, i.e. had come from Area 4. They were mostly long-timers, in terms both of their head sentences and of the time they had so far spent in the SHU. Several of them had been there since the Casuarina riot of 25th December 1998, i.e. for two years, or even longer.

1.9 As for the current Area 4 prisoners, they had been ordered into close supervision by the Superintendent either in accordance with Director General's Rule 3V (made by authority of s. 35 of the *Prisons Act* 1981) or by his direct authority under s. 36 of the *Prisons Act* 1981. Rule 3V makes it mandatory for a period of close supervision to follow upon a period undergoing punishment in relation to drug offences or offences involving serious acts of violence. The local prison practice is to place these prisoners in this area of the SHU. In other words, a two-stage punishment follows upon such convictions for prison offences, though it is questionable whether the magistrate or visiting justices who impose the initial penalty would be aware of this implication. The same rule also provides for downward progression under the Hierarchical Management System operative at the prison. Section 36 confers wide discretion for a variety of management purposes, with the consequence that this severe level of confinement has become less exceptional than ideally should be the case.

1.10 Area 4 would also normally be the location for prisoners who were being held under s. 43 of the *Prisons Act*. However, at the time of our inspection no prisoners fell into this category. This provision possesses two accountability safeguards – first, that the period in contrast to s. 36 close supervision should not exceed thirty days (though it may be extended for further periods) and, second, that the Minister for Justice should be informed "forthwith" of all such orders. In the past, a fair proportion of SHU residents had been held under this provision. However, the General Manager Prison Services recently instructed that he would only endorse a Minute to the Minister on the use of this section in the most exceptional circumstances. His intention was to convey the message throughout the prison service that "administrative segregation" should not be regarded as a primary management tool.

1.11 The unintended consequence of this instruction has been to shift management decision-making into the less accountable realms of s. 36 and Rule 3V. The application of section 36 lacks explicit guidelines either in the statute itself, in the *Prisons Regulations* 1982 or in the Director-General's Rules. Paradoxically, administrative segregation is now less regulated than previously.

1.12 Information elicited from the prisoner survey conducted as part of the inspection suggested that some prisoners had been on close supervision "countless times" – a comment confirmed by the Ministry. In these circumstances, one is bound to wonder whether the regime is in any way calculated to achieve its presumed purpose of modifying behaviour.

1.13 Area 3 housed prisoners who had been subjected to formal disciplinary procedures and awarded a finite punishment. As explained in paragraph 1.9., close supervision is, according to the nature of the offence, mandatory in relation to some prison offences upon the expiration of the finite period of punishment, with the effect that the prisoner would be moved from a cell in Area 3 to one in Area 4. This was one of the matters of concern to the Minister, causing him to direct this inspection. The justification for this procedure – either in terms of due process or management needs – is highly dubious. Amendment of Rule 3V is necessary.

1.14 The final category – prisoners in Area 2 - also gave cause for concern. One of the prisoners had absolutely no idea why he had been brought to the IOU and what it was he was supposed to have done to bring about his removal from mainstream. When we probed the matter by prolonged interview, the following elements of the story emerged. It seemed that the prisoner – a traditional Aboriginal from the Northwest – had been making a nuisance of himself by cadging cigarettes from other prisoners. This had stirred up some kind of trouble or resentment that, in the view of his Unit officers, should not be allowed to continue. He had been woken up that morning before normal unlock time, and removed to that area.[20]

1.15 The prisoner's puzzlement about all of this was undoubtedly exacerbated by the fact that his English language skills were limited, and we gained the impression that officers regarded it as not worth bothering to communicate with him about the matter. In other words, an informational vacuum had been created by a combination of ignorance and laziness (it takes much time and trouble to communicate effectively

[20] The Ministry's comments seem to suggest that a prisoner in this category should have been sent to Area 3 – indicative of the confusion that we monitored.

with such prisoners). We were not apprised of any documentation relating to his case.[21] The prisoner was returned to his Unit shortly after we had interviewed him, suggesting that the original basis for his transfer may have been rather insubstantial.

1.16 Is this an example of using the IOU when the prisoner could more appropriately have been managed within the mainstream? We raise this question because it transcends this particular case and is an integral aspect of proper usage of the IOU and the SHU. For example, a senior manager told us that in his view all but three of the prisoners held on the Level 3 regime in the SHU (i.e. residents of Area 5) could be effectively managed in mainstream. A similar view was expressed by two long-term prisoners (now back in the mainstream) whom members of the inspection team interviewed at length.

1.17 In summary, the Units are indeed "multi-purpose"[22], so much so that questions arise as to whether some of the occupants should ever have been admitted there in the first place. It is perhaps a little facile in the majority of cases to second-guess this with hindsight. However, there do seem to be real issues as to whether some of the current prisoners could not now be successfully managed elsewhere in Casuarina or in the prison system generally. Undoubtedly, the filtering mechanisms that initially sought to ensure low usage of the SHU have become less effective – indeed, quite ineffective - over time.[23]

EXIT GUIDELINES

1.18 This raises the question: how do prisoners get out of these Units? What are the exit guidelines? As with entry, the answer will vary with the type of prisoner. One group is fairly straightforward – high protection prisoners will leave when they are no longer in need of protection within Casuarina or when they are transferred to another prison.[24] Having said that, our strong impression was that most of this group of prisoners were relatively content to remain there - in a safe environment with reasonable facilities and some opportunity to work. They welcomed the stability and predictability of their situation.

1.19 With the other groups, the exit criteria were obscure. This obscurity commenced at the time of entry, when no information was given as to what was expected of the prisoner and what he could expect from the regime. Several prisoners told us that officers, if queried, had said that they should ask the other

[21] In its comments on the draft report, the Ministry claimed that a "Confinement Regimen Rules" form would have been filled in, certifying amongst other things that the prisoner had been made aware of the basis for his removal to Area 2. This is a tick-a-box form that frequently cites the process itself (use of s. 36) as the reason. In any event, no documentation was made available in the Unit about this prisoner's case nor were the staff given to explaining the circumstances to us when initially questioned about the matter.

[22] See footnote 18, above.

[23] The SHU is stated in Ministry policy documents to be a *State-wide* facility for managing prisoners in need of special handling. For example, escapees or prisoners convicted of drug use may be sent there from other prisons. Initially, admission could only be by order of the highest official in the prison hierarchy of the Ministry of Justice (or, formerly, the Department of Corrective Services). That person in turn was obliged to notify the Minister – not just in s. 43 cases but generally. That process tended to act as a filter. More recently, however, the Ministry has moved to a position where the first decision point is on a superintendent-to-superintendent basis. If the Casuarina Superintendent is satisfied that there is a proper basis for transfer, then he in turn will seek approval from the General Manager Prison Services through the Director Metropolitan Prisons. The Minister is not brought within the decision-making and accountability loop. The filter of Ministerial notification has thus been removed.

[24] But note the anomaly with regard to the prisoner being held there as the possible subject of an escape attempt: paragraph 1.7., above.

prisoners about these things. It was evident that the following things happened from time to time:

- As previously mentioned, some prisoners who had been initially sent to the IOU for finite periods of punishment were kept there under s. 36 after completion of that punishment; and
- Some prisoners sent to the SHU under s. 36 simply remained there indefinitely.

1.20 In addition, we discovered a case where one prisoner who had been offered the opportunity to return to the mainstream declined to leave and was permitted to remain there. The circumstances of this case are very complex, and we would be breaching privacy considerations to spell them out. But the general point is that nothing has been done to prepare him for safe release into the outside community – an event that is fairly imminent. He is angry and confused about his situation. But the prison system has taken the easy way out in dealing with him – minimising his danger to others whilst in prison but side-stepping the issue of his potential future danger to the community and to himself. The SHU alternative has distorted agreed correctional policy, as implicitly expressed in both the *Sentencing Act* 1995 and the *Sentence Administration Act* 1999, each of which proceeds on the basis that safe release into the community is an attainable goal for all but the most exceptional prisoners.[25]

1.21 With regard to the prisoners held under s. 36, a view that was commonly expressed by the officers was that the length of their segregation was a matter for management. They did not think of themselves as case managers, professionals having some input into outcomes, but rather as custodians. Indeed, the whole manner of communication with these prisoners epitomised this – dealing with them through the hatch, where staff considered it appropriate, and otherwise at the officers' post. It should be said that many of the prisoners also seemed to prefer this mode of interaction – or at least purported to do so. Yet by the same token they expressed frustration that they did not know what was expected of them if they were to earn release from the Unit.

