

Critical Incident Review into the events at Greenough Regional Prison on 24-25 July 2018

Jan Shuard PSM
21 November 2018



CONTENTS

ACKNOWLEDGEMENTS	1
EXECUTIVE SUMMARY	2
RECOMMENDATIONS	7
CHAPTER 1 TERMS OF REFERENCE, SCOPE AND METHODOLOGY	12
Terms of reference	12
Scope of the Review	12
Methodology	13
CHAPTER 2 OVERVIEW OF GREENOUGH REGIONAL PRISON	15
Brief history	15
Operating model	15
Prison operating capacity	17
Was Greenough over-crowded?	18
Who was at Greenough on 24 July 2018?	18
Prisoner demographics	19
Staff demographics	20
CHAPTER 3 SIGNIFICANT DEVELOPMENTS 2017-2018	22
Overview	22
Modifications to prison routine	22
Budget and use of overtime	24
Staffing review	25
Consultation with WAPOU and growing concerns in July	25
Effective communication in a period of change	27
Monitoring prison performance	28
CHAPTER 4 WHAT HAPPENED ON 24-25 JULY 2018?	29
Introduction	29
Chronology of events	30
CHAPTER 5 EMERGENCY MANAGEMENT	40
Legislative and policy framework	40
Prevention	42
Infrastructure	43
Security	44
Preparedness	49
Review of emergency management policies	49
Emergency training exercises at Greenough	49
Multi-agency arrangements	50
Special Operations Group	51
Response	52
Immediate response by prison staff	52

Establishing an Incident Control Facility and Incident Management Team	53
Activating resources from Corrective Services Head Office	54
Community safety – protection of the perimeter	56
Escape.	57
Safety of women prisoners	58
Special Operations Group and the multi-agency response	60
What worked well	61
Emergency Management Act 2005.	61
Safety of staff	62
Safety of prisoners	63
Forced surrender tactical options.	63
Recovery	64
Initial recovery plan.	64
Debriefing processes.	64
Staff welfare	66
Additional staff resources.	67
Prisoner management	67
Infrastructure.	68
Update on general purpose beds.	68
CHAPTER 6 CAUSES AND CONTRIBUTING FACTORS	69
Overview	69
Increasing lockdowns under the adaptive routine	71
What changed after March?	74
Impact of the adaptive routine on service delivery.	75
Education	75
Pre-release services	76
Therapeutic programs	76
Health services.	77
Recreation	77
Aboriginal engagement	78
Staff perceptions	79
Prisoner perceptions	80
External agency observations.	81
Independent Prison Visitor (IPV) reports	81
Governance framework.	83
CHAPTER 7 WOMEN PRISONERS AT GREENOUGH	84
Overview	84
Effect of adaptive routine on women	84
Male and female interaction at Greenough	85
Male prisoners breach into the Women’s Unit on 24 July 2018	85
Management of women prisoners post-incident.	86
Women prisoners’ perceptions	86
Future management of women prisoners at Greenough.	87
Defining a new model.	88
APPENDIX 1 MAP OF GREENOUGH REGIONAL PRISON ON 24 JULY 2018.	90
APPENDIX 2 GLOSSARY.	91

ACKNOWLEDGEMENTS

As the former Commissioner of Corrections Victoria, I was appointed to lead the Review and came to the task equipped with more than 34 years' experience in the field of Corrections.

Throughout this assignment I have been assisted by a team of five capable Departmental staff. Without their knowledge of the Western Australian Corrections system, dedication and expertise, the Report would not have been possible. Adrian Rivalland structured the project with the discipline it takes to deliver such a complex piece of work in a timely manner. Superintendent Jan Allen ACM provided her wise guidance on the policies and practices that govern Corrective Services and contributed her wealth of knowledge on standards for women prisoners. Jamie Richards' expertise in the Department's information systems and skillful analysis of data has been invaluable. Karen O'Sullivan led the writing of the report with outstanding skill. The team were all supported by Thea Bradley whose administrative assistance and record keeping were superb.

I am also grateful for the extensive and generous cooperation we received from the Superintendent and his team at Greenough, and other staff across the Department. They knew that our task was to conduct a thorough, independent examination of their workplace, and to recommend change where we judged it to be beneficial, and they continually displayed openness and transparency throughout the process. Their assistance allowed us to establish the facts and concentrate on what could be improved.

Finally, it is hard to imagine that the Review could have been better supported by the Director General of the Department of Justice and the Commissioner Corrective Services, both of whom were insightful and open to the learnings we identified. They are well aware of what has to be done to further advance the Corrections system in Western Australia. This Report aims to assist them and others to take the system forward.



Jan Shuard PSM

EXECUTIVE SUMMARY

This Critical Incident Review was commissioned by the Director General of the Department of Justice, Dr Adam Tomison, on 3 August 2018, in response to the serious events that occurred at Greenough Regional Prison on 24-25 July 2018.

Overview of the events of 24-25 July

Tuesday, 24 July 2018, commenced in what had become the normal fashion at Greenough over the previous three months. There were not enough prison officers to cover the roster and an 'adaptive routine' was implemented. This meant that a number of vocational support officers were redeployed to cover prison officer positions, some scheduled activities were cancelled, and rolling lockdowns occurred confining prisoners to their Units and cells for different periods throughout the day.

At approximately 4.00pm, a fire broke out in Cell 22 of Unit 2; one of the male accommodation units in the secure section of the prison. While prisoners from the Unit were being evacuated to safety, some began throwing projectiles at staff. Others joined in, and the riotous behaviour escalated rapidly, spreading into Unit 3. Amidst the growing chaos and disorder, a group of prisoners ascended onto the roof, broke into the maintenance workshop and used an unsecured battery-operated angle-grinder to cut chains and release two ladders stored in the workshop. They used the grinder to cut a padlock securing a staff access gate, allowing them to breach the internal perimeter fence, and then used the ladders to scale the external perimeter fence. By 4.52pm, ten prisoners had escaped the prison.

While the escape was occurring, and the riot was continuing to gain momentum in Units 2 and 3, other male prisoners had breached the Women's precinct within the prison. At 4.29pm, male prisoners were first observed inside the Women's precinct and 15 minutes later they were inside the accommodation unit. Some women were cut free from their cells and joined in the riotous behaviour, but many remained in their cells in distress and fear. The Women's Unit was trashed, fires were lit and the Unit was not able to be secured until ten past midnight by the Special Operations Group; nearly seven hours later.

While the majority of prisoners surrendered early during the disturbance, a group of approximately 30-40 prisoners continued to riot well into the night, armed with projectiles, Molotov cocktails, chemical agents, batons and tools. Other fires were lit within the prison, including a serious fire in Unit 3, creating life-threatening smoke which required the evacuation of more than 100 secured prisoners onto the oval. Extensive damage was caused across the prison. It was not until almost 4.00am the following morning that order was fully restored, and almost 6.00am before all prisoners were secured and accounted for.

This series of events involved three distinct critical incidents: the riot (including fires), the escape and the breach into the Women's Unit by male prisoners. Each is a critical incident in its own right. Together, they constituted a sustained and grave loss of control at Greenough.

It is fortunate that there was no loss of life and no serious physical injuries; to staff, prisoners or members of the public. This is a credit to the Greenough staff, who methodically secured surrendered prisoners and evacuated areas when they became unsafe, in a chaotic and complex situation involving multiple incidents. Their defensive actions, along with the swift response of WA Police Force and their apprehension of the escapees, are to be commended. The combined agency response to the critical incident involving Greenough officers, the Special Operations Group and the WA Police Force also contributed to its safe resolution.

The purpose of this Review

The purpose of this Review was not to attribute fault to particular individuals involved in the critical incident. Rather, the terms of reference required the Review to:

- examine the events and circumstances surrounding the incident;
- establish any factors that may have caused or contributed to the events;
- examine the adequacy of the emergency management response during the incident; and
- make recommendations for the management of offender cohorts, particularly women, and other strategies to mitigate any identified system weaknesses.

Factors that contributed to the critical incident

The Review found that there was no specific ‘spark’ or catalyst that triggered the riot or the escapes on the day of the critical incident. Rather, there were a number of inter-related factors that are likely to have contributed to an unstable prison environment leading up to the incident; and other factors that amplified the scale and seriousness of the incident.

As evidenced by previous reports by the Inspector of Custodial Services, Greenough is a prison that has long been under pressure. The Inspector’s November 2016 Report identified a number of problems at Greenough, many of which do not appear to the Review to have been properly addressed in the intervening period.

The Review found that the following factors contributed to the critical incident:

- First, the increasing frequency of lockdowns from March 2018 and implementation of the ‘Adaptive Routine’ following the signing of Standing Order E6 and the Daily Staff Deployment Agreement at Greenough. This resulted in constant uncertainty and disruption to normal routines for both staff and prisoners; and increasing limitations on access to work, recreation and services which led to frustration, disengagement and boredom among prisoners.
- Secondly, the underlying reason for the increasing frequency of lockdowns under the Adaptive Routine from March 2018 was increasing staff shortfalls within a tight fiscal environment. This included a cap on the number of overtime shifts the prison could use to fill vacancies on the roster, noting that exceptions could be made if there were grounds to believe the prison was unsafe or adversely affected. The adequacy of staffing levels at Greenough and ongoing vacancies on the roster was a recurring theme throughout the Review, and this issue underpins many of the other contributing factors. The question of how many staff it takes to run Greenough safely and securely is ultimately a matter for the Department and the Superintendent to determine in consultation with staff and the Union.
- Thirdly, a decline in attention to infrastructure and security at Greenough also directly contributed to the scale and seriousness of the critical incident. The prisoners’ ability to easily breach the fences between Unit 2 and Unit 3, and the fence into the Women’s Unit, allowed the initial disturbance to escalate rapidly into a full-scale riot. The prisoners’ ability to access an unsecured battery-operated angle grinder and ladders from the maintenance workshop inside the prison directly facilitated the escape of ten prisoners. Once the rioters had the run of the prison and access to fuel and improvised weapons, this severely constrained the emergency response options. These are all examples of poor physical and procedural security and require serious attention at Greenough.
- Fourthly, a lack of engagement with Aboriginal prisoners may also have contributed to the events of 24-25 July. Given that 70% of the total prisoner population at Greenough were Aboriginal, their needs should have been at the centre of the prison’s operating model in accordance with the Department’s values and expectations.

- Fifthly, the absence of a robust risk management process and governance framework at Greenough meant that not enough was being done to monitor the impact of the increasing lockdowns and the potential risks this posed to the security of the prison. Communication with staff and prisoners in this time of major change was also not as good as it should have been, with concerns about the rising tensions in the prison not receiving enough attention. There was also an absence of any active monitoring of the recommendations from previous reports by the Inspector or departmental audits at the local level.

Each of these issues played a part in the events of 24-25 July; and were also identified by the staff and prisoners interviewed by the Review team.

It is equally true, however, that responsibility for the critical incident also lies with the prisoners themselves. Those prisoners that chose to instigate or become involved in the riot, destroy property, trash units, set fires, attack staff and/or escape, are individually responsible for their own unlawful actions and must be held to account.

Emergency response

The Review identified a number of failures in each of the key areas of emergency management: prevention, preparedness, response and recovery. Most significantly:

- There was an unacceptable delay in protecting the external perimeter of the prison at the outset of the riot, and in responding to the initial activation of the perimeter security system alarms;
- There was an unacceptable delay in securing the safety of the women prisoners in Unit 4 – noting that there was no pre-prepared safety plan for the protection of women prisoners at Greenough in the event of an emergency;
- There was no properly-equipped secure space at Greenough from which to run an Incident Control Facility ('ICF'); and
- Contrary to the Department's own policies:
 - Greenough did not establish a formal Incident Management Team during the emergency to ensure that key functional responsibilities were clearly assigned (such as communications and logistics); and
 - Corrective Services Head Office did not establish a formally structured ICF with a functional Incident Management Team.

Had these matters been attended to, the scale and seriousness of the critical incident may have been better contained, and the recovery process for staff may have been easier.

In addition, the Review also found that there was a general lack of emergency preparedness at Greenough and across the Department. Key policy documents had not been reviewed, the critical MOU with the WA Police Force was out of date, and emergency practices and procedures were not well practiced at Greenough. The Review is aware that the Department is currently in the process of reviewing its emergency management system. There is a recognition that more must be done to embed an emergency management capability across Corrective Services.

These matters should not, however, detract from the positives. By all accounts, the Greenough officers were professional and courageous in their endeavours to contain the incidents of 24-25 July, despite not having recent training and suitable equipment. Their response was characterised by sensible decision-making in a time of crisis, with preservation of life and the safety of staff and prisoners remaining a priority throughout the course of the events.

Cooperation between the prison, WA Police Force, DFES and the Corrective Services Special Operations Group also worked very well throughout the incident, and this is a credit to the strong relationships that have been built in Geraldton and between the Department and other agencies. The SOG-led response to regain control of the prison was by all accounts excellent.

Women prisoners

The events of 24-25 July have shone a light on a number of issues relating to women prisoners at Greenough.

As noted above, the breach into the Women's Unit by male prisoners was a critical incident in its own right. While acknowledging that there were efforts by staff to monitor the women's welfare throughout the events and to defend the Unit, there was no pre-prepared safety plan to protect these women in the event of an emergency. The infrastructure, and prisoners' access to tools, failed to keep them safe.

The Review found that the post-incident management of women prisoners was generally handled well. Women prisoners were transferred to the metropolitan facilities of Bandyup and Boronia, and a dedicated and thoughtful strategy was put in place to ensure the continuation of services for those women affected.

More generally, the Review also found that the current operating model for managing women prisoners at Greenough is not working. The approach is neither integrated with, nor fully separated from, the male section of the prison. As previously identified by the Inspector, there has been ongoing tension between male and female prisoners at Greenough, given their close proximity to one another, and very few opportunities for meaningful and respectful interaction. The increasing lockdowns in 2018 were also thwarting the women's ability to attend program appointments and access services.

It is now incumbent on Greenough and the Department to develop a short, medium and long-term strategy for the management of women prisoners at Greenough. These strategies must take into account the fact that most of the women at Greenough are Aboriginal (73% on the day of the incident) and most come from the Mid-West or northern regions (57% on the day of the incident).

In the long term, the Review recommends that consideration be given to establishing a separate 'prison within a prison' for women prisoners at Greenough, using a culturally appropriate and gender-informed approach. The new women's section must be completely secure from the men's section of the prison and be self-contained with adequate services, so that women do not need to be escorted past male prisoners to attend an appointment or go to work. This will require an investment in new infrastructure. In the meantime, meaningful, supervised activities between male and female prisoners should be organised on an optional basis, recognising cultural sensitivities.

The Department would be wise to use the learnings from the critical incident as an opportunity to turn things around for women at Greenough.

Recommendations

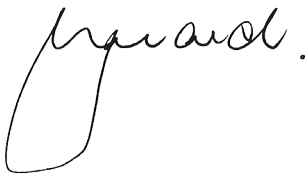
On the basis of the findings outlined above, the Review has made eleven recommendations to the Department on areas that require major improvement. Some of these matters are already in the process of being attended to. I have aimed to ensure that each recommendation is practical, achievable and measurable; however, some will require investment.

I have also included a list of additional matters for attention. These are ancillary matters that were not directly relevant to determining the causes of the critical incident, but nevertheless warrant further consideration.

Conclusion

The purpose and nature of a critical incident review such as this is to identify shortcomings and areas for improvement, even while acknowledging the challenging and chaotic nature of the events themselves. Prison administrators manage complex people in a complex setting, and that work often goes unrecognised. They balance risk every day, striving to create an environment where those who have harmed others have the opportunity to change; so that our communities are safer. It can be difficult and uncomfortable for those responsible when there has been a major prison incident, and they are confronted with aspects that are found to be not as good as they should have been. But this focus on what needs attention should not overshadow the good work that is being done.

It is to be expected that the Review's findings may differ from the perceptions of some of those involved in the events of 24-25 July. The Review has based its findings and recommendations on the information and evidence available to it, and has approached its task in a fair, balanced and objective manner. I trust that the recommendations I have made will be viewed in this spirit, and that this Report will provide an opportunity to move the system forward in Western Australia.

A handwritten signature in black ink, appearing to read 'Jan Shuard'.