1.22 An even more worrying factor was that many officers seemed to think that release into mainstream was a matter for the Minister for Justice. In other words, they insufficiently understood the difference between s. 36 and s. 43 segregation, and the fact that there were no s. 43 prisoners in the system any more (see paragraph 1.10., above) had not been made clear to or grasped by them. The corollary of this was a belief that they could not have any real influence on a decision to return a prisoner to mainstream – a convenient reinforcement of the custodial culture that characterised the Unit.[26]

[25] The Ministry disputes this interpretation, stating that "much has in fact been done for this prisoner …[who] is subject to the Serious Offender Management Committee". However, the focus of this Committee's work is evidently on "their satisfactory progress *within* the prison system". Our concern is no less, indeed more, for public safety and his own coping capacity upon his release. The Ministry's response does not address this issue, being focused on custody and control. There is no management plan directed towards post-release eventualities.

[26] The Ministry of Justice challenged this point in its comments. It claimed that the formal arrangements were such that officers did become involved in such matters. This decidedly was not our experience. The Ministry is not the only organisation where on-the-ground reality parts company with what senior management think is being done. Active management is required to bring about cultural change.

ABORIGINAL PRISONERS

1.23 To complete this brief overview of prisoners, mention must be made of the numbers of Aboriginal prisoners. We did not do a precise count, but our impression was that the numbers of Aboriginal prisoners in the non-protection categories was slightly but not significantly in excess of that found in the overall prison population. From the information we gleaned, it would not be possible to say that the segregation system is discriminatory - though, as mentioned in paragraphs 1.14 – 1.15., above, we were concerned at the treatment of one particular Aboriginal prisoner and wondered whether it might be indicative of a wider trend. If, as we suspect may be the case, that kind of information vacuum were a cultural norm in interactions with Aboriginal prisoners from remote areas, this in turn would make life in prison more frustrating and perplexing for them. This could then exacerbate their vulnerability to disciplinary or management interventions for reasons which, to them, seemed arbitrary.

SUMMARY

1.24 Paradoxically, despite the matters that we have mentioned, the atmosphere in the Units did not seem unduly tense. One prisoner was acting out very noisily in his cell for an hour or so on the first morning of our inspection, but the response of the other prisoners to this was relaxed. Neither the SHU and the IOU seemed to be volatile or explosive environments so much as ones that were depressed and resigned.

Chapter 2

THE OFFICERS

REACTION TO OUR INSPECTION

2.1 Officers in the Units were cooperative and open in their response to our inspection. Interaction with prisoners was facilitated in every reasonable way. Consequently, one-to-one discussions were able to be held, even with "two-unlock" prisoners; the confidential methodology we used for the distribution and return of prisoner survey questionnaires was respected; evening lock-up was delayed in the IOU (Area 1) to enable group discussions with prisoners to be completed; and a good response was made to the officer survey we undertook (eleven responses out of 18 questionnaires distributed). In summary, the interactions with the inspection team were exemplary.

STAFF PROFILE AND ATTITUDES

2.2 All officers working in the Units are male. They are strongly of the view that women should not be encouraged to work on the general roster in the Units. Their belief is that women are not physically strong enough to deal with these offenders and that, consequently, the male officers would be distracted from their normal routines in dealing with prisoners by the need to ensure that their female colleagues did not get, or put themselves, into vulnerable positions. This is an argument that is frequently heard (and can now be seen to be obsolescent) in relation to other law enforcement and disciplined service activities, such as policing or the armed forces, and ignores the fact that there are different ways – male and female - of successfully doing the same job. The present practice also gives no weight to the strong argument that female staff may assist in *preventing* incidents from occurring.[27]

2.3 On the basis of the survey responses, the following data emerged. The average age of staff was about 45, and they had worked in the Units for an average of two years and seven months. All staff had taken a period of sick leave in the last twelve months, but the periods were short. Similarly, workers' compensation claims were low. These factors are usually regarded as indicators of reasonably good morale.

2.4 This observation ties in with the responses received to the survey question asking staff to nominate the three best things about working in the Units. Every respondent cited "teamwork" as one of the best factors. They also said they felt "very safe" or "safe" in their working environment and had a high level of confidence in their colleagues. They valued the fact that there was a lot of continuity in the job in the sense that many of the prisoners were there long term, and they also enjoyed the fact that ability to maintain control was an important aspect of their job.

2.5 In other words, they felt none of the role confusion that sometimes comes with the more complex demands made upon prison officers, when unit management or case management or welfare support is expected of them. The predominant culture was that of minimal communication – through the hatch, where relevant, and otherwise at the officers' post.[28] Their relevant (and, as it turned out, most recent) training was not in "soft" occupational areas, such as psychology or human services, but rather in the use of restraints and chemical agents. Operationally, they were confident and competent as to how unit procedures worked, how to access the information they themselves needed, and how to go about their daily tasks safely. They maintained good separation of groups based on risk and need.

[27] See further paragraph 2.16.
[28] This was less true of interactions with high protection prisoners in Area 1.

2.6 They also welcomed the fact that they were largely quarantined from the dysfunctional and stressful effects of general overcrowding that has been omnipresent in the mainstream part of the prison for the past several years. Their prisoner load was predictable and manageable, and the operational rules applicable to the Units meant that the roster could not be reduced, in contrast to the situation in the main prison. Paradoxically, these Units were something of a "comfort zone" for officers.[29]

2.7 "Comfort zone" as it might be characterised, officers nevertheless felt a sense of marginalisation or grievance about their situation. A majority thought that senior management did not understand or appreciate the difficulties of working there. Contact with Head Office was, they said, minimal.[30] Also, most considered that there was too much outside influence – which presumably meant from lobby groups, official prison visitors and the like. Predictably – and it was perhaps not a fair question – virtually all officers agreed with the proposition that they should be paid a special loading to compensate for working in the Units.

2.8 All officers expressed confidence that they understood both the entry and the exit guidelines for prisoners. Demonstrably, this was not so – but the fact that they felt it to be so shows that their view of how the Units were actually functioning was equated in their own minds with how they *should* be functioning. They also claimed that there was "enough" case management to enable prisoners to get back into the mainstream if they were so inclined. The reality was that no case management at all was actually occurring.

2.9 In this regard, it should be noted that the 1991 Director General's Rule 3N – still formally the applicable source for managing the SHU – required that "a Review Committee shall meet at least once each month to review the management, operations, general progress and continued placement of the prisoners." In practice, the Review Committee meets irregularly, roughly speaking every three months or so.[31] Minutes are kept, but those for the 2000 meetings were not all available in the Unit itself.[32] It is perhaps not surprising in this context that prisoners said that they get no worthwhile information as to why they must remain longer or what more they must do to qualify for return to mainstream.

2.10 The tendency of officers to deceive themselves about the *status quo*, or simply to accept and condone it, was evident from their responses to questions about prisoners' privileges. Notably, most officers believed that there was sufficient access to the oval and the gymnasium for IOU and SHU prisoners. The objective reality is that there was no access whatsoever.[33]

2.11 We did not get the impression that racism was rampant in the Units, certainly no more than in the prison sub-culture generally. None of the inspection team overheard those unguarded expressions of prejudice that so readily emerge, however carefully people are trying to cull their language, in profoundly racist

[29] Some prisoners had manifested similar feelings for much the same reasons, as seen from their own perspective.
[30] See further paragraph 5.10., below.
[31] The Ministry has informed us that monthly meetings commenced again as from 2nd March 2001 – two months after receipt of our Interim Report.
[32] The Ministry's comments claim that they are kept in the Unit. The fact is that no one could produce them for us or had any knowledge of where they might be found.
[33] The Ministry informed us that IOU prisoners (i.e. Area 1) have now been given access to the gym, commencing January 2001.

settings. However, some Aboriginal prisoners had indicated that some officers had racist attitudes towards them. Conversely, some officers indicated that some Aboriginal prisoners were racist towards them. One officer cited this as one of the three worst aspects of his work.

PRISONER PERCEPTIONS OF THE ATTITUDES OF OFFICERS

2.12 Some prisoners complained of "mind games" that officers played – meaning the withholding of privileges one day or the granting of that same privilege to another prisoner or the failure to take forward a request or to unlock the door into the outer courtyard for those in solitary confinement, and so on. Lack of consistency between officers exacerbated these things. Most prisoners said that complaints about such matters were ignored. Generally, prisoners thought that the officers were uninterested in their welfare and more concerned about their own affairs, rosters, overtime, award conditions and so on. There were also complaints about the excessive use of restraints – a matter that will be discussed separately later.

2.13 Prisoners also commented that their interactions with the General Duties Recovery Team officers on duty in the Units or on night shifts were far more constructive than with the regular day-time roster of officers. Communication was better, the team members were much more likely to talk problems over with prisoners through cell doors or hatches. Quite possibly this was because, from the officers' perspective, lacking any back-up and less enured in the negative sub-culture, they really had little alternative but to deal with issues in this less formal way. It should be noted that some of these officers are women.

SUMMARY

2.14 All of the literature about prison officer sub-culture leads one to expect a conservative ethos, wary of the manipulative abilities and occasional physical dangers posed by prisoners, cynical about human capacity for self-improvement. This stereotype is gradually being broken down by prison authorities intent on getting more value for the correctional dollar. They see the successful delivery of programs as being partially dependent on improved communications between officers and prisoners.