Jan Shuard PSM

RECOMMENDATIONS

Recommendation 1 – Staffing

The Department must immediately reassess the overall staffing model for Greenough with the objective of minimising the number of lockdowns required to manage the prison and ensuring the prison can be run safely and securely. In particular, the Department must:

- a) finalise the current Staffing Review and new Staffing Level Agreement without delay to determine the appropriate allocation of Prison Officer positions and VSO positions; as well as determine the appropriate number of management positions for Greenough;
- b) ensure that the new Staffing Level Agreement is underpinned by an agreed staffing formula that more accurately identifies the number of FTE required to cover the agreed positions, taking into account current leave entitlements;
- c) fill all management positions during any short or long term absences; and in addition, ensure that prosecution of prison charges at Greenough are actioned in a timely manner by a core group of prison officers trained to fulfil this critical function;
- d) assist Greenough to develop a local recruitment strategy in the Mid-West region targeting uniformed officers, with an emphasis on attracting Aboriginal people;
- e) support the local recruitment strategy by establishing a prison officer pre-service training course in the region; and
- f) create a casual prison officer pool for Greenough, to cover short and long-term vacancies on the roster.

Recommendation 2 – Adaptive routine

When the Adaptive Routine is implemented at Greenough, more must be done to provide prisoners with some certainty around their daily schedule and constructive activities if they are confined to Units and cells. In particular, and subject to appropriate safety and risk assessments, the Review recommends that:

- a) a daily and weekly limit is set on the frequency and duration of lockdowns (save for emergencies or security reasons), similar to the cap on the overtime shifts set by the Department in December 2017. If this limit is reached the Superintendent must be automatically entitled to use overtime to cover vacant shifts;
- b) prisoner access to employment, education and programs should be prioritised when determining which, if any, VSOs are to be redeployed as prison officers;
- c) closure of workshops and work parties should be scheduled as half-day closures, so that more prisoners can go to work even if only for half the day;
- d) there should be a more creative approach to bringing programs and services into Units, such as education, to provide meaningful activity when prisoners are confined; and
- e) suitable dayroom amenity should be provided; for example, recreational and fitness equipment in Units.

Recommendation 3 – Infrastructure and security

The Department must:

- a) complete and implement the current Infrastructure Condition Review of Greenough. In doing so, it must ensure that any proposed improvements or hardening of infrastructure (sector fences, unit offices, cell doors, roofing, windows etc.) must:
 - align with the overall operating model of the prison, including any changes to the accommodation of women prisoners;
 - align with the emergency management response model at the prison, including any changes proposed below in recommendations 4 and 5; and
 - prioritise the secure storage of tools, ladders, fuel, accelerants, security equipment (such as batons) and medications; and
- b) formalise in a Prison Order the 'Action Plan: Enhanced Security Associated with Power Tools, Ladders and Ceiling Spaces' (July 2018), and any other directives in relation to the storage of items above.

Recommendation 4 – Emergency management preparedness

The Department must immediately progress the current project to overhaul the emergency management framework for Corrective Services. The new framework must be clearly articulated, practiced, embedded, understood and grounded in a culture of continuous improvement, and encompass the following elements:

- a) a strong focus on prevention activities that must be undertaken in prisons;
- b) all executives, senior management and senior officers must be trained and assessed in the Australasian Inter-Service Incident Management System ('**AIIMS**'), including how to establish an Incident Control Facility ('**ICF**') and Incident Management Team structure;
- c) a secure ICF space must be established at Greenough that is properly fitted out with: instructions and tabards to support functional management; technology that enables real-time information sharing; copies of relevant legislation, policies and emergency management plans; detailed site maps; radios, phones, computers, and electronic whiteboards;
- d) a Head Office space that can function as an ICF must be identified and fitted out with the amenities described above;
- e) critical MOUs with other emergency agencies must be immediately updated and regularly reviewed, noting that:
 - the MOU with WA Police Force should incorporate the learnings from 24-25 July, including in relation to the command structure to be adopted when both agencies are involved in combatting an emergency; and
 - the next review of the MOU with DFES should examine the arrangements for fire services assistance during a riot where prisoners are uncontrolled and explore options to mitigate any associated risks.
- f) a schedule of practical emergency training exercises must be implemented at Greenough and across all prisons that are independently monitored and assessed (by Departmental specialists); and
- g) Greenough must immediately develop a 'Safety and Protection Plan' for women prisoners to be activated in the event of an emergency.

Recommendation 5 – Tiered emergency management response model

- a) A capability assessment must be undertaken of the current available Corrective Services emergency management response assets, including immediate local emergency response groups and the Special Operations Group ('SOG'), and how these combined resources can work together with WA Police Force to respond to critical incidents in prisons in WA;
- b) Subject to the outcome of the capability assessment and the risk profile of each prison, the Department should establish a tiered emergency response model for prisons in WA, comprising:
 - (i) First responders – A defined number of Prison Officers at each prison who, in addition to performing their regular prison officer duties, are adequately trained and equipped for primary emergency response to a level where they can contain and control critical incidents until specialist forces arrive; supported by the local WA Police Force and other emergency services if required. For prisoner unlock periods, the local roster should provide an agreed quota of these officers on-station.
 - (ii) Emergency response specialists (SOG) – These centralised highly trained emergency response specialists must have sufficient resources and 'on call' availability for deployment to prison emergencies Statewide. Ongoing training with WA Police Force specialist groups in combatting large-scale serious prison incidents should also be explored; and
 - (iii) Statewide training group – This refers to the combined resources of the primary responders at each prison location and the SOG training together in combatting emergencies two or three times a year. Where practicable, joint training with the WA Police Force should also be explored, aligned to the agreed model for deployment and command under the revised MOU between Corrective Services and the WA Police Force (referred to above in recommendation 4(e)).

Recommendation 6 – Monitoring prison performance

The Department:

- a) must improve the current 'Capability and Development' Report and 'Temperature' Report, or develop alternative tools, to more effectively monitor safety and security-risks in prisons; and
- b) to help inform the above, must work with Greenough to strengthen its intelligence culture and the processes for reporting security concerns, recognising that staff must be able to see the value in their efforts reflected in timely and useful intelligence products to inform their work.

Recommendation 7 – Governance at Greenough

Greenough must establish a stronger local governance framework. Specifically:

- a) Greenough should institute a formal 'Risk and Audit Committee' chaired by the Superintendent to be accountable for:
 - implementing and monitoring any recommendations arising from internal and external reviews or audits, and any new policies or procedures; and
 - developing a 'risk register' to monitor other risks arising in the prison, such as a major change to the operating model.
- b) Greenough must also develop and implement a more formal Communication Strategy to share information across the prison in a regular and transparent manner. The Strategy should include a yearly diary for the key committee meetings, the attendees required at each meeting, and the processes for the distribution and sharing of minutes.

Recommendation 8 – Aboriginal services

Greenough prison:

- a) must immediately establish an Aboriginal Services Committee and engage with the local Aboriginal community and Aboriginal prisoners to improve access to dedicated services and monitor quality of life measures for Aboriginal prisoners; and
- b) should be funded to facilitate the regular, active involvement of Aboriginal Elders from the local community, as part of the above process.

Recommendation 9 – Women prisoners

Greenough must develop a short, medium and long-term strategy for women prisoners at Greenough.

- a) In the short-term, Greenough must develop a plan to address the needs of any women temporarily placed at Greenough either on remand, transiting to other prisons, for family visits, or received from police, including: access to the Women's Support Officer; access to external recreation and meaningful unit and in-cell activities if an Adaptive Routine is in place; and an interim emergency safety plan if they are housed within a male unit.
- b) In the medium-term, for women who return to Greenough who are sentenced prisoners:
 - infrastructure must be put in place to ensure that women prisoners are safe, such as a fence providing complete visual and physical separation from male units;
 - access to work, education, programs and external recreation must be facilitated;
 - meaningful unit and in-cell activities must be provided if an Adaptive Routine is in place; and
 - subject to a risk assessment, an interim plan for some supervised integrated activities with male prisoners must be developed.
- c) In the long-term, Greenough should establish a separate, purpose-built 'prison within a prison' for women prisoners, adopting a culturally appropriate and gender-informed approach. The new women's precinct must:
 - be completely secure from the men's section of the prison;
 - be self-contained with adequate services so that women do not need to be escorted past male prisoners to attend appointments or work;
 - subject to a risk assessment, a comprehensive plan must be developed for supervised integrated activities with male prisoners, on an optional basis taking account of cultural sensitivities.

Recommendation 10 – Operating Model at Greenough

Given Greenough's diverse functions, the prison should develop an overarching Operating Model that clearly articulates:

- the general philosophy of the prison;
- the different types of services to be provided to the different cohorts of prisoners;
- the prison's role within the broader prison system in Western Australia;
- a commitment to putting the needs of Aboriginal prisoners at the centre of the model;
- a requirement to review the model if there are significant changes at the prison (such as an increase in the remand population or women prisoners).

Recommendation 11 – Recovery at Greenough

The Department must establish and fund a dedicated ‘Greenough Recovery Team’ on-site for 12 months to support the Superintendent and staff in restoring the prison, rebuilding confidence, and to drive the changes recommended in this Review.

OTHER MATTERS FOR ATTENTION

- The Department should consider the advantages and disadvantages of amending the *Emergency Management Act 2005* (WA) to embed Corrective Services within Western Australia’s broader emergency management arrangements.
- The Department should consider developing a formal written process for conferring powers under section 15 of the *Prisons Act 1981* (WA) on police officers during an emergency.
- The Department should analyse the data held by it relating to the offenders charged with criminal offences from the critical incident at Greenough, to identify any commonalities among this cohort and to inform a more positive and innovative approach to engaging with these prisoners and other similar cohorts.

CHAPTER 1

TERMS OF REFERENCE, SCOPE AND METHODOLOGY

TERMS OF REFERENCE

- 1.1 On 27 July 2018, the Minister for Corrective Services, the Hon Francis Logan MLA, announced that there would be an independent critical incident review into the events that occurred at Greenough Regional Prison (**'Greenough'**) on 24-25 July 2018.
- 1.2 On 3 August 2018, the Director General of the Department of Justice (**'the Department'**) appointed Ms Jan Shuard PSM¹, former Commissioner of Corrections Victoria, to lead the critical incident review (**'the Review'**).
- 1.3 On 6 August 2018, the Director General issued the terms of reference for the Review. The purpose of the Review is to:
 - *"Examine the events and circumstances surrounding the incidents that occurred on 24 and 25 July 2018;*
 - *Establish any causal or contributory factors including, but not limited to, a review of the operating model, integrity of the security systems, facility infrastructure and security practices; taking into consideration the offender cohort management at Greenough at the time of the incident and recommendations for the management of offender cohorts (particularly women) going forward;*
 - *Review the adequacy of the emergency management planning and crisis/emergency management response; and*
 - *Recommend strategies to mitigate any identified system weaknesses."*
- 1.4 The Review commenced on 6 August 2018 and provided a final report to the Director General on 2 November 2018. The report was updated to incorporate comments from relevant agencies as noted in 1.12 below and reissued on 21 November 2018.

SCOPE OF THE REVIEW

- 1.5 In accordance with the terms of reference issued by the Director General on 6 August 2018, the following matters were agreed as being outside the scope of the Review.
- 1.6 First, the Review has not sought to attribute fault or blame to individual prisoners, prison officers or other Departmental staff members in relation to the events of 24-25 July 2018. Rather, the objective of the Review is to identify the strengths and weaknesses in the structure, systems and processes in place at Greenough, and any other systemic factors that may have contributed to the riot and the escapes. Individuals that are alleged to have committed serious criminal offences during the riot and the escapes are subject to an investigation by WA Police Force and the criminal justice system.
- 1.7 Secondly, the Review was conducted independently of the WA Police Force investigation into the events of 24-25 July, which was conducted in parallel to this Review. This constrained the Review's ability to interview prisoners directly involved in the events but did not otherwise significantly hamper the Review's research and analysis. The Review liaised with WA Police Force throughout the project and did not interfere with the police investigation or criminal justice process.

¹ Public Service Medal.

- 1.8 Thirdly, the Review was conducted independently of any review conducted by the Inspector of Custodial Services, Mr Neil Morgan, in respect of the events of 24-25 July at Greenough. The Review liaised with the Inspector throughout the project and understands that his office, the Office of the Inspector of Custodial Services ('OICS'), has commenced a review focussing on post-incident recovery and prisoner welfare at Greenough. The Review has therefore limited its inquiries on this topic. The Review has also considered, and is grateful for, a number of previous OICS reports relevant to Greenough; in particular:
- *Report of an Announced Inspection of Greenough Regional Prison No. 107* (November 2016) ('**OICS 2016 Report**');
 - *Female Prisons in Western Australia and the Greenough Women's Precinct No. 91* (July 2014) ('**OICS 2014 Women's Report**'); and
 - *Directed Review into an Incident at Banksia Hill Detention Centre on 20 January 2013 No. 85* (July 2013) ('**OICS Banksia Hill Report**').

METHODOLOGY

- 1.9 As noted above, the Review was led by the Project Director, Ms Jan Shuard PSM. The Project Director was supported by a team of five staff. The Review commenced on 6 August 2018.
- 1.10 The Review:
- Conducted site-visits to Greenough on 31 July 2018, 14 August 2018, 4 September 2018 and 12 October 2018, to observe the physical infrastructure of the site, the damage caused by the riot and the security systems in place at Greenough;
 - Conducted individual interviews and group discussions with prison staff members and other Departmental staff involved in the events of 24-25 July or connected with Greenough;
 - Conducted separate group discussions with male and female prisoners that were at Greenough during the critical incident;
 - Met with the following external stakeholders connected with Greenough and the events of 24-25 July:
 - Western Australia Police Force ('**WA Police Force**');
 - Department of Fire and Emergency Services ('**DFES**');
 - WA Prison Officers' Union ('**WAPOU**'); and
 - Community & Public Sector Union/Civil Service Association ('**CPSU/CSA**').
 - Collected and analysed relevant information provided by Greenough and the Department, including documentation, data, digital and electronic records, including CCTV footage, alarm perimeter records, radio communication logs and cell call recordings made during the incident;
 - Received and reviewed written submissions made by Departmental staff lodged via email at: grpreviewteam@justice.wa.gov.au;
 - Reviewed other relevant reference material, including similar reviews on prison riots in other jurisdictions.
- 1.11 The Review analysed the available evidence and formed an independent assessment regarding what happened at Greenough on 24-25 July and the likely causes and contributing factors.

- 1.12 A draft of this Report was provided to the Department to confirm factual accuracy. WA Police Force, DFES and WAPOU were provided with sections of the Report relevant to their specific agencies for their review and comment. Each of the agencies and the Department reviewed the draft Report and provided comments, and these comments have been taken into account during the finalisation of the Report. On advice from the Department, this Report has also been redacted to remove information that was considered likely to pose a security risk to Greenough or the Corrections system more generally.
- 1.13 The Review also provided a list of interim matters for attention to the Department during the course of the review period for the Department's consideration. These matters are raised in the body of this Report and are reflected in the recommendations made by the Review. The Review was provided with a status report by the Department in relation to these matters and understands that the Department has already taken, or is in the process of taking, action to address them.

Policy Directive 41

- 1.14 The Review was guided by Corrective Services 'Policy Directive 41 – Reporting of Incidents and Additional Notifications' ('PD41'). PD41 applies to all staff and contracted service providers working within public and privately operated prisons. It establishes the standards and procedures for the reporting of 'incidents' and 'critical incidents' that occur in prisons, with the aim of ensuring transparency, accuracy and accountability.
- 1.15 Section 5.2 of PD41 defines a 'critical incident' as one that is listed in either 'Appendix 1A – Assaults – Critical and Non-Critical' or 'Appendix 1B – Critical Incidents (Other than all assaults)'. These incidents are categorised as 'critical' because they:
 - involve a serious security breach;
 - may place staff or prisoners under significant risk;
 - may place the security of the prison under significant risk;
 - involve the serious injury or death of any person on prison property; and
 - may generate significant public or media scrutiny.
- 1.16 In accordance with the requirements of PD41, the events of 24-25 July at Greenough were reported by the Superintendent of Greenough as a 'critical incident'; initially categorised as a 'prisoner disturbance' and 'roof top incident'.² The critical incident report was then updated several times as the events unfolded on 24-25 July.³
- 1.17 This Report represents an in-depth comprehensive analysis of the critical incident that occurred at Greenough, and why it occurred.
- 1.18 The Review considers that the events of 24-25 July really constituted three separate critical incidents; namely:
 - the riot (including fires);
 - the escapes; and
 - the breach into the Women's Unit by male prisoners.
- 1.19 Each of these matters constitutes a critical incident in its own right and is examined in detail in this Report. For ease of reference, however, the events of 24-25 July are referred to collectively throughout the Report as 'the critical incident'.
- 1.20 PD41 also sets out a number of post-incident requirements, including the processes for debriefing. Adherence to the various aspects of PD41 is addressed at relevant points throughout this Report.

² The reporting requirements in relation to critical incidents are contained in DCS Prison Order No 10/2016, which revokes and replaces sections 8.1 to 8.8 of PD41.

³ TOMS Report number I50873795.

CHAPTER 2

OVERVIEW OF GREENOUGH REGIONAL PRISON

BRIEF HISTORY

- 2.1 Greenough Regional Prison is located 15 kilometres south-east of Geraldton and 420 kilometres north of Perth in Western Australia.
- 2.2 Greenough was commissioned as a low/medium security prison in 1984 with capacity for 139 prisoners. It was upgraded to medium security in 1990. The prison has since undergone several infrastructure upgrades to enable the site to hold an increased number and more diverse range of prisoners. The key infrastructure upgrades to Greenough were as follows:
- In 1995-1996, a dedicated minimum security precinct for male prisoners was established at the front of the prison grounds, outside the main secure section of the prison. This is now known as Unit 6. At the same time, a self-care unit for male prisoners was established towards the back of the secure section of the prison (now known as Unit 4);
 - In 2007-2008, Unit 6 was upgraded with additional accommodation;
 - In 2011, an additional five transportable accommodation units (4 beds in each) were added to Unit 6 to house a further 20 male minimum-security prisoners; and the external perimeter fence around the main secure section of the prison was upgraded;
 - In 2012, the existing Unit 4, which had previously housed male prisoners, was modified and converted into a dedicated Unit for women prisoners. Prior to this, there were 25 women prisoners at Greenough housed within Unit 5. Unit 4 was modified and demountable buildings were installed to facilitate education and other services for women prisoners. The new women's area, sometimes referred to as the 'Women's Precinct', opened on 19 December 2012, and now has capacity to accommodate 79 women.
- 2.3 The strategy to increase the number of female prisoners being managed at Greenough in 2012 was in response to a large increase in the number of medium security women prisoners being received in the metropolitan area. At that time, Bandyup Women's Prison was the only medium/maximum security women's prison in the metropolitan area and its existing infrastructure was inadequate to support any further increases to the prisoner population.⁴

OPERATING MODEL

- 2.4 Greenough manages a diverse range of prisoner cohorts accommodating both sentenced and unsentenced prisoners, across all security ratings: minimum, medium and maximum (remand⁵ only). Greenough holds both male and female prisoners, a high proportion of whom are Aboriginal.

⁴ See OICS, *Report of an Announced Inspection of Bandyup Women's Prison No. 93* (December 2014) and OICS, *Report Female Prisons in Western Australia and the Greenough Women's Precinct No. 91* (July 2014).

⁵ For the purposes of this Report, a 'remand' prisoner means a prisoner held on a remand warrant only who is yet to be sentenced.

- 2.5 At the time of the incident on 24-25 July 2018, Greenough was organised around six different accommodation Units for prisoners, as follows:
- **Unit One** – located within the main secure section of the prison – used for male maximum security prisoners and prisoners on observation/management regimes. On the day of the incident, the unlock count⁶ for Unit One was 16;
 - **Units Two and Three** – located within the main secure section of the prison – used as standard accommodation units for male minimum and medium security prisoners. On the day of the incident, the unlock count for Unit Two and Three was 70 and 68 respectively; a total count of 138;
 - **Unit Four** is the Women's Unit – located towards the back of the main secure section of the prison, separated by a fence from Units 1, 2, 3 and 5 – which houses minimum and medium security women. On the day of the incident, the unlock count for Unit Four was 56;
 - **Unit Five** – located within the main secure section of the prison – used as self-care accommodation for male medium and minimum security prisoners. On the day of the incident, the unlock count for Unit Five was 25; and
 - **Unit Six** – located outside the main secure section of the prison – is a separate minimum security unit for men which can accommodate up to 56 prisoners. On the day of the incident, the unlock count for Unit Six was 49.
- 2.6 The total number of prisoners at Greenough on the day of the incident and an analysis of their demographic features is set out in Table 1 at paragraph 2.16.
- 2.7 As a regional prison, mid-way between Perth and the northern regions of Western Australia, Greenough is required to perform a wide range of functions. Greenough:
- serves as a receiving prison for the local catchment area, which extends from throughout the mid-west region, extending from Exmouth in the north to Moora in the south, and east as far as Wiluna;
 - provides an in-transit function for male and female prisoners transferring onto other regional areas for court appearances;
 - accommodates male and female prisoners for local court appearances or on temporary placement to have social visits with family members;
 - functions as a pre-release and reintegration facility for prisoners who are preparing to re-enter the community at the end of their custodial sentence; and
 - manages up to 79 women prisoners with varying service requirements and needs.
- 2.8 Thus, like many regional prisons, Greenough is in the position of having to provide 'all things to all people'.
- 2.9 The Review was provided with copies of Unit Plans for Unit 4 (the Women's Unit) and Unit 2 (the general purpose men's living Unit). These comprehensive plans, recently reviewed in December 2017, are designed to *"provide a detailed description of how a particular Unit will function"* and are *"the foundation upon which all aspects of unit management were built"*. They are made available to prisoners in the Units and Unit staff.
- 2.10 Both Unit Plans advise on the day to day routine for the prisoners including their times of unlock, work, recreation, visits, education attendance, medication issue and remand prisoners visit times. Essentially, the Unit Plan is a blueprint for how prisoners can expect to live their day to day lives when incarcerated at Greenough. They are intended to provide certainty to allow prisoners to plan their daily lives such as social visit planning, improving their education and undertaking activities in preparation for their re-entry back into the community.

⁶ 'Unlock count' means the number of prisoners counted by staff at the first general unlocking of cells on the day.

- 2.11 All prisoners at Greenough, regardless of their security rating, sentence status, gender or length of stay, are supposed to be managed in accordance with the routines set out in the Unit Plans. When these routines are disrupted, this creates uncertainty for the prisoners, custodial staff and contracted service providers.
- 2.12 The Review observes that while the individual Unit Plans themselves are thorough, they do not constitute an overarching clear 'operating model' for Greenough as a whole.
- 2.13 An overarching 'operating model' should clearly articulate the general philosophy and direction of the prison and the different types of services that must be provided to the different cohorts of prisoners; not simply by Unit or security rating but according to their different needs. It should also articulate the prison's role within the broader prison system in Western Australia. This would then provide the basis for a local monitoring framework to ensure that Greenough is delivering services within the intent of the operating model. Any significant changes to operations at Greenough, such as prisoner cohort profiles, staffing levels or modified routines, could then trigger a review of the model.

PRISON OPERATING CAPACITY

- 2.14 As noted above, at the time of the riot, prisoner accommodation at Greenough was organised into six different residential units. The number of cells and beds within each unit is detailed in the table below⁷.
- 2.15 'General purpose beds' are beds in a standard cell used for the accommodation of prisoners on a normal regime.
- 2.16 'Special purpose beds' are beds used for short periods of time for a particular purpose and include infirmary, management/punishment or observation/crisis care.

Table 1 Prison Accommodation

Unit	Accommodation Purpose	No. of Cells	No. of General Purpose Beds	No. of Special Purpose Beds
One	Maximum-security accommodation and management regimes for men	17	34	6
Two	Standard accommodation for men	22	70	0
Three	Standard accommodation for men	21	69	0
Four	Standard and privileged accommodation and management regimes for women	48	79	6
Five	Privileged accommodation for men	13	25	1
Six	Minimum-security accommodation for men	56	56	
TOTAL		177	333	13

- 2.17 As at 24 July 2018, Greenough could accommodate 333 prisoners in general purpose beds across 177 cells. There were 254 male beds and 79 female beds.
- 2.18 Of the 177 general purpose cells, 101 had more than one bed. Specifically, there were:
- 76 general purpose cells with one bed;
 - 71 general purpose cells with two beds;
 - 21 general purpose cells with three beds (male);
 - one general purpose cell with four beds (male); and
 - eight general purpose cells with six beds (male).

⁷ Data provided by the Department on 12 September 2018.

- 2.19 Greenough also had 11 special purpose cells. These cells contained a total of 13 beds used to manage prisoners on management regimes or in crisis; for example, at risk of self-harm. Of the 11 cells, there were:
- 7 male special purpose cells – containing 7 beds; and
 - 4 female special purpose cells – containing 6 beds.
- 2.20 The above figures and configurations have not changed over the previous three financial years.

Was Greenough over-crowded?

- 2.21 Following the events of 24-25 July, there was much commentary on the question of whether Greenough was 'over-crowded'. It was not possible for the Review to undertake a detailed assessment of the physical conditions for prisoners in their Units at Greenough in order to fully answer this question, because of the destruction caused by the riot and reduced prisoner population.
- 2.22 However, the Review established the following facts:
- Greenough has increased its capacity by 194 beds over the life of the prison; noting that some of this expansion included new infrastructure, including the minimum security section outside the secure section of the prison (Unit 6);
 - it was noted by the Inspector in the OICS 2016 Report that some of the prison's facilities were simply too small for the prison population, with education, health and visits being the main areas affected;
 - in the twelve months leading up to the riot, from 24 July 2017 to 24 July 2018, the average daily population at Greenough was 300 prisoners, with the maximum count (on any single day) being 319 prisoners;
 - on the day of the critical incident, the total unlock count for Greenough was 284 prisoners; this represented 85 percent of the general purpose bed capacity; and
 - there had not been any significant increase in the number of prisoners over the last three years at Greenough, with the daily average population for 2015-16, 2016-17 and 2017-18 being 293, 320 and 301 respectively.
- 2.23 The above facts indicate that Greenough is certainly a crowded prison. However, the capacity and number of prisoners accommodated in cells and Units has not substantively changed in the last three years. The Review has therefore concluded that the question of whether Greenough was crowded or 'over-crowded' was not a direct cause or contributing factor to the critical incident. The Review does note, however, that in the three months leading up to the critical incident there was a marked increase in prisoners being locked down in cells and confined to Units (discussed in detail in Chapter 6). This is likely to have amplified the effect of the crowded conditions and added to prisoner frustrations.

WHO WAS AT GREENOUGH ON 24 JULY 2018?

- 2.24 To appreciate the operating environment leading up to the events of 24-25 July, the Review analysed demographic data relating to prisoners and custodial staff that were at Greenough on the day of the incident. In summary, the Review found that:
- Of the male prisoners housed within the secure section of the prison – where the riot broke out – 40% were unsentenced; the majority (56%) were aged between 23 and 37 years and 15% were young prisoners under 23 years of age. Almost two-thirds of the prisoners were local (from the Mid-West region) and 73% were Aboriginal;

- The custodial staff at Greenough on the day of the incident were a mature, experienced and stable group. The average length of service for prison officers was 11 years, increasing to more than 15 years in the senior ranks; and
- Retention rates over the last three years for custodial staff was 70%; with 35 officers currently wait-listed for potential transfer to other prisons across the State. Measured as a percentage of officers assigned to the prison, Greenough's wait-list to transfer out was similar to that at Albany and Roebourne Prisons, less than Eastern Goldfields and West Kimberley Prisons, and higher than Bunbury Prison.

2.25 Further detail in relation to both the prisoners and custodial staff is set out below.

Prisoner demographics

Table 2: Summary of the total prison population at Greenough on 24 July 2018

Category	Aboriginal Persons	Non-Aboriginal	Total
Sentence Status			
Sentenced	134	64	198
Unsentenced	66	20	86
Gender			
Female	41	15	56
Male	159	69	228
Security Rating			
Maximum	2	2	4
Medium	137	46	183
Minimum	61	36	97
TOTAL (each category)	200	84	284

2.26 Looking at the total prisoner population of 284 prisoners:

- there were 56 women prisoners and 228 male prisoners;
- 70% of the total prisoner population were sentenced and 30% were unsentenced;
- 70% of the total prisoner population were Aboriginal;
- 64% of the total prisoner population were classified as medium security, 34% classified as minimum security and less than 2% classified as maximum security;
- 41% of the total prisoner population identified 'Geraldton' as their last known address upon reception at the prison, with 59% hailing from the broader mid-west region;
- Young prisoners aged 18 to 22 comprised 12% of the overall population – while those 23 to 27 years were 20%; 28 to 32 years were 18%, 33 to 37 years were 17%, 38 to 42 years were 14% and the remaining 19% were 43 years or older; and
- A high proportion of prisoners had only been at Greenough for a short period of time:
 - 42% of prisoners had been there for 3 months or less;
 - 26% had been there for 3-6 months;
 - 24% had been there for 6-12 months; and
 - only 8% of the total prisoner population had been at Greenough for more than 12 months.

- 2.27 Looking more closely at the 228 male prisoners:
- 49 were being managed in the minimum-security precinct Unit 6 outside;
 - 179 were being managed in Units 1, 2, 3 and 5 within the main secure section of the prison and of these:
 - 60% were sentenced and 40% were unsentenced;
 - 73% were Aboriginal;
 - the majority (84%) were medium security;
 - the majority (63%) were from the mid-west region;
 - the majority (60%) were aged between 24 and 40; and
 - the majority (72%) had been in custody less than 6 months.
- 2.28 Looking more closely at the 56 women prisoners:
- 73% were sentenced and 27% were unsentenced;
 - 73% were Aboriginal;
 - the majority (59%) were medium security;
 - the majority (57%) were from WA regions in, or north of, the mid-west, and 30% were from the metropolitan area;
 - the majority (66%) were aged between 24-40 years; and
 - the majority (75%) had been in custody less than 6 months.
- 2.29 Greenough has experienced an increase in the proportion of unsentenced prisoners in the last three years, but it is not out of step with the rest of the prison population across the State. In the period between July 2015 and June 2018, the average daily unsentenced population at Greenough increased by 6%; from 24% to 30% of the total population. This is consistent with similar increases at West Kimberley Regional Prison (6%) and Roebourne Regional Prison (8%). During this same period, the average daily unsentenced prisoner population across the State increased by 4% from 25% to 29%.
- 2.30 Between January and June 2018, there were 265 discharges of 261 offenders to the mid-west region, representing 81% of the total discharges from Greenough for that period.

Staff demographics

- 2.31 To analyse the staffing demographics the Review examined the characteristics of the 145⁸ staff held against Adult Custodial Operations positions at Greenough for the 24 July. For the purposes of this Review these staff are broadly categorised into the following three groups, representing those primarily charged with prisoner management duties:
- **Uniformed Prison Officer** (includes First Class Prison Officer, Prison Officer, Senior Officer and Principal Officer);
 - **Vocational Support Officer** and **Industrial Officer**; and
 - **Prison Management** (includes Manager, Assistant Superintendent and Superintendent).
- 2.32 *Uniformed Prison Officers* are responsible for daily activities in relation to prisoner security, custody and wellbeing. They also perform tasks related to prisoner sentence planning and management, and facilitate communications between prisoners and their families. Uniformed Prison Officers work on a rotating 24-hour roster.

⁸ This excludes work functions defined in the Department's HR system as "Administrative, Clerical, Education Officer, Nurse and Officer". These categories refer to public servants performing administrative roles in the prison, such as human resource management. These staff are not directly involved in the management of prisoners and so have not been included in Table 3.

- 2.33 *Vocational Support and Industrial Officers* provide employment and training supervision to prisoners. Typically, these officers supervise prisoners attending a prison workplace during the day, and work during weekday business hours on an eight hour shift. For the purposes of this Report, all officers in this category are referred to as Vocational Support Officers ('VSOs').
- 2.34 *Prison Management* staff are responsible for the safe and secure operation of the prison and all staff at the facility. The Superintendent (and delegate) also has a comprehensive range of legislative functions under the *Prisons Act 1981* (WA) ('**Prisons Act**') in relation to the management of prisoners, including such matters as early release and the hearing of prison charges. Prison Management staff work weekday business hours, attending the prison after hours in an on-call capacity as required.
- 2.35 As at 24 July, Greenough employed 113 uniformed prison officers. Of these, 22 (19%) were female, with an average age of 51 years and average agency service length of 11.5 years, and 91 (81%) were male with an average age of 50 years and average agency service length of 11.1 years. The median ages of female and male uniformed prison officers were 54 and 51 years respectively.
- 2.36 Senior uniformed staff, including Senior Officers and Principal Officers, averaged 16.8 years of service.
- 2.37 There were four staff in the Prison Management category with an average age of 51 years and an average agency service length of 14.9 years.