2.15 The sub-culture in the Units we inspected – particularly in the SHU (Areas 4 and 5) – is largely unaffected by these modern trends and philosophies. The correctional task is seen in traditional terms – control and security in relation to some volatile and potentially dangerous people and some others whose offences are deeply distasteful. To some extent these attitudes and reactions are understandable; it is not to the point to preach about such matters to those who must actually perform these tasks. However, whilst this continues, nothing is likely to change in the management and outcomes of these Units.

2.16 Senior management at the prison recognises this. In a recent attempt to broaden the officer base, "expressions of interest" were evidently sought within Casuarina from officers who wished to be considered for the IOU/SHU roster. Not surprisingly, no women officers volunteered.[34] We were disappointed at this passive approach to leadership, for it encourages "management from below" – the dominant sub-culture can thus reinforce its standing. If the culture is to change, active leadership will be required – a management style that by its very nature challenges, even confronts, existing expectations.

[34] See further paragraph 5.12., below.

Chapter 3

LIFE IN THE UNITS

ACCOMMODATION AND BASIC NEEDS

3.1 Segregation areas are, by their very nature, less visible than other parts of maximum-security prisons. The frequent thoroughfare of lawyers or program staff or official visitors tends to have a beneficial impact on mainstream conditions; but these movements are attenuated in "prisons within prisons". Without scrutiny, conditions can deteriorate badly. For example, in the UK, HM Chief Inspector of Prisons, making an unannounced inspection of the segregation unit of Wandsworth Prison, found that "the central corridor was grimy … and that the cells were filthy with a discernible smell of urine in most of them".[35]

3.2 We are pleased to record that the conditions in the SHU and the IOU, whilst by no means ideal, did not replicate those dismal standards. Within the Level 3 part of the SHU (Area 5), cells were clean with reasonable quality bedding and adequate furniture and physical facilities, including toilets. Prisoners could lock their cells, though naturally officers had an override capacity. The same accommodation standards applied to protection prisoners within the IOU (Area 1). These two groups of prisoners also have reasonably generous allowances of personal effects, including the standard electrical and electronic appliances.

3.3 The close supervision, punishment and short-term confinement cells were far less satisfactory. By their very nature, they sustain a much higher level of damage and vandalism. Furniture is sparse, in some cells consisting of nothing more than a bed (from which bedding is removed during the day) and a plastic chair. Polystyrene cups littered a few of the cells on the days of our inspection.

3.4 Outdoor spaces are not particularly enticing. One small area available to high protection IOU prisoners is grassed with some shade. But all the other spaces available to those who are allowed out of their cells are concrete. There are very few facilities – the usual basketball hoop and a table tennis table. There are also tables and chairs in the outside areas. In the IOU there is an indoor recreation room, with a computer and an exercise bicycle. We were told that a walking machine broke down recently and has not been replaced.

3.5 Communal showering facilities were adequate and accessible to all prisoners, though obviously some could only shower under supervision, inevitably restricting the frequency to no more than once a day. Clean clothing was also readily available. In the case of punishment/close supervision prisoners, a change of clothes is normally available each day. In summary, basic hygiene standards were met in all parts of each of the Units. This view of ours, based on observation, was fortified by questionnaire responses from the prisoners.

FOOD

3.6 The food situation was not as satisfactory. In particular, Level 3 SHU prisoners and close supervision or punishment prisoners in either the SHU or the IOU (Areas 2-5) were critical of the quality and the hygiene standards. Food for these prisoners was prepared in a remote facility, and then brought down to the kitchen in the punishment area and served after being rego-thermically re-heated. Officers performed this task in kitchen conditions (refrigerator, floor cleanliness, equipment maintenance) that were marginal.

[35] HM Chief Inspector of Prisons: *Report of an Unannounced Short Inspection of HM Prison Wandsworth, 13-16 July 1999*, p. 139. London: Home Office.

Whilst they accepted that their responsibilities included that of being food managers, none of them had received training in food hygiene. We observed that neither hairnets nor gloves were used.

3.7 Not surprisingly, therefore, the various complaints, which were frequently explicit and sometimes quite crude, included statements that hair was quite often found in the food. Several prisoners told us that they used their "spends" to buy food so as to reduce their dependency on the food supplied.[36] The nutritious value of what was served was also questioned. In a prison setting, it is quite predictable that concerns of this kind will be expressed. Nevertheless, one officer in the SHU seemed to endorse the prisoners' concerns. On balance, it would seem that there is considerable room for improvement as to quality and hygiene, and that this could be achieved without undue cost or disruption to routine.

3.8 It should be noted, in this regard, that until two or three years ago Level 3 SHU prisoners prepared the food in the kitchen of that area for themselves and the other SHU and punishment/close supervision prisoners. However, the cooking facilities were then removed. We heard several explanations for this, but the one that seemed most credible related to the discovery that they were being used to concoct a "brew" of some kind.

3.9 Prisons often seem to operate on the basis of removing privileges not only from the group that has abused them but from all future groups; the notion of a temporary loss is one that managements historically have trouble in grasping. There seems to be every good reason for restoring this particular privilege, at least on a trial basis. To do so would help to remove a source of real discontent; it would foster some small sense of self-reliance; it would remove from officers a task for which they simply are not trained or particularly competent; and it would create one or two meaningful jobs in an environment that is impoverished for employment opportunities.[37]

3.10 As foreshadowed in paragraph 3.7., above, the food available to high protection prisoners in the IOU was of acceptable standard, hygienically served. Prisoners managed the process, and prepared the food both for themselves and for staff members. We heard no complaints about it.

EXERCISE AND RECREATION

3.11 As previously mentioned (paragraph 3.4), exercise opportunities were limited for all prisoners. They had no access at all to the oval or the gymnasium. Such access is much more restricted for all prisoners in Casuarina since the re-design of internal security following the riot of 25th December 1998. The logistics and the labour-intensive demands of moving high protection prisoners or management prisoners to these areas in ways that are consistent with safety and security seem now to be almost insuperable. Yet it does seem that the quality of life of these prisoners, and thus their manageability, has suffered as a consequence.[38]

[36] As many of them received the minimal level of gratuity, $13.50, it is doubtful that this would significantly reduce their dependency on food supplied from prison sources.

[37] The Ministry has now informed us that in future a prisoner will carry out food preparation.

[38] See now footnote 33, which indicates that IOU (Area 1) prisoners have been permitted access to the gym. The Ministry states that it also intends "to examine the potential to allow SHU (Area 5) prisoners structured access to recreation facilities".

3.12 Exercise for punishment and close supervision prisoners (Areas 2, 3 and 4) is restricted to use of the small yards adjoining their cells.[39] Strictly speaking, their entitlement is to have access to the outdoors for only one hour per day. However, it seemed that this restriction was not literally enforced; to their credit many officers treated that period as a minimum.

The exercise yard.

3.13 Mention has been made of access to radios, television sets, computers, videos and the like in Areas 1 and 5 - the high protection IOU and the Level 3 SHU prisoners. Personal effects are not available in the other parts. Access to reading material was raised as an issue with us. The situation is as follows. Every two weeks a trolley is taken from the library to the SHU/IOU areas. It contains about 150 books, forming a representative cross-section of the generally available books. Level 3 SHU and high protection IOU prisoners have access to this trolley and can borrow multiple copies. We were told that particular requests would also be met. The system, though obviously more restrictive for readers than full access to the library, is acceptable.

3.14 With regard to punishment and close supervision prisoners, boxes of discarded books are brought down every two weeks. Books are progressively discarded from the main library as they become too worn – broken spines, torn pages, markings, and so on. The Casuarina library is part of the LISWA system, and follows their protocols in this regard. Most of the discarded books are in fact still readable. The number of boxes brought to the Units varies from time to time, but on average about sixty books seem to be offered. The library staff justified this practice and that of not offering these prisoners access to the trolley on the grounds that books damaged beyond repair have to be paid for, and their experience over the years was that books loaned to prisoners in these areas were frequently damaged irreparably. As with changed food preparation arrangements for the SHU, however, we wonder why the sins of previous groups of prisoners must necessarily be visited forever on subsequent groups, and wonder whether there might be an opportunity, at least selectively, to bring some of these prisoners back into the system applicable in the remainder of these areas.

VISITS AND OTHER FAMILY CONTACTS

3.15 According to the Director-General's Rule 3N, each prisoner in these Units is entitled to two visits per week to a maximum of two hours' (total) duration. This entitlement is not met. This is hardly surprising; the requirement of double escort to and at the visits area would take up the time of two full-time officers if each prisoner took up his full entitlement. That in turn would mean the further scaling down of what activities there are in these areas.