Table 3: Adult Custodial Operations Staff employed at Greenough on 24 July 2018

Gender Role		Average Age	Average Service Years ⁹	Staff	% Total
Female	Uniformed Prison Officer	51	11.5	22	15%
	Vocational Support Officer	52	6.6	8	6%
	Prison Management	52	7.7	2	1%
	Total	51	8.6	32	22%
Male	Uniformed Prison Officer	50	11.1	91	63%
	Vocational Support Officer	50	7.5	20	14%
	Prison Management	50	22.1	2	1%
	Total	50	13.6	113	78%
Total	Uniformed Prison Officer	50	11.2	113	78%
	Vocational Support Officer	51	7.3	28	19%
	Prison Management	51	14.9	4	3%
	TOTAL	50	11.1	145	100%

- 2.38 The above analysis indicates that staff continuity at Greenough was generally very good. There was a high proportion of very experienced prison officers who had been working at Greenough for a long time.
- 2.39 In order to obtain a general sense of staff retention at Greenough, the Review acquired a count of substantive occupancy on 1 July in each financial year from 2016 to 2018 (inclusive). The average staff count of those three periods was then divided by the total staff, over the same period, to obtain an estimated retention proportion.
- 2.40 Using the Department's Human Resource records to compare public prisons¹⁰, the result is an average retention percentage for the State of 68%, which Greenough remained marginally above at 70%. In other words, the rate of staff turnover at Greenough was not substantively different to other prisons across the State.
- 2.41 Further discussion in relation to staffing levels on the day of the critical incident is contained in Chapter 6 – Causes and Contributing Factors.

⁹ Average years since first commencement date with the agency. Note that some people may have left and returned during this time therefore the figure is an estimate.

¹⁰ Excludes Wandoo.

CHAPTER 3

SIGNIFICANT DEVELOPMENTS 2017-2018

OVERVIEW

- 3.1 Greenough prison was going through a period of considerable change in the first half of 2018, with staff shortages, the implementation of an 'Adaptive Routine' on most days, and a staffing review. This Chapter details these developments.
- 3.2 These changes were disruptive to the prison's operating model, the manner in which staff went about their work and the daily routines of prisoners. It was inevitable that the process of change would create instability within the prison and the disruption is evident in the unsettled relationships across the prison during this period. Overall, the Review found that there was an absence of a structured process to manage and monitor the impacts of these changes in the prison.

MODIFICATIONS TO PRISON ROUTINE

- 3.3 The most significant change to Greenough's operating model in 2017-18 was the implementation of 'Standing Order E6 – Staff Deployment' (8 March 2018) ('**Standing Order**') and the 'Adaptive Routine'.
- 3.4 As a general rule in prisons, the normal operating environment works on a daily schedule of routine activities over a twenty-four hour period. This typically includes prisoner unlock in the morning, meals, attendance at structured activities (work, education, programs, visits, recreation) and prisoners secured in cells at night. Prison routine and activities are scheduled in line with the agreed number of staff to cover rostered positions associated with these routines and activities.
- 3.5 An 'Adaptive Routine' means a routine for a facility implemented in response to a staffing shortfall. It refers to the modifications or restrictions on a prisoner's normal daily routine or schedule of structured activity. In practical terms, this means:
insufficient staff to cover rostered positions on any day = changes to service delivery and prisoner's daily routine.
- 3.6 The stated purpose of the Standing Order is to:
"provide a framework for a Superintendent to refer to when identifying appropriate modifications to staff placement and service delivery when the agreed local staffing profile cannot be achieved on a particular day."
- 3.7 The Standing Order articulates a number of principles for the management of staffing shortfalls. The Superintendent must ensure that the focus of any daily staffing deployment agreement focuses on: "the normalisation of service delivery with consideration given to:
 - that modified routines and services are to be provided commensurate with available staffing and the operational priorities for the facility...;
 - that staffing must be considered in the context of the objectives of the facility, which may change depending on the operational philosophy of the facility."

- 3.8 The Standing Order required each prison across the State to develop a ‘Daily Staffing Deployment Agreement’ in consultation with the local WAPOU branch, to be endorsed by the Executive of WAPOU and the Department.
- 3.9 The ‘Daily Staffing Deployment Agreement’ for Greenough was signed on 8 March 2018 (**‘the Agreement’**). It was developed and agreed following a detailed consultation process between Greenough, the Department and the local WAPOU branch. It was endorsed by the Executive of WAPOU, the Superintendent of Greenough and the Department on 8 March 2018.
- 3.10 The Agreement prescribes the type of modifications to the normal routine that are to be implemented in the event that full staffing is not able to be achieved. The four types of routine prescribed in the Agreement are:
- **Routine 1 – Normal Routine**
Normal movement and all services delivered.
 - **Routine 2 – Modified Routine**
The redeployment or non-coverage of a range of listed positions (e.g. Textiles Officer, Maintenance Instructor, Woodwork VSO, Metalwork VSO, Reception Officer etc.), noting that: *‘These positions are in no particular priority order and are to be assessed for non-coverage/redeployment with the view to minimising the impact on normal operations, security, risk and performance.’*
 - **Routine 3 – Dayshift Lockdown Routine (Restricted Routine)**
A restricted routine: *‘consists of nightshift staffing levels and additional staffing to manage essential services.’* This regime results in rolling-lockdown of prisoners in Units and cells, with prisoners provided, at a minimum, with an opportunity to exercise, access ablutions, fresh air, visits and phone calls, dependent on the availability of staff.
 - **Routine 4 – Critical Staffing**
This routine is only be implemented in the event that staffing is insufficient to maintain the safety and security of the facility. This includes emergency situations or a pandemic event.
- 3.11 Appendix 1 to the Agreement then sets out the specific number of officers required to staff each Unit at Greenough.
- 3.12 In effect, the aim of the Agreement was to put in place an agreed framework to follow to allow changes to service delivery and restrictions to the normal daily routine of prisoners, on any day where there was a staff shortfall. Those changes and restrictions included the redeployment of staff, cancellation of structured activities, prisoners secured within Unit wings and systematic lockdown of prisoners in cells during the normal unlock periods.
- 3.13 It is of particular note that Greenough was recorded as being on Routine 2 - a ‘modified routine’ - each day between 1 July and 24 July 2018. A ‘restricted routine’ is recorded during this period on six days because there was a significant staff shortfall in the week preceding the critical incident. The full impact of the increasing lockdowns under the Adaptive Routine, and the context surrounding staff shortfalls, are discussed in Chapter 6 – Causes and Contributing Factors.
- 3.14 For the purposes of this Report, the implementation of the Standing Order and the Agreement described above at Greenough is referred to simply as the implementation of the ‘Adaptive Routine’.

BUDGET AND USE OF OVERTIME

- 3.15 The Adaptive Routine was essentially initiated to control and manage resources within Greenough's allocated budget.
- 3.16 The initial overtime budget provision for Greenough for the 2017-2018 financial year was \$1.659m, premised on an allocation of 40 overtime shifts per week.
- 3.17 The Review was advised that following a Superintendents Conference in September 2017, where the focus was on the tight fiscal environment, budget pressures and the need to reduce overtime costs, Greenough reviewed its overtime expenditure for 2016-17 and 2017-18. This review revealed that for the first three months of the 2017-18 financial year, the prison had expended between 58 and 69% of its overtime allocation. In light of this, the Superintendent proposed a reduction in the Greenough overtime budget to reflect current practice on the use of overtime and to contribute to the savings required by the Department. The Greenough annual overtime budget was subsequently reduced by \$489,000 in early October 2017 (the equivalent of 12 shifts per week that historically were not being used).
- 3.18 Prior to December 2017, the operational practice at Greenough had been to cover up to 28 shifts per week on overtime to manage within the budget.
- 3.19 On 11 December 2017, the Department introduced a requirement for all prisons to regulate the amount of overtime shifts they were using. Each facility was given an allocation of overtime shifts per day and per week. Greenough was allocated a maximum of 28 overtime shifts per week – not including medical and hospital escorts. When this allocation was exhausted on any day or week, or overtime shifts were not able to be filled, then the Adaptive Routine was implemented.
- 3.20 A key feature of the implementation of the Adaptive Routine was the capacity for Superintendents to seek approval from the executive to exceed the prison's overtime allocation if the Superintendent considered that staff shortages were adversely impacting the safety and security of the prison. The business rules required the request to be in writing to the Assistant Commissioner Custodial Operations for an individual day only, and was not to be applied for as an ongoing arrangement.
- 3.21 From 11 December 2017 until 24 July 2018 – a total of 226 days – the Department's records show that Greenough requested, and was approved, an additional allocation of overtime shifts on 14 days. Seven of those additional shifts were allocated in the week prior to the critical incident. The records available to the Review indicate that the Adaptive Routine was activated on 216 of the 226 days during that period.
- 3.22 Unit 5 – the men's self-care accommodation for medium and minimum security prisoners – was particularly affected. Prior to the implementation of the Adaptive Routine on 8 March 2018, the practice had been for one officer to remain in Unit 5 after prisoners had attended their employment/education for the day. After 8 March, the new requirement was for one Senior Officer and two Officers to be allocated to Unit 5. If this could not be achieved, the Unit was to be locked down; and this began occurring regularly after 8 March.

STAFFING REVIEW

- 3.23 A further significant development at Greenough was the 'Staffing Review' conducted in April/May 2018. The purpose of the Staffing Review was to determine the appropriate allocations of prisons officers and VSOs to meet each prison's needs, to inform the development of new Staffing Level Agreements at each prison. This was a government requirement resulting from the Agency Expenditure Review and the *Memorandum of Agreement (Statewide Baseline Staffing Agreement) 2010*.
- 3.24 Under Greenough's existing *Staffing Level Agreement* of 11 April 2016, the agreed number of uniformed staff at Greenough (for Adult Custodial Operations roles) is 147 Full-Time Equivalent ('FTE') for a prisoner population of 334 prisoners.
- 3.25 Consultation meetings for Greenough were conducted at the end of May 2018. The prison made a submission to the Staffing Review dated 19 June 2018 (later forwarded to Head Office on 17 July) outlining concerns regarding the current staffing situation at the prison. The submission highlighted that:
- the current staffing at Greenough was not adequate to cover the prison's service delivery requirements which was evidenced by the fact that despite having full daily staff, lockdown of Unit 5 was still required to manage the prison; and
 - on seven days of the week following visits, staff had to be sourced from the units to conduct prisoner searches which resulted in further unit lockdowns and delays to the provision of prisoner meals and the issue of medication.
- 3.26 At the time of writing, the Staffing Review for Greenough was yet to be finalised.

CONSULTATION WITH WAPOU AND GROWING CONCERNS IN JULY

- 3.27 The *Department of Corrective Services Prison Officers' Industrial Agreement 2016* ('**Industrial Agreement**') registered in accordance with the *Industrial Relations Act 1979* (WA), sets out the requirements of change, consultation and dispute resolution. The Industrial Agreement requires the establishment of a Local Consultative Committee ('**LCC**') at each prison to facilitate communication and consultation regarding workplace issues with a view to resolution at a local level. In addition, a Department-wide Prisons Consultative Committee ('**PCC**') must be maintained.
- 3.28 Two disputes were lodged by WAPOU with Greenough in 2018. The first related to overtime, lodged on 2 March.
- 3.29 In April 2018, at the LCC meeting, the minutes record discussion in relation to the Adaptive Routine and the Standing Order. In an attempt to address the negative impact the Adaptive Routine was having on the prison, the Greenough Superintendent prepared a proposed amendment to the Standing Order for redeployment and staffing of Unit 5. The local WAPOU branch did not support any change to the Standing Order and therefore this did not proceed.
- 3.30 The second dispute, lodged on 11 July, related to '*vacant lines on the roster not being covered*'; with the resolution sought being that the funding associated with vacant lines should be utilised to cover as many positions as feasible, without further delay.
- 3.31 At the time of writing, the Review understands that both disputes remain unresolved.
- 3.32 In addition to the above developments, a review of the Prison's regular internal 'Debrief Meeting' minutes from April to July 2018 also reveals consistent issues with vacancies, redeployment and the Adaptive Routine.
- 3.33 Greenough operates a twice weekly 'Debrief Meeting' for the senior management, operations and service areas. This is the main mechanism for sharing information across the prison. The Unit Managers report on the mood and activities affecting their Units, and the senior management team share information on matters of importance to the prison.

- 3.34 On 6 July 2018, the Debrief Minutes record:
- “Thanks to staff for yesterday 5 July, 10 positions short, and rolling lockdowns all day. Despite the lockdowns prisoners seem in good spirits.”* It is also recorded: *“Staffing at the moment is not good, but is unavoidable and no relief in sight at this stage. 63 vacancies this week and not possible to fill all resulting in vacant shifts. No information about the new budget yet and no dates for prison officer schools yet.”*
- 3.35 On the same day, at the LCC meeting, it is recorded that Greenough had made a submission to the Staffing Review for extra staff for Unit 5, and the Superintendent stated that the Standing Order needed to be reviewed with input from staff.
- 3.36 On 17 July, Greenough’s submission to the Staffing Review was forwarded to Head Office outlining concerns about the current staffing situation at the prison, detailed in paragraph 3.22.
- 3.37 On 20 July, the Debrief Minutes recorded that:
- “redeployment is occurring on a daily basis; and while the intent is to minimise the amount of redeployment each day it must be understood it is a requirement to ensure the prison remain compliant with Standing Order E6 and the processes in accordance with the Adaptive Routine”.*
- There is also reference in the minutes to the union dispute with regards to covering of vacancies.
- 3.38 On 24 July 2018 – the morning of the critical incident – the PCC meeting occurred between the Department’s Corrections Executive and the WAPOU Executive. The minutes record the basis for the overtime reductions in the Department, and explain that a package will be provided to Superintendents to assist them with how to manage the Adaptive Routine with the Staffing Level Agreement and the Daily Staff Deployment Agreement; and how to manage the interaction with the overtime restrictions.
- 3.39 Among other things, the WAPOU representatives placed the Department on notice asserting the following matters: members were very angry about the Adaptive Routine; the restrictions on overtime with no new prison officer schools planned; and they stated that the temperature in prisons was rising and locking people up every day of the week would have consequences.
- 3.40 Later that afternoon, Senior Corrective Services Executives held a phone conference to further discuss the interaction between the Adaptive Routine, overtime restrictions and vacancies. At approximately 4.00pm, the riot commenced at Greenough.
- 3.41 Greenough had scheduled a full staff meeting for 25 July 2018 to discuss the Standing Order and associated issues. The notice highlights that previously the local WAPOU Branch and Superintendent had agreed to review the Standing Order after the Staffing Review, and the prison was looking for volunteers to assist with the review of the Standing Order. This meeting did not eventuate due to the critical incident.

EFFECTIVE COMMUNICATION IN A PERIOD OF CHANGE

- 3.42 As a general observation, it was clear to the Review that communication within the prison during the course of these significant developments in late 2017 and 2018 was problematic.
- 3.43 Throughout the consultations conducted by the Review, the subject of communication across the prison was raised consistently. According to the majority of people who made submissions, there had been a breakdown in communication at Greenough and more specifically, a poor appreciation of the impact of the Adaptive Routine on staff and prisoners, which in their view was a contributing factor to the riot.
- 3.44 The Review explored the communication structures, processes and records available at Greenough. The Review found the prison did not have a formal 'Communication Plan' detailing the channels and layers of communication exchange across the prison. That is not to say that efforts were not being made to communicate and consult with staff, but it appears that the effectiveness was hampered by the absence of a clear, shared understanding of how to facilitate a constructive exchange of information within a twenty-four hour operating environment. This is even more critical during a period of major change as was the case at Greenough.
- 3.45 As discussed in detail in Chapter 6, the Independent Prison Visitor (**IPV**) had been raising serious concerns about the prison in the months leading up to the riot. The Review was provided with records that show a staff meeting was held on 9 May 2018, for all uniformed staff as a direct result of the IPV's visit, and previous visit, to cover the matters identified by the IPV. It is recorded in the IPV report response from the Superintendent that:
- "Whilst it is acknowledged that staff are reluctant to raise their personal issues in such a forum, no staff have reported any issues or concerns directly to the senior managers prior to or following the staff meeting."*
- 3.46 This comment illustrates the disparity between staff/prisoner perceptions, and management perceptions, about the extent of discontent at Greenough leading up to the events of 24 July.