3.16 At one time consideration was given to bringing visitors to the prisoners rather than vice-versa. An area was identified within the IOU where such visits could take place. However, the idea was allowed to lapse. There seem to be almost insuperable security issues in pursuing it further. We are left with the conclusion

[39] Note, however, that Level 2 regime close supervision prisoners in Area 4 have access to a reasonable-sized concrete courtyard. It is only Level 1 regime prisoners who are confined to their individual courtyards.

that increased staff levels would have to be made available if prisoners are to be able to take up their entitlement.

3.17 Prisoners claimed that telephone access was unsatisfactory, as indeed it is in other parts of the prison. The complaints about the Arunta system are legend – too few phones[40], badly positioned (behind a grilled area), too expensive, inadequate access during cheap rate times and so on. The Ministry of Justice was due to re-negotiate its contract with Telstra in December 2000. It is certainly to be hoped that a cheaper and user-friendly service has been or will be provided. Segregated prisoners, if their lives are to remain tolerable, have even greater needs in this regard than mainstream prisoners, and the fact that many of them are on the lowest level of gratuities ($13.50 per week) exacerbates their disadvantage.

3.18 It was not easy to pin down the operation of mail services. However, SHU prisoners claimed that long delays (up to two weeks) were commonplace. Nothing that came to our attention explicitly corroborated this claim, though some staff conceded that the additional security procedures applied to mail coming into these areas could sometimes cause slight delays. On the other hand, several prisoners explicitly indicated that it was not a problem. We would simply emphasise that this means of outside contact is particularly important in segregation areas.

MEDICAL AND WELFARE SERVICES

3.19 We received some complaints, both in the survey responses and verbally, about medical services. They related in the main to their availability and to the attitude of the service deliverers. As to the first, a few prisoners claimed that it might take weeks to get an appointment with a doctor and that related services, particularly dental, were virtually non-existent. On the other hand, the Nurse-manager stated that there was a medication drop to the IOU/SHU each morning – a claim supported by the Occurrence Book entries – and that during that time (usually about 15-20 minutes) all prisoners, especially those on punishment/close supervision, were directly asked if they had any problems. If they had, they were told to fill out the orange "triage form", in exactly the same way as every other prisoner at Casuarina, and they would get priority according to prison-wide criteria.

3.20 The best custodial practice found in some jurisdictions is for segregation prisoners to be seen daily by the prison medical officer. Unfortunately, this is not the case in Casuarina. We concluded that any shortfall of services to these groups reflected the general under-supply of such services within the prison, exacerbated somewhat by the necessity of double or even triple escort arrangements in some cases.

3.21 With regard to welfare services, the Prisoner Support Officer and the Chaplain each visited the area reasonably often. Beyond that, welfare issues depended on the communications with and responses of officers. However, as mentioned previously (paragraph 2.5., above), officers on the whole felt more comfortable with their custodial duties – which is not to say that welfare requests would be ignored. A few inmates actually stated that some officers had been considerate of their needs. But for the most part this channel of help in welfare matters did not seem to be as active as it should be.

[40] The Ministry correctly pointed out that the number of prisoners per telephone was lower in the IOU (Area 1) and the SHU (Area 5) than in other parts of the prison. However, the other problems with the system remain.

DRUGS

3.22 An unannounced raid on the Units on 29th September 2000 by the ESG and the Canine Section found very low indications of drug use. Of course, that is the way it should be in closed areas where, by definition, interaction with the remainder of the prison population and with outsiders is infrequent and takes place in controlled conditions. Our own survey responses corroborated these findings, with prisoners from both main areas saying that drug use was either non-existent or infrequent.

WORK AND PROGRAMS

3.23 The high protection prisoners all had some work. Some assisted officers in the Reception area; others were involved in cooking for themselves and the officers; cleaning work was available; and two worked in the gardens outside the main gate under the provisions of s. 94 *Prisons Act*. The Level 3 SHU prisoners, however, do not have access to work of any kind; their lives do indeed consist of little more than "killing time". The punishment and close supervision prisoners have no work opportunities.

3.24 Programs were non-existent in any of the areas. Educational programs are apparently not encouraged because of the fact that they mostly involve female teachers. Programs – such as substance abuse or sex offender treatment – that may be required by the Parole Board as a prerequisite to release are also not available within these locations.

3.25 Nor does anything occur that can be described as case management. It has already been mentioned that both officers and prisoners were confused as to how exit mechanisms would be triggered, particularly in relation to Level 3 SHU prisoners. There were no exit guidelines and no process in place, even in the absence of clear guidelines, to give prisoners some useful idea of "how they were going". The requirement of Director General's Rule 3N that monthly meetings should be held by the Special Handling Unit Management Review Committee have been systematically breached: see paragraph 2.9., above. Reviews of "the management, operations, general progress and *continued placement of prisoners* in the SHU" did not take place, as they should have done.[41]

3.26 Case management of such prisoners is by no means impossible. The thematic inspection of "Close Supervision Centres" by HM Chief Inspector of Prisons (1999) describes the graduated regimes, incentives and programs in England and Wales. Whilst acknowledging (page 5) that "the whole area of managing those who pose a high risk of harm to others … is an experimental one and that there is no established wisdom about how this should be done", the report nevertheless concluded on the basis of the inspectors' observations that "the effectiveness of any system will depend on the viability of the exit options which will need to be able to support change and offer some incentive to returning prisoners" (page 4). The Casuarina regime fails according to this test.

[41] It is worth noting that it is a disciplinary offence under s. 98(1)(a) of the Prisons Act 1981 for a prison officer to commit "a breach of any … responsibility imposed on him by … the rules or standing orders". No disciplinary charge has been laid against any person for failure to discharge the responsibility of causing such meetings to be held. Head Office monitoring of this function had evidently been deficient.

SELF-HARM

3.27 Prisoners claimed that self-harm incidents were quite frequent, particularly in the punishment areas. As with much of the information we received, this was anecdotal and imprecise. The Superintendent was firm in his view that self-harm occurs infrequently. An apparent absence of appropriate record-keeping meant that it was not possible objectively to cross-check these matters. Self-harm records are entered into the daily Occurrence Book and also go onto a prisoner's file. But they are not registered by location. Yet it is evident that the location of such events is important information in itself.

SUMMARY

3.28 The quality of life in the Units was variable. For high protection prisoners it was as comfortable as their lives would be in any prison in the State, with the exception of the best of the minimum-security prisons. The only substantial drawbacks were the fact of segregation itself and the lack of programs; but the attractions of safety from other prisoners, single cells with personal locks, entitlement to a wide range of personal effects and reasonable quality food more than compensated for most of them. As mentioned in paragraph 1.18., above, there was no real incentive to move on, and no evidence that management had structured plans in place to try to return them to ordinary protection, let alone mainstream.

3.29 For Level 3 SHU residents, there was something of a paradox – a wish not to be there and an equally cogent wish not to leave. Answering the survey question that invited prisoners to nominate the three worst and the three best things about the SHU, one prisoner wrote:

> "The worst things include: the isolation from mainstream prisoners, and only mixing with seven to nine other prisoners.
>
> The best things include: the isolation from mainstream prisoners, and only mixing with seven to nine other prisoners."

This response epitomised the ambivalence that we encountered amongst quite a few prisoners.

3.30 Nevertheless, it was clear to us that some prisoners would prefer to work towards exit, but did not know how to do so or what was expected of them. Two former SHU prisoners, who had been incarcerated there for long periods, told us how much they had wanted to return to mainstream long before they actually were permitted to do so. Neither of them was able to elucidate for us what exactly had occurred to bring about their exit.[42]

3.31 We reached the view, therefore, that there was no case management worthy of the description in the SHU.

3.32 For the remaining prisoners, life in the Units essentially involved coping with absolutely basic conditions and "killing time" until the moment arrived when they would be released and returned to mainstream. As mentioned, some periods of punishment merged into s. 36 close supervision, according to mandatory criteria set out in Rule 3V. It is dubious whether this is a necessary or proper provision. What can be said is that, once those prisoners crossed that divide, life in the Units took on a different dimension.

[42] One of them speculated that the very fact that he had "played up" and kept doing so in the end assisted his re-settlement. However, that tends to contradict our impression that the SHU regime was well capable of controlling "troublemakers".

Chapter 4

SAFETY

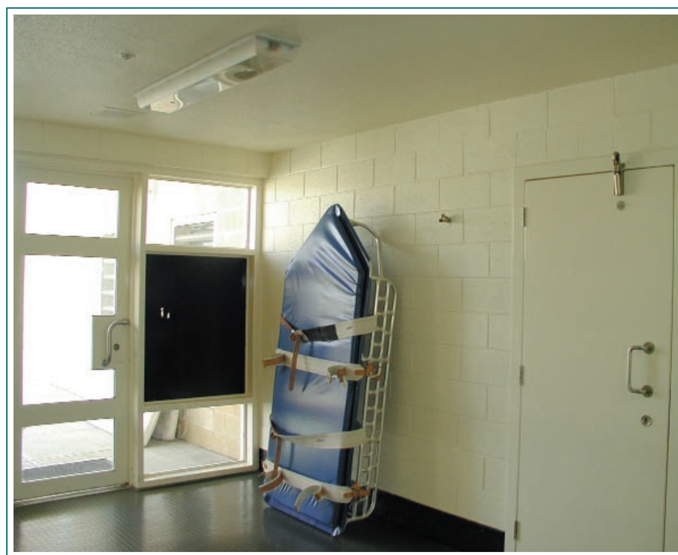
ASSAULTS UPON PRISONERS BY STAFF

4.1 As mentioned in the Inspector's Overview, the inspection team arrived unannounced and was admitted to the Units before unlock time. Consequently, we were able to observe directly whether any prisoners showed signs of recent injury and we were available to hear any current complaints. The custodial snapshot we were thus able to construct was reassuring. No complaints were made to us at that time, and there was no evidence of recent or current brutality.

4.2 However, that was just a single snapshot. What about a retrospective overview? In answering our survey questions and in direct discussion, most prisoners from the SHU and IOU punishment areas (but none from the high protection group) asserted that assaults or brutality by staff were commonplace. "Brutality" in this context included unnecessary or excessive use of restraints or chemical agents or of force in cell extractions. One prisoner stated that he had been placed in restraints "like a dog – shackles, chains and handcuffs". Another said, "Two big cans of mace and small cans – the works", in describing his experience of chemical agents. A third claimed to have been strapped to the restraint mattress – known throughout the prisons as the "blue bed" - for more than 24 hours, obliged to urinate into his pants, kept there long past the time when he had settled down. When pressed, he conceded that this alleged event happened more than a year ago. Generally, the extent and similarity of anecdotal evidence arguably amounted to some sort of evidence that these practices do occur from time to time.

4.3 In that regard, comments from some officers lent further credence. One officer stated: "In this type of work it is inevitable that there is some physical violence". Another went further: "Violence is a big part of our life. The frustrations of the job are enormous". A non-uniformed staff member confirmed that he had occasionally seen evidence of prisoners having been beaten up. He also thought that the "blue bed" was used fairly often, though could not put a figure on this.

4.4 The "blue bed" merits special description. It has come to form part of the mythology of the SHU – the so-called "Hannibal Lector" bed.[43] During our first day in the SHU, several prisoners said that "they [the officers] had hidden the blue bed so that you couldn't see it". But it was actually in its usual place (observed there by one of us on a previous visit) lying on its side against a wall, quite unconcealed. Its purpose is said to be akin to that of a padded cell – a place where a person can come to feel the pointlessness and futility of his



The "blue bed".

[43] This was the term used in the submission of the Deaths in Custody Watch Committee to the UN Committee against Torture: see footnote 6, above. Director General's Rule 2K is the formal source authorising its use.

own aggression or "acting out", eventually exhausting himself if he continues to struggle. The purported purpose is not just to control but also to be in some sense therapeutic, preventing self-harm, and its usage is meant to be short-term until the main objective can be achieved. Of course, it is claustrophobic in its effect, and there can be no doubt that it is capable of abuse – for punishment rather than prevention. The prisoners fear it.

4.5 It is not easy to draw these assertions and comments together in a reliable way. However, it is absolutely inevitable that, in dealing with punishment and close supervision prisoners, officers must use force from time to time; and it is likely that the frequency and extent of such force sometimes may go beyond what is, according to objective and retrospectively applied criteria, strictly necessary or appropriate. However, the evidence of this inspection suggests that these occasions are likely to be "one-off" or incident-driven rather than systematic or planned.

4.6 Having said this, allegations of brutality that cannot be convincingly refuted constitute a significant political and correctional system risk. It is not good management of that risk to rely on the fact that prisoners may not be able to prove allegations; the Ministry must be in a position to disprove them. Thus, the most robust way of guarding against these risks is to have comprehensive record-keeping practices in place that are, in turn, indicative of effective accountability processes. From this perspective, the Casuarina practices are defective.

4.7 For example, there is no register of the use of the "blue bed". We asked officers when it had been last used, and received vague answers ranging from "last spring" to "at least seven months ago". How could more reliable information be obtained? We were told that each incident would be recorded in the Occurrence Book records of the day. In other words, to check the extent of its usage would require that we went through months of Occurrence Book records – a fatuous exercise. Moreover, even if we did stumble across a relevant entry, all that it would show is the fact that the bed had been used and the name of the prisoner, possibly with a very brief description of the triggering incident, signed off by the senior officer in charge of the Unit on the particular day.

4.8 To meet desirable standards of accountability, a proper record-keeping system should be created along the following lines:

- The register would be specific to usage of the blue bed;
- It would be readily retrievable in hard copy and computerised format;
- The record would contain full particulars including:
  - a detailed statement of the reasons for use and thus the reasons for not using some alternative;
  - the time at which the prisoner was first restrained;
  - the names of the officers who were involved in the cell extraction or other event immediately preceding his being put under restraint;
  - a notation of his physical and mental condition once under restraint; and
  - a statement that the duty medical officer had been notified and asked to attend;
- This would all be signed off by the senior officer;

- The duty medical officer would then note and sign off the time of his/her arrival, observations made of the prisoner, any action taken or recommended, and the time scheduled for the next visit;
- The Assistant Superintendent Incident Management should also attend and note the actions taken, his or her own observations of the prisoner, and any instructions issued;
- If available, the Prisoner Support Officer should be asked to attend;
- These processes should be repeated at regular intervals during the period of restraint; and
- The Superintendent should attend at or immediately after the time that the prisoner is released back into his cell, interview him and note and sign off any complaints made by the prisoner.

4.9 This may sound elaborate. But use of the most extreme form of restraint in the most closed part of the most closed prison in the State must be logged in a way that facilitates accountability. *Record-keeping protocols must match the seriousness of the events and the political and management risks that they pose.* At the present time, allegations of abuse mostly fall into the category of "not proven" – assertion and counter-assertion. Records must be kept in a way that enables all such events to be properly scrutinised; this is the best form of protection against unfounded allegations and the optimum way of ensuring that the public interest in maintaining justice within the prison system is assured.

4.10 Similar comments can be made as to the use of chemical agents – which, according to prisoners, is quite a common event - and of major force, such as batons and shields. Record-keeping is deficient. In the case of CS or OC aerosol dispensers, there is no central register of how often canisters are replaced in the Unit. In other words, it is not even possible to gain a reliable picture of the gross amount of usage within the Unit, let alone some information about the circumstances of particular events.

4.11 Management has evidently grasped that this is not good enough, and on 3rd November 2000 – five weeks before our inspection – new forms were introduced relating to cell extractions and the use of chemical agents. However, no properly completed examples of these forms could be shown to us. Moreover, in themselves they certainly go nowhere near meeting the desirable standards.

4.12 A system of specific registers akin to that suggested in paragraph 4.8., above, is required for these matters also. It is not sufficient to enter them up on the TOMS IT system, as was suggested to us, where they become swamped in (literally) millions of items of generic management information and where inevitably the required detail must be stripped out for data entry purposes.

STAFF SAFETY

4.13 This has already been commented upon in paragraph 2.4., above. Safety was a daily concern, and officers said that one of the best things about working in the Units was the strong mutual trust that they had in their colleagues. It was our own observation that standard prisoner interactions and movements were carried out with confidence and competence. It was this that, perhaps, explained the paradox of officers telling us that their job was a dangerous one, yet not presenting as people who felt they were under threat as they went about their daily routines.

4.14 It was on this account that existing staff were resistant to the employment of women officers in the Units and sceptical as to their ability to discharge the necessary duties (see paragraphs 2.2. and 2.16., above, and

5.12., below). It is our own belief that the two things – staff safety and the employment of women officers – are not irreconcilable and that the first may actually be enhanced by the second.

PRISONER SAFETY FROM OTHER PRISONERS

4.15 The high protection prisoners welcomed the safety, predictability and stability of their situation (paragraph 1.18., above). The safety aspect exceeded what they could expect anywhere else in the prison system. Their lives, though circumscribed, were tolerable (paragraph 3.28., above). On the other hand, sufficient attention was not paid to the question of whether their cases could be managed so as to advance them to a different setting.

4.16 Some of the Level 3 SHU prisoners also welcomed the fact that they did not have to associate with mainstream prisoners (paragraph 3.29., above). However, despite having personal locks to their cells, there was some evidence to suggest that they were not always safe with each other. We were told that, if there were disputes within the Unit, officers would turn a blind eye whilst the antagonists went down to the far end of the Unit to sort it out for themselves. As with many assertions we heard, it was not easy to assess their accuracy; there is an endemic tendency to generalise and exaggerate in these closed environments. Nevertheless, the unanimity of prisoners about this causes us to tend to the view that this may occasionally have happened, though it is certainly not the standard form of dispute resolution. If this is correct, it is completely unacceptable - irreconcilable with the omnipresent duty of care imposed upon prison authorities. However, on the basis of a single inspection, we cannot take the matter any further.