MONITORING PRISON PERFORMANCE

- 3.47 Finally, the Review also makes a general observation that the Department's method of monitoring the performance of Greenough during this period of significant change in 2017-2018 was less than optimal.
- 3.48 The Department's primary mechanism for measuring a prison's performance is the *Capability and Development Report* ('**CAD Report**'), which reports on a quarterly basis.
- 3.49 The CAD Report measure performance against benchmarks. The Review examined the selected measures below, which are intended to be general indicators of:
- Good order and security (indiscipline incidents, critical incident reports, prisoner grievances recorded and positive drug tests);
 - Safety (prisoner assaults on staff and prisoner on prisoner assaults); and
 - Prisoner engagement/structured activity/programs (Aboriginal Services Committee, Aboriginal people employed, average out-of-cell hours, scheduled programs delivered, prisoners enrolled in education and training courses, and prisoners in case management).
- 3.50 For the reporting year of 2017-2018, the CAD Report for Greenough shows that the majority of the good order, security and safety indicator targets were achieved, showing no concerning patterns. It is difficult to reconcile this with the events of 24-25 July and the increasingly unsettled environment within the prison in the first half of 2018.
- 3.51 The CAD Report also shows a pattern of failure to achieve benchmarks in prisoner participation in rehabilitation activities and Aboriginal services:
- Failing to maintain an Aboriginal Services Committee for the full performance year;
 - Below benchmark in two of four quarters for treatment programs operating – achieving only 25% (Q1) and 50% (Q2);
 - Below benchmark for prisoners enrolled in education – achieving 75% (Q1) 25% (Q2) 25% (Q3) with Q4 not reported;
 - Below benchmark for prisoners in training courses – achieving 0.00% (Q1) and 50% (Q2 and Q3) with Q4 not reported; and
 - Below benchmark in two of four quarters for prisoners in case management – scoring 85% (Q1) and 95% (Q2).
- 3.52 These matters are explored further in Chapter 6 – Causes and Contributing Factors. It is noted that the CAD Report is a relatively new tool that was introduced in Corrective Services in 2016. The OICS 2016 Report observed that while the CAD system was 'a welcome first step in driving accountability, performance, innovation and better outcomes', the model did not recognise differences between facilities. The Inspector further stated that: *'Over time, the Department intends to modify them to reflect each prison's role and focus. We hope to see a Greenough-specific capability and development agreement in place by the end of 2017, and some tangible positive outcomes when we next inspect the prison in 2019'*. This has not occurred.
- 3.53 The Review observes that there are several measures within the CAD reporting framework that present challenges with respect to performance evaluation because of definitional uncertainties, particularly in relation to the data-points that feed into the 'good order and security measures', such as 'indiscipline incidents'. The Review suggests that the tool should be reviewed.

CHAPTER 4

WHAT HAPPENED ON 24-25 JULY 2018?

INTRODUCTION

- 4.1 Tuesday, 24 July 2018, commenced in what had become the normal fashion at Greenough prison – staff shortages, modifications to the normal daily routine, and rolling lockdowns with prisoners confined to Units. As outlined in Chapter 2, there were 284 prisoners at Greenough on this day; 228 men and 56 women.
- 4.2 What happened just after 4:00pm – and continued for more than twelve hours – was extremely serious in any prison context. There was a loss of control of the main secure section of the prison. Male prisoners gained access to the Maintenance Workshop and obtained tools and ladders; while others breached the Women's Unit. Staff were attacked, fires were lit, and there was riotous behaviour causing major damage. Ten prisoners escaped. Given the severity of these incidents, it is very fortunate that there was no loss of life or serious physical injury to staff, prisoners or members of the public.
- 4.3 To objectively understand the sequence of events and actions that occurred on 24-25 July at Greenough, the Review prepared a chronology of events presented in the table at paragraph 4.16.
- 4.4 On 24 July, the roster for the day had nine vacancies. This was due to six vacant FTE positions on the roster, plus two absences on personal leave and one person away on workers compensation. Eight of the nine vacancies were prison officer positions. Overtime was used to cover one of these positions.
- 4.5 Thus, the prison began the day short staffed by seven officers. Four of these positions were covered by the redeployment of VSOs into officer roles – leaving three positions not covered. One of the Senior Officers departed the prison at 13:25hrs and did not return. At 16:00hrs, the redeployed VSOs finished their rostered eight-hour shift and departed the prison.
- 4.6 A modified routine was in place in accordance with the 'Adaptive Routine' to manage the staff shortfalls, which was not dissimilar to the regime that was being used most days at Greenough from March 2018 onwards. The vocational skills, activities, gardens and some external activities had to be cancelled due to the redeployment of the VSOs, and rolling lockdowns were scheduled.
- 4.7 Unit 5 (the men's self-care accommodation) was locked down from 09.00-13.00hrs. Unit 1 (men's maximum-security/management accommodation) was locked down from 12.00-16.00hrs. Unit 4 (the Women's Unit) was locked down from 15.30hrs onwards, initially due to short staffing and then the riot. Units 2 and 3, where the riot commenced, were not locked down during the day and were fully staffed for that time of the day with one Senior Officer and three Prison Officers.
- 4.8 There were no particular occurrences of note during the early part of the day. At 15.00hrs, there were four officers positioned in the Gatehouse performing control and security duties (one Senior Officer, two Prison Officers and one VSO). The VSO finished duty at 16.00hrs, as per usual shift arrangements.

CHRONOLOGY OF EVENTS

- 4.9 A chronology of events is provided at 4.15. It incorporates extensive feedback provided by the Department, which was incorporated into the finalised chronology. It is noted that some of these important details were not documented or recorded on the night of the event.
- 4.10 The chronology of events was prepared using the following source material:
- Closed Circuit Television footage ('CCTV') from multiple cameras on site;
 - Cell call recordings;
 - Alarm and event perimeter logs;
 - Greenough radio logs;
 - Emails from Greenough to the Head Office Operations Centre ('Operations Centre') during the course of the event;
 - SOG radio logs;
 - SOG chronology;
 - Operations Centre running sheet;
 - Adult Justice Services chronology; and
 - Greenough chronology.
- 4.11 The preparation of the chronology was a difficult task. The Review was provided with a number of different running sheets, email records and chronologies relating to the critical incident, many of which were reconstructed after the event and were inconsistent with one another. The issue of record-keeping during the critical incident is discussed more fully in the context of Chapter 5 – Emergency Response.
- 4.12 A further challenge was the fact that the CCTV footage of the events of 24-25 July was downloaded without functionality of exact times of images being visible. This oversight made the task of precise reconstruction of the events more difficult. Nevertheless, the Review was able to correlate the alarm perimeter logs and radio traffic logs against the CCTV footage for the purposes of establishing a minute-by-minute sequence of events, noting some of the events as recorded on CCTV were not known at the actual time they were happening.
- 4.13 Despite these challenges, the Review has created the chronology by analysing all of the available information recorded during the critical incident, particularly the digital evidence of the CCTV footage and alarm logs, and further information provided subsequently by the Department.
- 4.14 For ease of reference, the colour code used in the chronology is as follows:
- Pink – the events specific to women prisoners in Unit 4;
 - Yellow – the escape; and
 - Green – the recapture of the escapees.

4.15 CHRONOLOGY OF EVENTS

Time	Events, Actions and Decisions
24 July 2018 16:02	<p>First Code Red called on the radio – Fire in Unit 2, Cell 22</p> <p>Attending officers find a mattress in the cell on fire emitting smoke into the unit. Staff use the fire extinguisher to quell the fire.</p> <p>Due to the smoke in Unit 2, staff issue verbal instructions to prisoners to clear the wings and move to the basketball court in Unit 2 for muster.</p>
16:03 – 16:05	<p>Second Code Red called on the radio – Riotous Behaviour</p> <p>Some prisoners are throwing projectiles at staff in Unit 2 – but not all prisoners are involved in riotous behaviour. Radio broadcast warns that prisoners on Unit 2 basketball court are throwing rocks (broken up paving bricks) at staff.</p> <p>Prisoners observed attempting to damage Unit 2 office window and day room.</p> <p>Staff re-enter Unit 2 office via rear door and attempt to gather restraints and prevent access via window. Integrity of window structure is compromised and staff retreat to Unit 3.</p> <p>Assistant Superintendent Operations and Assistant Superintendent Security are in the area of the Units under attack. Superintendent seeks a status report on the fire via radio.</p>
16:09 – 16:12	<p>Radio broadcast requests Unit 3 staff to put a call out to all prisoners not wanting to take part in the disturbance to return to their cells. A number of prisoners are permitted access to Unit 3 basketball court so that a muster can be completed.</p> <p>Prisoners on Unit 2 basketball court continue to throw projectiles at staff who are attempting to corral prisoners in Unit 3 and secure them in cells. Prisoners in Unit 3 are becoming increasingly agitated and refuse to follow direction. An estimated 130-140 prisoners in adjacent basketball court areas of Units 2 and 3.</p> <p>Staff withdraw to the Unit 3 office for safety. Superintendent requests an update on the evacuation of prisoners from Unit 2 and the securing of all other units, to free up resources.</p>
16:15	<p>Approximately 12 prisoners observed damaging infrastructure in Unit 2 and riotous behaviour reported in Unit 3.</p> <p>Corrective Services Head Office Operations Centre, WA Police Force and Department of Fire Emergency Services ('DFES') notified.</p>
16:17	<p>Prisoners observed breaking down the dividing fence between Units 2 and 3 and throwing projectiles within Unit 3. Rocks, bricks and concrete are thrown towards the Unit 3 office and windows. The office is subsequently breached and all staff retreat from Unit 3 to Central Control.</p> <p>A staff count is conducted with all staff accounted for. Non-essential staff are sent off-site.</p> <p>Unit Muster: Unit 2 = 70 and Unit 3 = 69 = Total 139 prisoners.</p>
16:25 – 16:28	<p>Radio broadcast and CCTV reveal prisoners on the roof of Units 2 and 3.</p> <p>A large number of prisoners seen congregating between Units 3 and 4 (Women's Unit) and multiple prisoners are gathering along the fence between Units 3 and 4.</p>

Time	Events, Actions and Decisions
16:29	<p>Radio broadcast: Male prisoners in Unit 4 – Women’s accommodation compound</p> <p>Cell call received from a prisoner in Unit 3 reporting that the Unit 3 office is burning.</p>
16:30 – 16:40 (estimated)	<p>CCTV shows multiple prisoners on the roof gaining access to the circular air vent above Unit 2 office directly over the Maintenance Workshop.</p> <p>Prisoners exit the workshop through the door at ground level in possession of two ladders and a battery powered angle grinder.</p> <p><i>The ladders were accessed using an unsecured battery powered angle grinder located in the Maintenance Workshop. The grinder was used to cut a security chain securing ladders.</i></p> <p><i>The workshop held ladders chained to the wall and padlocked, as well as cordless tools including the angle grinder. The majority of tools were kept within locked cabinets and a lockable trolley. Other tools including the grinder were left on top of a maintenance trolley.</i></p>
16:45	<p>Greenough notification to Special Operations Group ('SOG'). The SOG Superintendent and Assistant Superintendent in Perth are briefed on critical incident. Assistance is requested.</p> <p>Head Office Operations Centre notification on developing critical incident to:</p> <ul style="list-style-type: none"> • Acting Deputy Commissioner, Adult Justice Services and Acting Assistant Commissioner, Custodial Operations • Acting Director General, Department of Justice and Acting Commissioner, Corrective Services • WA Police Force
16:45	<p>Cell call received from a female prisoner who advises that male prisoners are in the Women’s Unit. The female prisoner asks for assistance.</p> <p>Male prisoners are heard in the background yelling and laughing. Banging is also heard.</p>
16:46	<p>Superintendent SOG authorises:</p> <ul style="list-style-type: none"> • immediate deployment of a vehicle and team to Greenough • stand-up of additional on-duty team • driving to be under emergency conditions (lights and sirens)
16:47	<p>Multiple prisoners are at the internal perimeter fence adjacent to Zone 11. Prisoners commence cutting the padlock that is securing a staff access gate using the battery powered angle grinder.</p> <p>Prisoners enter the sterile zone in the vicinity of zone 11 and 12 triggering the electronic security detection systems. Multiple perimeter alarms are activated in Zone 11 and 12.</p>

Time	Events, Actions and Decisions
16:47 - 16:52	<p>CCTV footage reveals:</p> <ul style="list-style-type: none"> • 10 prisoners entering the sterile zone carrying two ladders – one long, one shorter; • the longest ladder is placed on the internal side of the external perimeter fence reaching above the cowl drum; • the shorter ladder is placed on the outer side of the external perimeter fence but appears too low to climb down; • all 10 prisoners climb the long ladder and stand on top of the cowl drum; • three prisoners walk along the top of the cowl drum towards zone 9 adjacent to Unit 4 (assumed to have jumped); • the longer ladder is pulled up and carefully balanced over the cowl drum and positioned on the outer side of the external perimeter fence; • the remaining seven prisoners lower themselves down the ladder and run into adjacent bushland; • both ladders are left on the outer-side of the prime external perimeter fence; and • two more prisoners enter the sterile zone and then retreat back into the prison.
16:48 – 16:50	<p>Superintendent SOG briefing to Acting Deputy Commissioner, Regulation and Operational Support on current actions – <u>endorsed</u>. Plan to call-out and deploy additional SOG resources – <u>authorised if required</u>. SOG vehicle and resources prepared in Perth for deployment to Greenough. Second SOG team and call-out of off-duty SOG – <u>authorised</u>.</p>
16:52	<p>10 male prisoners escape Greenough Prison – there are no awaiting vehicles or other assistance visible from the CCTV.</p> <p><u>Note:</u> The specific number of escapees was not able to be confirmed until 05:57hrs on 25 July (13hrs later) when the first complete muster was able to be confirmed.</p>
16:57	<p>A/Director General notification to Office of the Minister for Corrective Services and briefing provided to the Chief of Staff.</p>
16:58 – 17:19	<p>Multiple alarms in perimeter zone 12 and CCTV footage of the area reveals three prisoners within the sterile zone; one carrying an angle grinder.</p> <p>Two (of the three above) prisoners visible on CCTV moving within sterile zones 11 and 12 with an improvised grappling hook and rope. The prisoners make multiple attempts to throw the grappling hook over the external perimeter fence cowl drum, attempting to pull the long ladder back into the prison. The prisoners retreat into the prison through the unsecured personnel access gate 21 minutes later.</p>
17:00	<p>Greenough Officer Response Teams at the Gatehouse wearing Personal Protective Equipment ('PPE').</p> <p>Geraldton Police arrive on site at Greenough prison.</p> <p>A/Deputy Commissioner and A/Assistance Commissioner arrive at the Operations Centre.</p>

Time	Events, Actions and Decisions
17:08	<p>An email from ASO Greenough providing Superintendent's update to Operations Centre, stating:</p> <ul style="list-style-type: none"> • "All staff accounted for • 2 x teams of 6 geared up • Unit 2 and 3 prisoners (139 in total) a number have been secured • Approx. 12 main offenders • Prisoners were on the roof, broke into Unit 2 SO office and main office • Broke into maintenance • Approx. 10-12 escaped • WAPOL on site – cordoning and manning external perimeter for escapee* • DFES on site** • Prisoners broken into garden shed – fuel?? • SOG requested" <p>*WA Police Force were positioned at the railway line approximately 100 metres from the external perimeter fence of the prison to intercept any escapees.</p> <p>**DFES were positioned outside the external perimeter fence.</p>
17:10	<p>SOG Team 1 are deployed from Hakea Prison Base with SOG Commander and four officers. Vehicle with full emergency response (lights and sirens).</p> <p>Greenough Response Team attempt reconnaissance along the western side of the main prison accommodation units, commencing at Unit 1 and proceeding along the oval perimeter to Unit 5 to identify and assess the situation in Unit 4 – Women's Accommodation</p>
17:14	The Acting Minister for Corrective Services is provided with a briefing by the A/Director General on the unfolding critical incident at Greenough.
17:18	The Director General, who was on leave overseas, is provided with a briefing by the A/Director General.
17:21 – 17:22	<p>Greenough Response Team wearing PPE enter the sterile zone and secure the personnel access gate at zone 11 and 12 with a set of handcuffs.</p> <p>This response to the internal perimeter fence breach is 30 minutes after the ten prisoners had escaped over the prime external perimeter fence.</p>
17:22 – 17:24	<p>Prisoners have access to fuel and there is a fire in the gardens area outside the Unit 3 office adjacent to the Unit 4 fence. Prisoners are observed extinguishing fires with fire extinguishers.</p> <p>The muster is reported as 64 plus 26 secured in cells of the original 139.</p>
	It is reported there are approximately 12 male prisoners in the Women's Unit.
17:24 -17:25	<p>The second Response Team is assembled to attempt to advance towards Unit 4-Women's Unit. The team's advance is repelled by prisoners throwing projectiles – rocks, bricks, pavers, concrete chunks and D-cell batteries from the accessway adjacent to Unit 3.</p> <p>A fire has been relit near access grille leading to Unit 3 and 4 alleyway. Other prisoners are observed extinguishing this fire.</p>
17:30	Additional local Geraldton police resources arrive on site and are tasked to the escape incident and recovery of the escapees.
17:35	SOG Team 2 are deployed from Hakea Prison Base.