SUMMARY

4.17 Safety factors are complex; prisons can be predatory and intimidatory environments. We have documented some problems found in the Units. However, on balance the atmosphere in the Units has a degree of orderliness that exceeds what is found in comparable Units in other Australian States and overseas.

Chapter 5

MANAGEMENT

HEAD OFFICE MANAGEMENT

5.1 Management of the Units has been characterised by passivity and drift. The mere fact that the basis for management of the SHU remains the 1991 Director General's Rule 3N, promulgated as a start-up when the main prison was opened, gives cause for concern, as radical changes have occurred in the size and profile of the WA prison population since that time.

5.2 Perhaps recognising this, the then Director General, Dr McCall, initiated a review of the SHU in 1996. That review[44] identified many of the same problems that were evident during our own inspection: for example, confusion as to entry criteria and exit guidelines; lack of case management; inadequate information for prisoners as to the reasons for their admission; the need for access to programs; the problem of too narrow a staff recruitment base. The report was adopted and sent on to the Director of Prisons for implementation. Thereafter, it stalled. By July 1997 a further report had been written about the report, and as far as we can tell the whole matter was lost in a bureaucratic maze shortly thereafter. The 1991 protocol thus continued to be the formal source for running the SHU.

5.3 As for the IOU, this was never used for its originally intended purpose – to receive new prisoners. From the very outset Casuarina became a high turnover prison, with the number of arriving prisoners far outstripping the capacity of the IOU to absorb them for periods necessary for induction and orientation. In 1991, therefore, it commenced its role as an area for accommodating high protection prisoners. Meanwhile, punishment prisoners as well as s. 43 and s. 36 prisoners were being sent to both the IOU and the SHU. The process of cross-designating accommodation in these areas for multiple purposes, described in footnote 18 in Chapter 1, gained momentum at this time.

5.4 The consequence is that the Units now serve a variety of purposes that are not particularly congruent with each other – thus the phrase "multi-purpose" is loosely applied to them. Management systems do not seem to have moved in line with this changing situation. A graphic example of this concerns the decision of the General Manager Prison Services to minimise or virtually eradicate the use of s. 43 orders. Line officers seemed to be unaware that this had been done or what impact it might have on the management of prisoners: see paragraphs 1.10. and 1.22., above.

5.5 In mid-2000, the Director of Metropolitan Prisons ordered a review of the SHU. The subsequent report[45] identifies many of the same problems as the earlier report, emphasises the need for clear entry criteria and exit guidelines and case management, recommends that programs should be introduced within the Unit and calls for fuller staff involvement in decisions relating to prisoners made by regular meetings of a Special Handling Unit Management Committee. A draft Director General's Rule A3 purports to pick up much of this, though it is too lean to capture fully the spirit of the report. In any case, at the time of our inspection, it had not been promulgated nor had the report been implemented[46].

5.6 Note that the 2000 report does not cover the IOU area (Areas 1-3). Yet, as has been seen, the activities of the two Units are intertwined, particularly with regard to punishment and close supervision prisoners. In

[44] The report was signed off on 29th June 1996. The review team was chaired by Mr Peter Upton-Davis and involved a wide cross-section of senior Ministry. The main recommendations are set out as Appendix 2 of this Report.
[45] The Project Manager was Mr Stephen Kelly and the report is dated 15th September 2000.
[46] As noted above, implementation was to commence as from 2nd March 2001.

1991 it was appropriate to make regulations for the SHU alone; in 1996 it was still just about defensible to commission a report on the SHU alone; but by 2000 the two Units should be considered jointly, for their problems, their staff and the issues relating to their appropriate use overlap.

5.7 A notable management failure over the years has been the ongoing breaches of clause 5 of Director General's Rule 3N – the monthly meetings of the Review Committee. As mentioned in paragraphs 2.9. and 3.25., above, quarterly meetings are the norm and the feedback to prisoners is virtually non-existent. Indeed, at the time of the inspection copies of the Minutes of these meetings were not even available in the SHU area itself. Failure to oversight this would seem to be a Head Office deficiency.[47]

5.8 This in turn has led to a situation where case management is non-existent, so that Units hold some people longer than they should. As previously mentioned, a member of the prison's senior management group told us that in his view all but three of the prisoners currently held in Level 3 SHU could with some imagination be successfully managed within mainstream. Prisoners are "over-classified" as to their dangerousness or unmanageability, therefore. This has knock-on effects that distort other aspects of prison management – notably the fact that punishment prisoners are also held in Unit 1: see paragraph 1.6., above.

5.9 Another Head Office management failure relates to record keeping. As mentioned in Chapter 4, paragraphs 4.1 – 4.12., records are quite inadequate in relation to a range of high risk matters – notably, the use of the "blue-bed", chemical agents and other restraints. Although it might be thought that this reflects local failures at Casuarina itself, it has always been emphasised that the SHU is a State-wide facility and the protocols are subject to Head Office direction.

5.10 In this regard, it must be said that the survey results indicated officers' views that they did not see nearly enough of the senior Head Office personnel. They believed they were running one of the most important and difficult parts of the State prison system, and that senior managers should be more directly apprised with what they were doing. We cannot comment on whether this observation is correct, merely that it is a strongly-held perception. Of course, on-the-ground visits are not the only way of staying in touch, though they are undeniably one of the best.

LOCAL MANAGEMENT

5.11 Officers said that local managers in the Units regular visited the Units, and they appreciated this. Even though in a sense local management should accordingly have been more familiar with issues that concerned officers, there are more excuses for local management failures. For they have been operating within a policy vacuum. Nevertheless, some matters could have been handled better.

5.12 A key example relates to recruitment of staff for the Units. Following the 2000 review and report, in which a more constructive form of interaction between staff and prisoners was urged, local management called for "expressions of interest" for employment within these Units. It was entirely predictable, given the sub-culture of "mateship" that exists there (see paragraphs 2.2. – 2.5., above), that no applications were received from "alternative" sources. One female officer from the mainstream prison, for example,

[47] See again footnote 41 in Chapter 3, which points out that this failure could amount to a disciplinary offence under s. 98(1)(a) of the *Prisons Act* 1981.

told us that there was "no way" she would have applied in the face of what the Union and the predominant sub-culture wanted: see also paragraphs 2.2., 2.16 and 4.14., above. In addressing the issue in this way, therefore, local management seems to have been condoning "management from below" or, at the very least, was naïve in its expectation of drawing out new blood. Management must lead, not wait to be pushed.

5.13 There were other ways in which local management could have done better. All the "little" problems – visits, phone access, food quality and so on – which add to the frustrations of life in the Units are exactly the sorts of things they are appointed to manage. But it is understandable if, trying to run an overcrowded prison with a budget over which it has almost no influence,[48] local managers give higher priority to the mainstream part of the prison.

5.14 Record keeping has already been mentioned; expectations must be set from the centre. Nevertheless, some issues are so crucial for local management that systems should be in place whether the Head Office has required this or not. Examples include self-harm incidents – crucial to any manager's ability to manage a prison.

LINE MANAGEMENT

5.15 The tone of the Units comes back to the attitudes of line managers – senior officers in the Units themselves. We have seen that these were in many ways somewhat negative – no more contact than was necessary, reluctance to get involved in "welfare" matters, inclined to let prisoners sort out their own problems with fist fights – though this picture was by no means uniform and we also saw positive aspects. The 1996 and the 2000 inquiries and reports highlighted the need for a changed culture, and we share that view. This can only be achieved if line managers positively set out to encourage and bring about change.

SUMMARY

5.16 Prisons throw up so many acute problems that those that are merely chronic are often allowed to drift. That seems to have happened with the SHU and IOU units. Passivity has been evident at all management levels. Yet this is not because the problems have been unnoticed or undiagnosed. On the contrary; they have been perceived at the highest management levels from where it is possible to commence the process of change, as the 1996 and 2000 reviews demonstrate. Of course, diagnosing the problems is the easy part; implementing changes is much more difficult. The history of these Units is that of managerial passivity in the face of the challenge of implementing change.

[48] The Inspector has been told at various prisons around the State, including Casuarina, that for 2000/2001 Head Office sent budget figures to superintendents rather than seeking prior inputs as to their needs, cost pressures and so on. Even though the 1999/2000 expenditure was $21m (including capital expenditure of about $2 million), the 2000/2001 was unilaterally set at $17.5.m.