Time	Events, Actions and Decisions
17:37	A/Commissioner Corrective Services arrives in the Operations Centre.
17:46	WA Police provided notification that some escapees have been apprehended with names and total number of escapees not known at this time.
17:47 – 17:56	Prisoners are reported as lighting fires to fruit trees and targeting the Unit 2 office. A palm tree is on fire in front of Unit 4 causing smoke to drift into Unit 3. Cell call received from a male prisoner in Unit 3 reporting that fires are being lit and requests assistance with getting out.
	It is reported that 5-7 male prisoners have accessed the Women's Unit with shovels and are attempting to break in the doors. Cell call from unknown female prisoner in Unit 4: <i>"They are burning the place down, they are fucking burning the unit, get us fucking out of here"</i>
18:00	A/Director General arrives at the Operations Centre.
18:01	Greenough accounts for 56 women prisoners with 49 reported as being secured in Unit 4. 195 prisoners accounted for in the prison using the muster numbers as provided.
18:05	Code Red called – Urgent request for assistance in Unit 1. Unit 1 prisoners, plus Units 2 and 3 surrendered prisoners secured in the area are aggressive because they had not received medication and meals. Staff provided information, meals and tobacco and prisoners calmed to a manageable state.
18:05	DFES are on site, stationed outside the external perimeter fence. St Johns Ambulance have been placed on call. Fire is reported as not a threat to buildings.
	Estimated that at least two females are now unlocked and with the men in Unit 4. More male prisoners are now smashing at cell doors on top level of the Women's accommodation unit.
18:10	SOG Team 3 is deployed from Hakea Prison Base.
18:11	Cell call – Female prisoner sounding distressed seeking assistance from staff: <i>"Please come here to me... I am so frightened... Please help me".</i> Banging, screaming and other destructive behaviours audible in the background for 5 minutes.
18:12	Telephone conference with Premier, the Premier's Office and the Minister for Corrective Services' Chief of Staff to provide an overview of the critical incident and timeline.
18:15	SOG Team 4 is deployed from Hakea Prison Base.
18:16 – 18:34	Male prisoners are seen using pruning saws to cut through cell doors in Unit 4. Seven women are confirmed as been broken out of their cells in Unit 4 by male prisoners. Prisoners are using the Public Announcement system in the Unit.

Time	Events, Actions and Decisions
	101 prisoners from 139 in Unit 2 and 3 are confirmed as contained and compliant.
18:48	Police remove ladders resting on external perimeter fence (used in the escape)
18:51	<p>Wheelie-bins are filled with rocks and broken up paths by prisoners in readiness (attack).</p> <p>Planning is underway with DFES and Police.</p> <p>WA Police Force are entering the prison to coordinate resourcing.</p> <p>Two (later a third) prison officers are sprayed with chemical agent by prisoners.</p>
19:00 – 19:03	<p>Prisoners have access to fuel from garden sheds (area and locks have been penetrated via roof access).</p> <p>Prisoners are inhaling intoxicants, armed with shovels, pitch forks, screw drivers, pruning saws and projectiles.</p> <p>36 identified prisoners unaccounted for.</p>
19:05	Department formally requests further police assistance from the Police Command. A/Commissioner Corrective Services confers powers on police officers under section 15 of the Prisons Act, to assist in the exercise or performance of any power or duty conferred or imposed by the Act.
19:19	Rocks being thrown by prisoners at police vehicles patrolling the sterile zone and protecting the perimeter.
19:37	The Minister for Corrective Services, who is in the United Kingdom, is provided with a telephone briefing on Greenough by the A/Director General.
20:15	WA Police report that two prisoners have been recaptured.
20:19	A female prisoner uses the staff telephone in Unit 4 and makes telephone contact with WA Police Force; advising that she is hiding under a desk, and that male prisoners have female prisoners in cells and have weapons and petrol.
20:24	Prisoners are reported as being on the roof above Central Control area of the prison.
20:40 – 20:43	<p>SOG Commander commences Emergency Action Team preparation.</p> <p>A multi-agency brief is conducted and negotiations with prisoners on the main roof takes place.</p> <p>A/Commissioner confirms with Incident Controller activation of Emergency Action Plan and approval granted for SOG to use force in accordance with section 48 of the Prisons Act (use of force on serious breach of security).</p>
20:56	Cell call – Female prisoner in Unit 1 reports prisoners are lighting fires as she can smell smoke.
21:10 – 21:25	<p>SOG Commander briefs the Greenough Incident Control Team on Emergency Action Plan – EA (Emergency Actions) Triggers: Female prisoners' duress, critical infrastructure and male prisoners' duress.</p> <p>Incident Controller authorises Emergency Action Plan (non-lethal use of force options permitted). SOG Team Leader delivers Orders to Emergency Action Team.</p>

Time	Events, Actions and Decisions
21:45	Prisoners attacking the Unit 5 office windows, suspected via roof access into the unit. Staff retreat with restraint equipment and knives to Central Control.
22:10	SOG Operations commence Deliberate Action Planning. WA Police Force Commander approves Regional Operations Group (' ROG ') to form part of response sections under command of SOG team leaders.
22:12	WA Police confirm one more prisoner has been captured.
22:28	Cell call – Distressed female prisoner in Unit 1 reports smoke is entering her cell and she can't breathe – requests help. Staff reassure her there is no fire in Unit 1 and to get down low and slow her breathing.
22:30 – 22:33	Fire in Unit 3 is reported with smoke significantly impacting across the other units due to the shared roof space. Prisoners are on the reception area roof top. Fire is reported above the kitchen area.
22:34	Unit 1 prisoners are reported as suffering from smoke inhalation. Staff are requesting direction as prisoners are covered in smoke. Smoke from the major fire in Unit 3 impacts on Unit 1 and panics prisoners in the unit, causing the prisoners to damage grilles, windows, doors and other areas in their attempt to escape through the emergency door at the back of the office.
22:40	The Incident Control Facility is relocated to the Gatehouse due to smoke exposure and increasing damage due to prisoner access on the administration building roof.
22:45	SOG Emergency Action Plan actioned due to infrastructure damage. SOG Team Leader is advised that prisoners in Unit 1 are affected by the smoke. Incident Controller makes a direction for an evacuation of Unit 1 prisoners to the oval.
22:50	Officers arrive at Unit 1 and observe prisoners in the office trying to force the escape backdoor open. Officers assist prisoners attempt to breach the backdoor to exit the unit to avoid being overcome by smoke. The door was unable to be opened.
23:00 onwards	SOG response teams deployed riot control munitions to cause the prisoners to disperse or move back outside of projectile throwing range, to protect the officers as they moved through the prison.
23:01	SOG response team wearing Breathing Apparatus (' BA ') enter Unit 1 to unlock and evacuate prisoners. SOG apply MOE tools to breach the emergency escape backdoor because of lock damage. SOG safely evacuate prisoners and relocate them to the oval in restraints.
23:02	WA Police Force (with canines) tasked with security of evacuated prisoners on oval, with Greenough officers.
23:03	SOG response team are under substantial resistance in Unit 3 – petrol bombs and chemical agents used by prisoners against officers.
23:09	St John Ambulance is en route to the prison in response to reports of one female prisoner unwell.
23:23	WA Police Force report that two more prisoners have been captured.

Time	Events, Actions and Decisions
23:41 – 23:50	Unit 1 reported as being all clear of prisoners (111) evacuated on to the oval. Prison and police officers supervising restrained prisoners on the oval.
23:50	WA Police Force Tactical Response Group ('TRG') arrives on site and are briefed by SOG Commander.
23:50 – 23:55	A large fire is reported in Unit 4 (Women's Unit) yard with multiple prisoners on the roof and roaming the site. Nine prisoners observed on the roof near Unit 5.
25 July 00:10 – 00:41	SOG has breached Unit 4 to clear the unit of male prisoners and to attain a muster count. SOG confirms prisoners contained in Unit 4. 49 prisoners are secured – 46 females accounted for and 3 males. 56 women now all safe and secured (46 + 10 women secured elsewhere)
00:44	Four prisoners escorted to the Gatehouse for medical triage due to: <ul style="list-style-type: none"> • one possible dislocated shoulder • one female prisoner appeared to have a seizure • two prisoners with smoke inhalation
01:01	SOG teams are on the roof corralling prisoners. Other response teams are facilitating a sweep and clearance of all common areas.
01:10	SOG Operations develop an Action Plan: <ul style="list-style-type: none"> • SOG to conduct coordinated clearance of the roof • Oval and Unit 4 prisoners to be relocated to Industries as a secure area.
01:26	Nine prisoners are reported as being on the roof.
01:30	35 male prisoners unaccounted for in the prison – including escapees seen on CCTV. Prisoners are observed in possession of chunks of concrete, projectiles, D size batteries, 'Molotov' cocktails, chemical agent, batons and shovels.
01:31	A/Commissioner Corrective Services, in consultation with WA Police Force Commander, agree that TRG expertise was not required at this time and that the police would maintain the security of the perimeter.
02:01 – 2:11	SOG confirm they now have 16 prisoners in custody. Prisoners are being relocated to Central Control and Reception. Unit 1 prisoners and known instigators are to be secured in Unit 1. Remaining prisoners are to be held in Central Control until all units are cleared.
02:30	WA Police Force to be withdrawn from the prison by Police Forward Commander (Inspector) on site and through the SOG Commander.
02:45	SOG team re-enter the prison to Unit 5 to account for prisoners secured in cell. SOG to clear unit prior to systematically searching cells in Unit 2 and 3 searching for unaccounted for prisoners.

Time	Events, Actions and Decisions
03:03	Superintendent debriefing with WA Police Force who are withdrawing resources from the site. WA Police Force advise TRG and the Dog Squad will remain in Geraldton overnight if any further assistance at the prison is required.
03:05 – 3:12	SOG complete the clearance of Unit 3 and extinguish the fire. 10 prisoners are located in unsecure cells and removed from the unit.
03:43 – 3:48	DFES is off site. <i>DFES had remained on site throughout the night, with trucks stationed outside the external perimeter fence, liaising with other agencies in the Gatehouse. They did not enter the prison; fires were extinguished by SOG, prison staff and prisoners.</i> SOG has attended Unit 3 to extinguish a recurring fire.
04:30	Prisoner movements commenced from the oval and back to secure accommodation areas.
05:30	A/Commissioner and A/Assistant Commissioner departed the Operations Centre.
05:57	All prisoners now secured in cells and the number in the prison confirmed at 274 Pre-riot count was 284 prisoners (minus 5 escaped prisoners recaptured by Police) = 279 <u>Confirmed Prison Population 274 – Identifying 5 Prisoners Missing</u> The Number and Names of Escaped Prisoners still at large verified and confirmed. New Unit Muster Sheets being compiled to identify location of all prisoners for ongoing accounting of the prison population.
06:00	Superintendent commenced Hot Debrief.
06:40	Greenough staff off-duty and sent home.

- 4.16 The ten prisoners that escaped were apprehended by WA Police Force within 40 hours of the escape. On 23 October 2018, WA Police Force confirmed to the Review that, in total, 27 prisoners had been charged with criminal offences relating to the events of 24-25 July. Of the 27:
- seven were charged with both 'escaping lawful custody' and 'rioters causing damage' (by fire) under sections 146 and 67(2) of the *Criminal Code* (WA) respectively;
 - three were charged with escaping lawful custody; and
 - 17 were charged with rioters causing damage (by fire).
- Those charged were summonsed to appear in the Perth Magistrates Court on 30 October 2018. Most of those charged were male prisoners aged between 18 and 35, with one woman charged.
- 4.17 The Review conducted a detailed analysis of the data held by the Department in relation to the 27 prisoners charged with criminal offences. This analysis has not been included in the Report given the ongoing criminal justice process, but the Review suggests that it be considered by the Department in order to gain a deeper understanding of any commonalities among these offenders. In particular, the Review suggests that this analysis be used as an opportunity to inform a more positive and innovative approach to engaging with these prisoners and other similar cohorts.

CHAPTER 5

EMERGENCY MANAGEMENT

LEGISLATIVE AND POLICY FRAMEWORK

Legislation

- 5.1 The *Prisons Act 1981* (WA) (**'Prisons Act'**) makes very few express references to 'emergency' but sets out various powers and duties for the management of the security of prisons generally.
- 5.2 Section 7 stipulates that the chief executive officer of the Department is responsible to the Minister for Corrective Services for the proper operation of every prison. He or she must notify the Minister as soon as practicable of any escape by a prisoner from lawful custody; and any accident, serious irregularity, or any other unusual event which affects the good order or security of a prison.
- 5.3 Section 36 provides that the superintendent of a prison is responsible to the chief executive officer for the good government, good order and security of that prison, and is liable to answer for the escape of any prisoner in his charge.
- 5.4 Section 48 permits the chief executive officer to order the use of force against a prisoner where a serious breach of the good order or security of a prison has occurred or appears to be imminent, and no other reasonable means of control are available at the prison.
- 5.5 The *Prisons Act* also permits the making of subsidiary rules, standing orders and regulations in relation to a range of matters.
- 5.6 The *Emergency Management Act 2005* (WA) (**'EM Act'**) governs the coordinated organisation of emergency management in Western Australia. Significantly, the EM Act does not authorise the taking of measures directed at 'controlling a riot or other civil disturbance' (section 9(b)).
- 5.7 Despite not applying to riots or civil disturbances, including in prisons, the EM Act contains a widely-recognised definition of 'emergency management'. Section 3 provides that 'emergency management' means:
'the management of the adverse effects of an emergency including:
 - a. **Prevention** – *the mitigation or prevention of the probability of the occurrence of, and the potential adverse effects of, an emergency; and*
 - b. **Preparedness** – *preparation for response to an emergency; and*
 - c. **Response** – *the combating of the effects of an emergency, provision of emergency assistance for casualties, reduction of further damage, and help to speed recovery; and*
 - d. **Recovery** – *the support of emergency affected communities in the reconstruction and restoration of physical infrastructure, the environment and community, psychosocial and economic wellbeing.'*
- 5.8 This Chapter adopts this schema to examine the effectiveness of the emergency management response at Greenough during the events of 24-25 July.

Policy framework

- 5.9 At the time of the incident on 24 July 2018, the key policy documents that governed the management of emergencies within Corrective Services in Western Australia were:
- the *Emergency Management Framework* ('**EM Framework**'), first published March 2009 and last updated in March 2014; and
 - *Policy Directive 72 – Emergency Management* ('**PD72**'), approved 24 August 2009 and last updated on 8 December 2014.¹¹
- 5.10 The EM Framework is the overarching policy. It sets out '*the general policy on emergency management planning in the Department of Corrective Services*' and is intended to guide the development of local emergency management plans at individual prisons or facilities. According to the EM Framework, the objective of emergency management planning is to '*ensure incidents are resolved with the minimum risk of harm to staff, offenders and members of the public*'. The principles that should be followed are:
- preservation of life and prevention of injury;
 - maintain community safety;
 - prevent escapes and protect the security of the perimeter;
 - maintain the security of and minimise damage to property;
 - restore normality as soon as possible;
 - provide care and support during and after an incident for staff, offenders and their families; and
 - preserve evidence.
- 5.11 The EM Framework also states that the risks associated with an emergency are minimised by:
- giving staff the confidence to manage incidents safely and within pre-prepared, tested and approved procedures;
 - ensuring that incidents are reported to applicable persons/units in order that resources and support can be activated without delay where required; and
 - ensuring that duty of care to staff, prisoners and the public are met by supporting those involved directly with an incident both during and after serious incidents.
- 5.12 The Review was advised that the Department is in the process of replacing the EM Framework. In January 2018, the Department's Security and Intelligence Committee approved the development of a project plan to deliver a more robust and sustainable emergency management capability across the Corrective Services system. The Review was provided with a draft copy of the new framework, titled '*Corrective Services Emergency Management System*', detailing the Department's proposed approach to developing a comprehensive emergency management system. This project is ongoing at the time of writing and it is hoped will address some of the issues identified in this Chapter.
- 5.13 PD72 requires all Superintendents to ensure that their prison has in place a local emergency management plan that is aligned with the EM Framework. It sets out detailed requirements for the review and testing of the local emergency management plans, including requirements to undertake regular training exercises.

¹¹ PD72 was recently revoked and replaced by Prisons Order No. 04/2018, effective from 27 August 2018. However, the governing policy at the time of the critical incident was PD72.

- 5.14 In accordance with PD72, Greenough had in place its own local emergency management plan at the time of the incident on 24 July (**'the Greenough EMP'**). The Greenough EMP was first published in July 2009, reformatted in August 2013, and last amended in September 2016. In accordance with the EM Framework, this 240 page document contains 24 discrete 'Emergency Procedure Action Plans' to deal with specific types of emergency incidents, including: hostage taking, deaths in custody, bomb threats, natural disasters and pandemics. The 24 Action Plans set out a prescriptive list of procedural steps that staff must follow depending on the type of incident that occurs, with each step coded in red, amber or green.
- 5.15 The following three Action Plans were relevant to the incident on 24 July:
- *Action Plan No. 1 – Riotous Behaviour – Major Prison Disturbance* (**'Greenough Riot Action Plan'**);
 - *Action Plan No. 2 – Escape from Prison* (**'Greenough Escape Action Plan'**); and
 - *Action Plan No. 13 – Fire* (**'Greenough Fire Action Plan'**).

Agreements with other agencies

- 5.16 The following Memorandums of Understanding were also relevant to the inter-agency arrangements during the critical incident at Greenough and are discussed where relevant later in this Chapter:
- Memorandum of Understanding between the Department of Corrective Services and Department of the Attorney General and The Western Australia Police in relation to *The Co-operative Provision of Services and Information*, dated February 2014;
 - Service Memorandum of Understanding between the Department of Corrective Services and Western Australia Police in relation to *Major Prison Incidents Occurring in Western Australia*, Version 3, dated January 2007 (unsigned); and
 - Memorandum of Understanding between the Department of Fire and Emergency Services and Department of Corrective Services for *All Hazard Emergencies Occurring at Prisons & Detention Centres*, dated 8 December 2016.

PREVENTION

- 5.17 'Prevention' is a key part of an holistic emergency management response. It refers to actions taken in advance to mitigate the risk, or reduce the probability of, an emergency occurring.
- 5.18 In many ways, all of the issues identified by the Review in Chapter 6 of this Report go to the issue of prevention. Keeping prisoners engaged and meaningfully occupied is fundamental to preventing a major prison disturbance from arising.
- 5.19 The Review found that the Department's EM Framework referred to above generally provides a clear and robust set of standards for emergency management within prisons. However, it would benefit from the inclusion of a dedicated section on 'prevention' to reinforce that an emergency management culture in prisons is built on a strong foundation of robust security procedures, dynamic security and a comprehensive operating model that keeps prisoners engaged.
- 5.20 Examples in prisons of prevention activities that should be constantly ongoing include:
- maintenance and testing of physical infrastructure and security systems;
 - compliance with day-to-day security procedures and safety and security audits;
 - an effective information collection and intelligence model and culture;
 - readjustment of emergency management frameworks and response resources to match the changing prison population and staffing model;
 - appropriately managing prisoners' poor behaviour; and
 - a structured, comprehensive operating model that keeps prisoners engaged.

- 5.21 The local Greenough Riot Action Plan identifies the following more limited range of 'prevention strategies':
- unit management and regular unit meetings;
 - regular reviews and unit plans;
 - grievance procedures;
 - regular reviews of prison procedures; and
 - intelligence gathering.
- 5.22 Overall, while there was some evidence of the above activities being undertaken, the Review was advised that the restrictions of the Adaptive Routine meant that maintaining standards was not as good as it should have been. There was no consistent recording of active emergency management prevention activities available to the Review. The assessment of this critical element of emergency management has therefore had to rely on evidence of how the prison performed during the emergency. Based on this analysis, the Review has identified the following matters as requiring urgent attention:
- a 'Security Infrastructure Condition Report' to address infrastructure failings that occurred during the riot and the current state of amenity at Greenough;
 - the need for ongoing maintenance and testing of security systems and infrastructure;
 - enforcement of security procedures and standards for the storage and access to tools, ladders and fuel;
 - a proactive, contemporary approach to information gathering, analysis and intelligence sharing;
 - a review of the reliability of the current 'temperature' reporting mechanism; and
 - timely prisoner disciplinary action in response to contraventions of prison rules.

Infrastructure

- 5.23 During the events of 24-25 July 2018, there were examples where the prison infrastructure failed to provide containment and delay, which allowed the prisoners' riotous behaviour to magnify and escalate rapidly. For example:
- **Fences:** As explained in the chronology in Chapter 3, the separation fence between Units 2 and 3 was able to be penetrated within 15 minutes of the initial outbreak of fire in cell 22. This fence had been identified as deficient with missing bolts on the day before the riot, and a maintenance request had been submitted, but not yet addressed;
 - **Roof tops:** When the riot erupted, prisoners were able to quickly and easily ascend the roof of the main buildings to gain entry to the Maintenance Workshop and other areas of the prison; making isolation and containment more difficult;
 - **Cell doors:** As the riot continued, prisoners were able to breach the cell doors using tools and garden equipment. This was particularly problematic in the Women's Unit, discussed in detail later in this chapter.
 - **Unit offices and fixtures:** Throughout the riot, prisoners attacked the officer's posts using projectiles and improvised implements. This force caused serious damage and eventually penetrated the staff areas. It is noted that the integrity of the security glass held for sufficient time to allow officers to evacuate, but once breached, the prisoners were able to access security equipment and staff belongings.

- 5.24 The Review understands that as part of the reconstruction and recovery process following the critical incident, there has been ongoing work to strengthen the infrastructure in certain parts of the prison, as discussed at paragraph 5.216. As part of this process following the riot, the Department has prepared and provided the Review with a draft copy of a 'Security Infrastructure Condition Report' for Greenough. The draft report, albeit not complete, provides a detailed account of the direction the Department is taking with infrastructure hardening and improvements at Greenough.
- 5.25 The Review recommends that as the Department progresses the infrastructure review, it should ensure that any infrastructure changes are aligned with Greenough's operating model (the different cohorts managed) and its emergency response capability, including any changes flowing from the critical incident and this Review. In particular, Greenough and the Department should ensure that the infrastructure review considers:
- the effectiveness of the various fencing options at Greenough with particular attention given to the time required to defeat without aids;
 - the effectiveness of cell doors and the time required to compromise their integrity; and
 - the integrity of storage spaces used to store restraint equipment (such as batons and OC spray), fuel and medications; and
 - a mechanism to ensure that regular security integrity checks are conducted at Greenough.

Security

- 5.26 Security is a multi-faceted but critical concept within the prison environment. The Review has focused on the following three elements of security: physical, procedural and dynamic security.

Physical security

- 5.27 Greenough has multiple layers of physical security systems around the perimeter of the prison. The most obvious physical barrier is the external perimeter fence, sometimes referred to as the 'prime barrier'. This fence structure is fitted with an anti-grappling cowl and is further complemented by electronic detection technology.
- 5.28 In sum, there are two physical structures (the internal perimeter fence and the prime external perimeter fence) complemented by various layers of electronic detection systems.
- 5.29 The Review found that during the course of the escape on 24 July 2018, both physical structures and the electronic detection systems operated as intended. Yet the physical security was defeated with the aid of a battery-powered angle grinder tool ('grinder') and two ladders, discussed in detail below.

Procedural security

- 5.30 Procedural security refers to the processes and procedures within the prison used to ensure a consistent approach to security standards. The Review identified a number of significant deficiencies in this area:
- **Tools:** Once inside the Maintenance Workshop, the prisoners were able to access the unsecured grinder, enabling them to cut through chains securing the ladders, and then a gate, to effect their escape. The grinder used was registered on the Facilities Officer's tool list but was left unsecured on top of a mobile trolley in the Workshop. All tools in the trolley are the property of the Department and are used on site to perform maintenance. Such a tool should not have been left unsecured. The Review found that while Greenough did complete an inventory of all tools in the prison between March and July 2018, this did not appear to have resulted in any changes to the procedures for storing and managing these tools.

- **Ladders:** The Review found that ladders were stored in the Workshop inside the secure perimeter of the prison. They should have been stored outside the secure perimeter; only to be brought into the prison under supervision for a specific purpose. The ladder of most concern was the long ladder that extended to the height of the external perimeter fence. The ladders accessed by prisoners were chained with padlocks, but prisoners used the grinder left unsecured in the same workshop, to cut through the chains and release the ladders.
 - **Fuel:** Prisoners were also able to easily get hold of fuel once they had tools and the run of the prison during the riot. The fuel was used to light fires and make 'Molotov' cocktails used as weapons. The fuel was stored in the gardens shed for lawn maintenance.
 - **Medications:** A range of medications were also accessed from within the Women's Unit during the course of the riot. The medications were stored in a trolley, and the trolley was stored in an office that prisoners broke into.
 - **Keys:** The Review also found that Greenough did not have an up-to-date central Keys Register. Although not directly relevant to the events on 24-25 July, this is also an example of poor security practice at Greenough.
- 5.31 Many of the procedural security failings identified above had previously been the subject of a Departmental 'Greenough Regional Prison Compliance Review' Audit in January 2016 ('**Audit**'). The Audit identified that significant improvement was required in the area of 'Tools and Equipment' management. In particular, the Audit noted that general security practices were not being followed in the carpentry and metal shops, identifying 16 points to be addressed. Some of the matters that the audit commented upon were: not all tools could be accounted for; storerooms containing hazardous liquids were found to be unlocked; not all tools were secured; and makeshift weapons being found in prisoners' lockers. Some improvement was also identified as being required in perimeter security, key management and emergency management.
- 5.32 While the Audit acknowledged that some immediate actions were put in place and Greenough provided a detailed response to the Department; the Review could find no evidence that the prison was monitoring these recommendations and actions at the local level.
- 5.33 Importantly, the Review also found that the position of Assistant Superintendent Security at Greenough was vacant from October 2017 until mid-July 2018; a period of eight months. The position was covered by acting arrangements for only six weeks. Also during this period, another senior management position was abolished; leaving only two senior positions in place throughout 2018. The senior oversight of security functions and offender services had to be absorbed by the two remaining managers. It appears unrealistic to expect that the functions and standards maintained by four, could be properly acquitted by two.
- 5.34 This limitation on resources may help explain the decline in attention to security practices at Greenough during this period. The consequences of this are even more serious during a period of major change to the operating model with the implementation of the Adaptive Routine during this period.
- 5.35 Since the riot, the Department has acted to ensure that all power tools and ladders are stored outside the external perimeter fence of all prisons in Western Australia.¹² On 27 July 2018, the Department instituted an '*Action Plan: Enhanced Security Associated with Power Tools, Ladders and Ceiling Spaces*'. The Review was advised that the Department is also currently working with prisons to improve the secure storage of fuel and accelerants, including through the use of inventory processes. While this is positive, the Review notes that the Action Plan for tools and ladders, and any new requirements in relation to fuel storage, have not been enshrined as a formal Prison Order to ensure that Superintendents clearly understand the new requirements.

¹² Parliamentary Question Without Notice C625, Hon Jim Chown to the Minister for Environment representing the Minister for Corrective Services, answered on 15 August 2018.

Dynamic security

- 5.36 Dynamic security – sometimes referred to as relational security – refers to the relationship between staff and prisoners and the ability to garner information and pre-empt emerging problems in an ongoing fashion.
- 5.37 In line with the principles of dynamic security, the gathering of information from within the prison environment and the analysis of that information should be the foundation of preventing major disturbances, escapes and criminal activity in prisons. Prison intelligence can provide pre-warning and assist with the focusing of resources in the right areas to prevent planned actions from taking place.
- 5.38 The benefits of a good prison intelligence model include but are not limited to:
- supporting informed decision making;
 - preventing escapes, riots and disturbances;
 - protecting vulnerable prisoners; and
 - identifying individuals and groups who pose a risk to the management and good order of prison operations.
- 5.39 The Review found that prior to 24 July, there was little known information to indicate that such a significant critical incident would occur. In particular:
- it was reported that there was a relatively low volume of security reports coming out of Greenough prior to the incident; and
 - the ‘temperature’ reports prepared by the Department showed Greenough as ‘stable’.
- 5.40 Each of these matters is discussed in turn below. Two further matters related to dynamic security are also discussed in this section:
- information sharing within the prison; and
 - management of prisoner behaviour.

Intelligence model and security reports

- 5.41 The Review was informed that the Department’s information collection processes for the creation of intelligence products, mainly rely on security reports provided from across the custodial and relevant community environments. These raw security reports, submitted by security managers and individuals in prisons, provide context to local issues and events. This reporting stream is supplemented by additional information collected by a specialist central directorate within the Department, known as Intelligence Services.
- 5.42 The security reports submitted by facilities are analysed by Intelligence Services, who in turn develop the raw information into ‘intelligence products’ suitable for the Department. Intelligence Services advised that given resourcing limitations, their activity is principally targeted towards maximum-security metropolitan facilities, and they largely rely on locally generated information reporting from regional facilities.
- 5.43 The Review was advised by Intelligence Services that there was a notable drop in reporting activity coming from Greenough in the two months preceding the riot. There are a number of possible explanations for this: either there was nothing to report; or there were things to report, but prison officers had stopped noticing and/or stopped submitting reports. If it was the latter, this may have been because of a belief that the reports would not be acted on, the absence of an Assistant Superintendent Security, reduced time for staff to interact with prisoners, or other reasons.
- 5.44 After the critical incident, and with the benefit of hindsight, Intelligence Services collated the following intelligence information which was provided to the Review. Most of this information has been redacted on the basis that it may be prejudicial to the criminal justice process, apart from the following more general observations:
- Several prisoners involved in the incident cited broad dissatisfaction with prison conditions, including access to the Prison Telephone System, visits, and the inability to attend key family and cultural events such as funerals, as reasons for the incident;

- Dissatisfaction with conditions at Greenough continued to be the main motivating factor identified for the disturbance/escape. Some prisoners continued to assert that unsanitary conditions, poor food, excessive lockdowns, limited access to the Prison Telephone System, and delays in facilitating access to key Indigenous events.
- 5.45 The above information was collated from multiple sources after the critical incident by Intelligence Services and provides the perspectives of prisoners on the events of 24-25 July. For the purposes of this Chapter on emergency management and prevention, and considering the important part that dynamic security plays in preventing an emergency, the important thing to note is that the information provided by Intelligence Services above was not produced prior to the critical incident.

Temperature reporting

- 5.46 Intelligence Services also produce a weekly 'Temperature Report' (to monitor the stability of each prison) which covers all eighteen correctional sites across Western Australia. The stated purpose of the Temperature Report is to provide '*information and analysis on significant security and safety incidents in Western Australian prisons and youth detention facilities.*' The Report is compiled using a number of indicators such as the number of incidents reported in prisons. These indicators are used to categorise each facility as either stable, elevated, rising or declining, using the following definitions:
- Stable** – *there has been no or minimal change in the level of most indicators from last week;*
- Elevated** – *there has been an increase in the level of several indicators from last week;*
- Rising** – *there has been an increase in the level of several indicators for the past two or more weeks; and*
- Declining** – *there has been a decrease in the level of most indicators from last week.*
- 5.47 The Department's Temperature Report for Greenough from 7 March to 25 July 2018, showed a 'stable' environment for every week. It is noteworthy that for the period mentioned, all Western Australian prisons were assessed as 'stable' weekly for the five month period, which appears remarkable for a prison environment.
- 5.48 The Review found it difficult to reconcile the assessment in the Temperature Report with what is known about the rising tensions within the prison (for example, the Independent Prison Visitor reports detailed in Chapter 6) and the events that occurred on 24-25 July. The Review understands that there have been efforts within the Department to improve the reliability of the temperature reporting tool to enable it to better identify relevant trends. The Review strongly supports this ongoing work.