Chapter 6

RECOMMENDATIONS

UNDERLYING PHILOSOPHY

6.1 As this is the first prison inspection report by the Office, our philosophy with regard to making recommendations needs to be explained. The starting point is that we do not believe that it is the proper role of the Inspectorate to make detailed recommendations about daily operational matters. Obviously in any prison that we inspect, we shall observe things that we ourselves, if we were the managers, would do differently. However, to make recommendations about such matters would be to presume that there is only one correct way of doing things. Manifestly, in day-to-day operations that is not the case. Our inspections are not compliance audits, but strategic assessments. That being so, we look to the Ministry to respond in a strategic manner.

6.2 Our hypothesis is that if strategic issues and major operational objectives are brought into focus and balance, day-to-day operational matters should follow. For example, if a case management approach is implemented in the SHU, the practice whereby officers primarily communicate with SHU prisoners through the hatch or at the officers' post will inevitably begin to change. It would be superfluous to make a recommendation about the style of communication, therefore. On the other hand, if case management were not introduced, it would be futile to try to drive change by making a recommendation about the manner of communication with prisoners.

6.3 It follows from this that, *when we do make recommendations, it will be understood that we regard the matters covered as having high priority*. We would expect that these recommendations would be rejected or ignored only in quite unusual circumstances. Conversely, other observations that we make, falling short of formal recommendations, should be noted by the Ministry of Justice, considered on their merits, and implemented, modified or even ignored on their merits. Of course, major operational or management issues meld into strategic considerations; there will always be a grey area, therefore. In summary, we wish to avoid a situation where we make a plethora of recommendations that are inadequately differentiated as to their importance.

6.4 Finally, our reports are intended to be read as a whole, so that recommendations arise naturally and cogently from the "story" that has been told. Reports should normally be reasonably short. Our target audiences are Parliamentarians, our responsible Minister, the Ministry of Justice, relevant private contractors, the media, our own Community Consultative Council, all stakeholders including other relevant government agencies, the academic world, other inspectorial or regulatory bodies in Australia or overseas who carry out comparable functions, and of course the general public either directly via our website or mediated through one or more of these other sources.

6.5 In today's world, no one has the time to read verbose documents. It is incumbent upon us to write succinctly and cogently. However, we are always available to develop and detail our recommendations further, relying on our field notes and earlier drafts of reports. We anticipate that the Ministry of Justice or our Minister or members of the Parliamentary Committee to which these reports are sent may require detailed briefings from time to time. In the case of the Ministry our standard practice[49] of sending draft reports for comment before they are finalised and tabled in Parliament provides a natural opportunity for detailed interchange, though we reiterate that we hope for strategic responses above all.

[49] This is a statutory requirement under s. 109Q of the *Prisons Act* 1981.

RECOMMENDATIONS

6.6 Our principal recommendations are based on the premise that the strategic use of all aspects of the so-called multi-purpose cells area (i.e. what we called Areas 1-5: high protection IOU, residential or Level 3 SHU, punishment/close supervision IOU, punishment/close supervision SHU and temporary placement IOU) require integrated review and that piecemeal reform is liable to be counterproductive. Our first recommendation is thus:

1. That the Ministry of Justice broaden its current review mechanisms (epitomised by the Kelly Report of 15th September 2000) to consider the appropriate use of the multi-purpose cells area, as defined.

   Specific recommendations within that overarching framework are as follows:

2. That entry criteria and exit guidelines to all areas be clarified along the lines suggested in this report.
3. That, in particular, the use of s. 36 orders be made subject to rigorous Director General's Rules so as to push accountability for the imposition of such orders to the highest levels within the Ministry of Justice.
4. That, furthermore, Rule 3V be reviewed and strict rules be imposed to regulate the circumstances in which a s. 36 order may follow upon a period of punishment.
5. That there be further review of the relationship between s. 36 and s. 43 orders.
6. That the practice of "cross-designating" cells for multiple purposes be reviewed.
7. That individual case management be actively pursued in relation to prisoners whose presence is not time-limited by the circumstances of their commitment to these areas.
8. That a Case Management Review Committee be re-established to monitor the progress of all prisoners held in these areas; that the Committee be constituted by medical, psychological and program staff as well as by uniformed officers and management; that it meet no less than monthly; that its deliberations be properly minuted and made available to prisoners to whom those deliberations relate; and prisoners be permitted to present their cases to the Committee as appropriate.
9. That planning should commence at once to enable appropriate rehabilitative and educational programs within the high protection IOU and Level 3 SHU areas.
10. That the Ministry actively attempt to broaden the employment base within these areas and in particular to recruit female officers.
11. That prisoners undergoing punishment no longer be housed in Unit 1, enabling that Unit to revert to its intended use.
12. That record-keeping in relation to major events – particularly the use of the "blue bed", chemical agents, abnormal restraints, cell extractions and self-harm incidents – be radically improved along the lines specifically set out in paragraphs 4.8.- 4.10. of this report.

13. Finally, that the overall review by the Ministry of Justice of the SHU/IOU areas recommended above take note of the need to integrate practices in the other main closed prison areas in the State – Hakea, Albany and Acacia prisons – with those at Casuarina.

6.7 This Report has commented on specific matters including communication with prisoners whose English language skills are limited, visits, exercise facilities, food, access to telephones, medical facilities, access to library books, and the occasional condonation of fights between prisoners, and we request that the Ministry take note of these and implement action that they consider appropriate.

6.8 It is our belief that the main recommendations we have made could be implemented within six months of the Ministry receiving this report in draft form. Accordingly, it is our intention to inspect these areas again before the end of 2001.

Appendix 1

TERMS OF REFERENCE AND CORRESPONDENCE

Author: Hon Peter Foss QC MLC
Telephone (08) 9321 2222
Email: pfoss@mpc.wa.gov.au

INSPECTOR OF CUSTODIAL SERVICES

CASUARINA PRISON – CONCERNS AS TO PROCESS IN IOU AND LOCK DOWN TIME

I have received correspondence from a prisoner, which relates to trends dealing with prisoners at Casuarina which, if true, would be a cause for concern.

In particular, it would indicate that prison officers were not following matters set out in the Director General's Rules.

I attach a summary of the concerns expressed by the prisoner. I would if you wish, be happy to provide the original correspondence and identify the prisoner.

I have had other indications which tend to support the allegations made by the prisoner.

Pursuant to Section 109L I direct you to investigate the allegations raised by the prisoner.

Hon Peter Foss QC MLC
Attorney General;
Minister for Justice

Wednesday, 22 November 2000

MATTERS RAISED BY PRISONER – CASUARINA PRISON

The following matters have been raised in correspondence by a prisoner at Casuarina Prison. The General Manager, Prison Services has been requested to provide a report with regard to those matters raised below:

Isolation due to placement in IOU

In the application of 'close supervision' prisoners in IOU the following procedures are followed:–

- At the end of a punishment term, prisoners remain in that cell or are moved to another in the same area and given a mattress, clock radio and $13 per week spend (at the officers' discretion). This effectively means that the prisoner is serving solitary confinement to which he has not been sentenced – it is seen as such by prisoners because there is no communication with other inmates for periods of between one and three months.
- Prisoners are denied any 'break' in order to minimise the effect of long periods of solitary.
- IOU prisoners are entitled access to the library – however, they are only being provided with boxes of books that had been withdrawn (the reason for them being withdrawn is that they are of no interest to the prisoners).
- Television is supposed to be available at the Senior Officers' discretion, but there is no television available.
- There are no contact visits which further aggravates the situation.

Increase in Lock Up Time

- Lunchtime lockup has increased from 12pm – 1:30pm to 12pm – 2pm.
- Nightly lockup – standing order directs nightly lock up at 6:55pm – however, it is actually being done at approximately 6pm.

Access to Sporting and Recreational Activities at Casuarina

- Access to facilities and equipment (including the oval) has been reducing over time.
- Each block has exercise at the same time.
- Boxing bag, speedball etc have been removed from the gym. Prisoners advised that this is because of blood borne viruses.
- If not participating in group sports, prisoners are prevented from access to gym and facilities because the requirement to qualify for gym time is being involved in organised activity.
- Access to oval has been only once per week during football season, but has not increased since football season finished. Prisoners are not permitted to use the oval on weekends.

Specific questions raised by your direction under s. 109L(2)

ISOLATION DUE TO PLACEMENT IN THE IOU.

- Some prisoners do remain there at the expiry of the punishment term. Others occasionally opt to do so. This occurs under s. 36, and is indeed a form of further 'punishment', even though not formally designated as such. On the other hand, a s. 36 device is crucial for the management of a maximum security prison. The key matter seems to be the lack of entry and exit criteria: see above.
- In cases where prisoners go straight into s. 36 close supervision after punishment, there is indeed no 'break' as is required between periods of punishment. The fact that prisoners see such management options as equivalent to formally imposed punishment is a matter of concern.
- Library access for close supervision prisoners is indeed confined to choosing from discarded books. This practice has arisen because of high damage rates amongst those prisoners. Casuarina library is part of the LISWA system and must bear the cost of damaged books. This discard system takes worn, but not unusable or unreadable, books out of the system regularly; there were five boxes with a total of about 130 books in them on the day of the inspection.

  Prisons always seem to operate on the basis of taking privileges away not only from the current muster of prisoners but also from all future musters. Consideration should be given to reinstating the system of permitting close supervision prisoners access to the library trolley and monitoring the use.
- Under existing procedures, televisions do not have to be supplied to close supervision and punishment prisoners. Most of the prisoners in Level 3 SHU and protection IOU have their own TV sets.
- Visits are normally contact visits, under escort according to the prisoner's security status.

INCREASE IN LOCK UP TIME

- Lock up time is affected by the fact that the staff in these areas also function as the back-up Recovery Team for the whole prison. We found no evidence that lock up times were being increased systematically and deliberately.

ACCESS TO SPORTING AND RECREATIONAL ACTIVITIES

- Access to the oval has not been available for a long time.
- Access to the gym is not available.
- The need for labour-intensive escorts and the fact that other prisoners must be kept away from these areas whilst prisoners from any of the closed units are using these facilities underlies these practices.

Subject: **Terms of the Minister's direction under s. 109L of the Prisons Act**

Date: Friday, 01 December 2000

From: Richard Harding rharding.inspector@mydesk.com.au

Organisation: Office of Inspector of Custodial Services

To: ksmith@mpc.wa.gov.au

Dear Karry

As discussed with you by phone on 30 November, the Minister's direction is in its specific terms confined to inspecting certain matters in the Induction and Orientation Unit. In his earlier conversation with me about the matter, he had referred to the Special Handling Unit as being the source of the problems. In fact, the nature of the regime is such that the closed units (IOU, SHU and Disciplinary Unit) are to some extent inter-dependent in their operations, particularly as to staffing matters and recreational opportunities. One cannot thoroughly deal with issues arising within one unit in isolation from the others. I shall interpret the Minister's direction in this way, therefore.

I leave it to your judgment whether you believe the direction needs formal amendment, though if so I would think that acknowledgement of this message by the Minister would suffice.

Richard Harding

Appendix 2

REVIEW OF THE SPECIAL HANDLING UNIT, CASUARINA PRISON 1996

RECOMMENDATION 1.

That the SHU be retained and that it operate on the philosophical basis of responsible citizenship, with residents taking responsibility for their actions and behaviour.

RECOMMENDATION 2.

That the following policy be adopted for the management of the SHU. The SHU will be used as a placement of last resort for those prisoners who have demonstrated through their extreme behaviour, that for the safety of others they must be isolated and confined in a controlled environment. Those prisoners confined in the SHU will have individual management plans developed in order to maximize their capacity to demonstrate attitudes and behaviours that will enable them to return to the prison mainstream at the earliest possible opportunity.

RECOMMENDATION 3.

That the proposed SHU inclusion/exclusion and exit criteria be adopted as policy.

RECOMMENDATION 4.

That a formal process of referral/admissions assessment be implemented, based upon the policy of maintaining admissions at a minimum level and reducing stay in the SHU to a minimum. Further assessment is needed post-admission, this assessment would form the basis of the case management plan, interventions and criteria for exit.

RECOMMENDATION 5.

Major changes be made to the SHU complex to make it a more positive environment for both staff and residents. These changes would include putting a garden, painting the unit and maximising the amount of natural light coming into the unit courtyards.

RECOMMENDATION 6.

That the principle of graduated progressive return to mainstream activities be adopted. The details of these should follow from the case management plan. Access to mainstream activities should be implemented unless it can show to represent a danger to other prisoners or staff. This would include access to the oval and other recreational facilities on a structured bases.

RECOMMENDATION 7.

That, except where it endangers the safety of others, residents be fully advised of the reason for their placement in the SHU and the requirements they must fulfil to exit from there as expeditiously as possible.

RECOMMENDATION 8.

That group and individual behavioural intervention programmes be developed for the unit. Additionally educational and other formal and informal activities be introduced into the unit and that a budget be allocated for that purpose.

REVIEW OF THE SPECIAL HANDLING UNIT, CASUARINA PRISON 1996

RECOMMENDATION 9.

That the SHU staff selection, training and duty requirements be reviewed as a matter of priority to ensure that these requirements mirror the new practice and philosophy of the unit.

RECOMMENDATION 10.

That a psychologist or other appropriately qualified professional be dedicated to the unit. This person would be responsible for coordinating the assessment and behavioural change programmes and the training and development of SHU staff to assist in these programmes.

RECOMMENDATION 11.

That the Superintendent of Casuarina be responsible for the successful implementation of the new SHU. The implementation process will be overtly supported by the prison executive. To mark the transition the SHU should be re-named.

Appendix 3

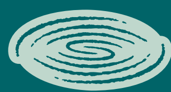
MINISTRY OF JUSTICE ACTION PLAN SUBMITTED IN RESPONSE TO THE INSPECTION REPORT

Attachment 1: Ministry of Justice Action Plan for Specific recommendations of Inspector of Custodial Services` Report of an unannounced inspection of the Special Handling Unit and Induction and Orientation Unit at Casuarina Prison, 11-12 December 2000.

Inspector of Custodial Services` Recommendation	MOJ Response (March 2001)	MOJ Officer(s) Responsible for Action	To Be Actioned By (Date)
1 MOJ broaden its current review mechanisms (epitomised in Kelly Report) to consider appropriate use of the multi-purpose cells area.	Agreed.	Steve Kelly and Superintendent Casuarina Prison (Jim Schilo)	Before August 2001
2 Entry and exit criteria to all areas be clarified.	Agreed.	Superintendent Casuarina Prison	Before August 2001
3 Use of s36 orders be made subject to rigorous DG`s rules so as to push accountability to the highest levels within MOJ.	The ability of Superintendents to exercise the broad provisions of s36 are important to ensure the good order and management of the prison. However, the issue of greater accountability will be further examined.	General Manager Prison Services	Before August 2001
4 Strict rules be imposed to regulate circumstances in which s36 order may follow a period of punishment.	It appears that reference to a s36 order relates to use of close supervision after a period of confinement. Close supervision may follow a period of punishment and new DG`s rules have been drafted to provide improved regulation of this practice.	Executive Director Offender Management	New DG`s rules already drafted.
5 Further review of the relationship between s36 and s43 orders.	The only relationship between s36 separate confinement and s43 order is that s36 confinement may be used pending s43 approval.	N/A	N/A
6 The practice of cross-designating for multiple purposes be reviewed.	The multi-purpose use of cells is necessary for flexibility at this time, but will be kept under review.	N/A	N/A
7 Individual case management be actively pursued in relation to prisoners whose presence is not time limited by the circumstances of their commitment of these areas.	Agreed (for all prisoners, not just those on indeterminate placements)	Superintendent Casuarina Prison and Steve Kelly	Before August 2001

MINISTRY OF JUSTICE ACTION PLAN SUBMITTED IN RESPONSE TO THE INSPECTION REPORT

Inspector of Custodial Services` Recommendation	MOJ Response (March 2001)	MOJ Officer(s) Responsible for Action	To Be Actioned By (Date)
8 A case management review committee be re-established to monitor the progress of all prisoners held in these areas; the committee be constituted by medical, psychology and program staff as well as uniformed officers and management; meet no less than monthly; deliberations be properly minuted and made available to prisoners to whom it relates; prisoners be permitted to present their cases to the committee as appropriate.	Mainstream improvements (such as Individual Management Plans and case management) will provide a better standard of case management. High protection prisoners will be managed in this way. All other prisoners (ie. designated SHU, or those who are not high protection but have been held in the area for more than one month) will be overseen by the case committee.	Superintendent Casuarina Prison	Before August 2001
9 Planning should commence at once to enable appropriate rehabilitation and education programs within the high protection IOU and level 3 SHU.	Agreed.	Superintendent Casuarina Prison	Before August 2001
10 MOJ actively attempt to broaden the employment base within these areas and in particular to recruit female officers.	Agreed.	General Manager Prison Services	Before August 2001
11 Prisoners undergoing punishment no longer be housed in Unit 1, enabling that unit to revert to its intended use.	A degree of flexibility in the use of Unit 1 is required, especially with current prisoner numbers.	N/A	N/A
12 Record keeping in relation to major events - particularly “blue bed”, chemical agents, abnormal restraints, cell extractions and self-harm incidents - be radically improved along the lines specifically set out in para 4.8 - 4.10 of this report.	Agreed.	General Manager Prison Services	Before August 2001
13 The overall review by MOJ of the SHU/IOU areas recommended above take note of the need to integrate practices in the other main closed prison areas in the state - Hakea, Albany and Acacia prison - with those at Casuarina.	Agreed.	General Manager Prison Services	Before August 2001



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