Conclusion in relation to intelligence

- 5.49 In light of the above, the Review considers that there was somewhat of a disconnect between the Department's formal 'temperature' assessment of Greenough leading up to the riot, and the rising strain within the prison on the ground. The Review was not able to establish the underlying cause of this disconnect, but the absence of a permanent Assistant Superintendent Security for eight months cannot have helped.
- 5.50 More generally, the speed with which the escape was effected indicates that there was a degree of planning involved. The facts are: prisoners broke into the Maintenance Workshop; accessed an unsecured angle grinder and released ladders; breached the internal and external perimeter fences; and escaped the prison within 22 minutes (16:30hrs – 16:52hrs). It seems unlikely that the prisoners acted spontaneously and got 'lucky' when they broke into the Workshop. It is more probable that they broke into the Workshop with prior knowledge of what they required and the intent to escape the prison.
- 5.51 The Review was not able to determine whether the fire and riot created an opportunity or was a deliberate decoy to facilitate the escape. This is for the criminal justice process to determine. What is of interest is the apparent pre-planning that occurred for the escape. If this was the case, and several prisoners were involved, then the robustness of the information collection processes at Greenough, and the intelligence model as a whole, requires attention.

Information sharing and reporting

- 5.52 As discussed in Chapter 3, the local arrangement at Greenough for information sharing within the management group was a twice weekly 'Debrief Meeting'. At each meeting, the minutes record an overview of each Unit and the Superintendent provides information and direction.
- 5.53 The Review analysed the minutes for the period of April to July 2018. On 23 July – the day before the riot – Unit 1 was 'quiet over the last week'; Unit 2 was 'cool'; Units 3 and 4 had 'nil reports'; and Unit 5 and 6 were 'cool'. The rating of 'cool' was explained to the Review as meaning the environment was 'stable'; while 'warm' was described as meaning 'somewhat elevated'. These terms are not consistent with the 'Temperature Report' described above. The Superintendent raised some minor security matters and the future visit of the monitoring and compliance team.
- 5.54 In the week prior, Unit 2 was recorded as 'warm' – noting that prisoners were getting agitated from constant lockdowns behind the grilles and no external recreation. Unit 3 had 'unit temperature manageable' and Unit 4 was recorded as on an Adaptive Routine with the Unit temperature 'warm'. Unit 5 was 'cool'. It was also recorded by the Assistant Superintendent that: *'Not many complaints re staffing – prisoners are understanding as to the reasons for lock-ups; appreciate the communication in regards to lock-ups, plenty of notice etc.'*
- 5.55 On 9 July, the temperature for Units 1, 2, 3, 5 and 6 was recorded as 'cool' and Unit 4 was reported as 'settled despite short staffing'. The reporting of the Unit temperatures as 'cool' commonly features throughout the debrief minutes during the April to July period.
- 5.56 While staff observations after the critical incident were that there were numerous indicators of prisoner unrest at Greenough in the weeks and months leading up to the event, as noted above, the Review has found little recorded information that indicated major unrest. This contradiction may be a function of heightened staff reflections following the critical incident, or it could be that without any concerted planning for the 24 July, the opportunity was there for reckless prisoners to express their frustrations in an irresponsible manner and this quickly got out of hand. Alternatively, it may be that the absence of recorded information is the product of deficiencies in communication across the prison as discussed in Chapter 3.
- 5.57 Whatever the scenario, the Review considers that more effort is required to embed a strengthened information sharing and intelligence culture, and to improve dynamic security at Greenough. This is a key aspect of prevention in the emergency management context. However, this will only succeed if staff can see the value of their efforts reflected in timely intelligence products to inform their work. Communication and intelligence systems at Greenough – including the gathering, reporting and feedback on information and intelligence – require attention.

Management of prisoner behaviour

- 5.58 There had been no Prosecutions Officer at the prison throughout the eight months preceding the riot, with the consequence being that no formal disciplinary action against prisoner contravention of prison rules has been actioned. Throughout this period, just six shifts were allocated to clear up all outstanding charges against prisoners, however, the outcome was that no charges proceeded to a disciplinary hearing.¹³
- 5.59 This calls into question the integrity of this important legal process and highlights the importance of having in place a prosecutions function, and trained staff to support officers in managing prisoners' poor behaviour.
- 5.60 A number of staff felt that prisoner misconduct was not taken seriously because prison charges were not processed, and that this undermined their management of prisoners. The absence of a prosecution officer for such an extended period validates this position.

¹³ Part VII of the Prisons Act specifies a number of minor and aggravated offences with which a prisoner may be charged during their time in prison, and the process for the hearing of charges and imposition of penalties.

PREPAREDNESS

- 5.61 Preparedness encompasses the actions that should be happening on a regular basis. This is so that when an emergency situation arises, it is not an unexpected event and there are clear up-to-date plans to follow, and a practiced, competent response. Where there are major changes to the prison operating model that have the potential to adversely impact on prisoners, attention to preparedness is even more critical.
- 5.62 The Review identified a number of deficiencies at Greenough and across the Department with regards to preparedness, each of which is discussed below:
- key emergency management policies and the vital memorandum of understanding with WA Police had not been recently reviewed and were out of date;
 - although emergency training exercises were conducted at Greenough in the twelve months prior to the critical incident, there did not appear to be a consistent approach to implementing action items or lessons learned from the exercises; and
 - there was an absence of any recent appraisal of local emergency management expertise, capability or equipment required to contain a large scale incident.

Review of emergency management policies

- 5.63 The Department's EM Framework requires that it must be reviewed at least once annually (or as appropriate). The most recent recorded update to the EM Framework was in March 2014; more than four years ago.
- 5.64 Local EM Plans must also be reviewed annually and submitted to the Manager, Emergency Management by 1 October each year; in accordance with PD72. These reviews are supposed to be activated by the Manager who is to forward the template to all prisons a month in advance. The Review was advised that the position of Manager, Emergency Management, was abolished in December 2015.
- 5.65 The local Greenough EMP is dated September 2016. The Review could not find evidence of the annual review having been conducted in 2017. There was a review conducted in March 2018, but this was confined to the reconciliation of current duty statements and the staff redeployment agreement for the purpose of aligning staff changes to the EMP. While the amendments were not significant, the changes from the March 2018 review had not been actioned in the Greenough EMP as at 24 July.
- 5.66 PD72 – the policy that governs emergency management preparedness across prisons – was almost two years overdue for review at the time of the critical incident. It has since been replaced by Prisons Order No. 04/2018, with effect from 27 August 2018.

Emergency training exercises at Greenough

- 5.67 PD72 mandates the following testing of emergency management plans:
- each facility must hold at least one emergency management exercise every two calendar months; and
 - each facility must complete at least one exercise once every calendar year for death of a prisoner, escape from a prison, fire, hostage, major disturbance and medical emergency.
- 5.68 The mandatory exercises listed above must include, at a minimum, one *live exercise* and other exercises may be *desktop exercises*. A fire evacuation drill must be practiced, consistent with security requirements for each prison, at least once every six months and can be a component of a live fire exercise or a separate training drill.

- 5.69 Records provided to the Review show that in 2018, Greenough conducted the following exercises:
- 27 February 2018 - Desktop exercise – Fire / Medical Centre Evacuation - to test the preparedness of the medical staff to conduct a building evacuation in the event of a serious fire within the medical centre. This was a table-top exercise confined to the medical centre only, as required in the EM Framework; and
 - 7 May 2018 – Live exercise – Operation Dalmatian – Inter-agency Fire exercise with DFES. The purposes of this exercise was to test the effectiveness of the Greenough EM Plan for Fire; gauge inter-agency synergy; and identify gaps in equipment, training, supervision and other supportive elements. This was a significant live exercise and a number of lessons learned were identified.
- 5.70 For 2017, the Review was provided with records of eight emergency management exercises conducted as follows:
- | | | |
|----------|---|--|
| March | - | Perimeter Breach (live) |
| April | - | Fire/Evacuation (live) |
| May | - | Fire/Evacuation (live)
Concerted Indiscipline/Riot (desktop) FESA, Geraldton Police |
| July | - | Medical Emergency (live) |
| November | - | Death in Custody (desktop) |
| December | - | Escape (desktop)
Hostage/Medical Centre Evacuation (live) |
- 5.71 The timing of these exercises throughout 2017 and 2018 appears to broadly comply with the requirement to hold one emergency exercise every two months in PD72. It was not possible for the Review to assess the standard or quality of each individual exercise. It is noted, however, that some of the lessons learned in the exercises do not appear to have been actioned. For example, a proposed change from the ‘Concerted Indiscipline/ Riot multi-agency exercise’ conducted in May 2017, required Greenough and WA Police Force to produce a chain of command flow chart to be appended to the Action Plans and procedures. This action had not been acquitted as at 24 July 2018. This is another area that would benefit from a more formal governance framework at Greenough – to oversee the implementation of these action items and thereby improve Greenough’s level of emergency preparedness. The need for a local governance framework at Greenough is discussed further in Chapter 6 – Causes and Contributing Factors.
- 5.72 Separate to emergency management exercises, the Review also notes that entry-level prison officers only receive one-off ‘primary response’ training during their pre-service training course (also called ‘basic riot control training’). There is no mandatory requirement for this basic training to be updated, or for any ongoing refresher training in this area, and this is another aspect of preparedness that requires attention at Greenough.
- 5.73 The Review also found an absence of any recent assessment of local emergency management expertise and resource requirements; or appraisal of the capability to adequately contain a large prison incident should it eventuate at Greenough.

Multi-agency arrangements

- 5.74 The Department’s EM Framework requires: an initial response at the prison to set up an incident control facility and incident management team; the activation of emergency management plans; and the capacity to isolate, contain and hold an incident. This is until the centralised, highly-trained Special Operations Group (**‘SOG’**) arrives on site to lead and actuate a planned response. This process is discussed in detail in the following section on ‘Response’. The support of local emergency service agencies (police, fire and ambulance) should be engaged where needed.

- 5.75 The Review was provided with the most recent copies of three multi-agency MOUs that the Department has with relevance to emergency management, listed at the beginning of this Chapter.
- 5.76 The MOU between the former Department of Corrective Services and WA Police in relation to *'Major Prison Incidents Occurring in Western Australia'*, dated 3 January 2007, requires that it must be reviewed every 24 months from the date of commencement or at any other time at the request of the parties. The Review could not find any evidence that this important MOU has ever been reviewed in the eleven years since it was put in place.
- 5.77 This is concerning for a number of reasons. Most critically, given the mandatory requirement to conduct a 'major disturbance' exercise annually, is the practical application of the MOU and the testing of procedures during the exercises that were conducted. There was no mention of the MOU being referenced in the Concerted Indiscipline/Riot exercise at Greenough in May 2017. The fact that the exceedingly overdue date for the review of this MOU has gone unattended to in the Department highlights flaws in the conduct of emergency exercises Statewide.
- 5.78 The Review could find no reference to the MOU in Greenough's or the Head Office records of the critical incident, but was told that the document was referred to in the Operations Centre and was noted as being out-of-date. The Review was advised that the command and control model put in place between the multi-agencies on the night of the riot was a *"unified command"* model. This model of command is not that which is described in the MOU.
- 5.79 The other two relevant MOUs are not yet due for review.
- 5.80 The Review was advised by both WA Police Force in Geraldton and DFES that they shared strong and respectful relationships with Greenough prison. This is very positive. All agencies considered that cooperation, communication and information sharing over a long period had built solid supportive partnerships between the emergency service agencies.
- 5.81 However, good relationships alone do not suffice in an emergency situation. The strength of the emergency management response must go beyond personal goodwill in a particular location. It must be embedded and reflected in the authorising documents themselves so that anyone can pick up the document and know what to do during an emergency. The purpose of regularly reviewing these documents is to create an ethos and culture of continuous improvement within the emergency management context; thereby improving the level of preparedness generally. The Department must do more to promote and instil such a culture when it comes to emergency management in the prison environment.

Special Operations Group

- 5.82 The involvement of SOG is discussed in detail in the following part of this Chapter dealing with 'Response'. However, in the context of considering 'Preparedness', the Review makes the following observations.
- 5.83 While the SOG officers are highly-trained specialists in Statewide emergency management response, the resources allocated to SOG have remained static throughout the last decade. In 2007, the SOG had a set number of positions when the State adult prison population (at June 30) was 3847. On 30 June 2018, the State adult prison population was 6868, an increase of 79 percent in the last 11 years, with most of this expansion being absorbed within existing prisons and therefore significantly increasing the number of prisoners contained within each prison. However, the size of the SOG unit has remained the same, as has the emergency response model; noting that a recent change to the deployment model for SOG – removing static gatehouse positions at one prison – has somewhat increased the flexibility of the group's resources.
- 5.84 In May 2016, a proposal was put forward to expand SOG. This was founded on an increase in tasking and the need for the group to field additional capacity to perform the roles and tasks directed in a functional review and to maintain expected standards of service delivery. The Review understands the proposal did not proceed due to budget implications.

RESPONSE

- 5.85 Emergency response refers to combating the effects of an emergency, including the provision of emergency assistance for casualties, reduction of further damage, and help to speed recovery.
- 5.86 The Review considers that the front-line response to the riot and fires at Greenough was good in the circumstances; but in certain critical respects, the overall response to the emergency was hindered by a lack of preparedness, poor incident management structure and a failure to comply with the Department's own policies and procedures.
- 5.87 Specifically, the Review found the following positive themes:
- the response to rioting prisoners by Greenough officers who were on the front-line quelling fires, securing surrendered prisoners and attempting to contain the incident was commendable;
 - the first priority throughout the incident was the 'preservation of life' and this is evidenced by the fact that there were no serious injuries;
 - the SOG response was excellent – they carried out careful planning, made considered decisions and took appropriate offensive action;
 - the resources and speed of deployment by WA Police Force to the incident and region was also excellent;
 - the multi-agency arrangements and 'unified command' model worked well; and
 - the planning and execution of direct action had the safety of staff and prisoners at its forefront.
- 5.88 But there were also some fundamental failures in the response:
- Greenough did not have a properly-equipped secure space from which to run an Incident Control Facility;
 - contrary to the Department's policies Greenough did not establish a formally structured Incident Management Team;
 - contrary to the Department's policies, Head Office did not establish a formally structured Incident Control Facility with a functional Incident Management Team;
 - there was an unacceptable delay in protecting the external perimeter at the outset of the critical incidents;
 - there was an unacceptable delay in response to the breach of the perimeter; and
 - there was an unacceptable delay in securing the safety of women prisoners in Unit 4.
- 5.89 At the outset, it is noted that the Review's task of analysing the emergency management response was made significantly more difficult by poor record keeping during the incident. In the absence of formal contemporaneous logs, the Review was instead provided with various running sheets and chronologies, some of which were prepared by the Department after the incident from notes, emails, and individual recollections of the series of events. As noted in Chapter 4, the Review drew on this information, as well as other technical data such as radio call logs, CCTV footage and alarm logs, in order to establish the chronology of events, which has also informed the findings in this Chapter.

Immediate response by prison staff

- 5.90 By all accounts, the Greenough prison staff were courageous in their endeavours to contain the incidents on 24-25 July, with preservation of life the priority. The initial response to the fire in cell 22 and the calling of a 'code red' was swift, as was the evacuation of prisoners from Unit 2 to avoid smoke inhalation. Within a few minutes, staff were confronted by prisoners throwing rocks at them and they tried their best to defend Unit offices before they were penetrated.

- 5.91 Amongst the confusion and growing disorder, officers secured those prisoners they could, moved staff to safety, and called for those prisoners not wishing to be involved to surrender. Officers attempted to account for secured and surrendered prisoners, while riotous prisoners continued their rampage. Within 15 minutes, two Units were overtaken by prisoners and the separation fence between Units 2 and 3 was breached (as noted above in the section on 'Infrastructure'). Officers continued to facilitate the surrender of those prisoners who did not want to partake in the riotous behaviour.
- 5.92 Within 28 minutes, CCTV footage shows prisoners scaling the roof of Unit 2 and breaking into the Maintenance Workshop. Within 50 minutes of the initial fire and code red being called, ten prisoners had breached the internal perimeter fence in possession of two ladders and were ascending the prime external perimeter fence and escaping the prison.

Establishing an Incident Control Facility and Incident Management Team

- 5.93 An Incident Control Facility ('ICF') is the location where the incident controller and members of the incident management team provide overall direction/control of an incident occurring within that establishment.
- 5.94 The Department's EM Framework provides that:
- "Serious incidents are those that require activation of a **local Incident Control Facility (ICF)**, Head Office ICF and/or state command centres to be opened and would feature one or more of the following elements – loss of control, be ongoing, a threat to security/safety, multi-organisational involvement and political, public, media interest. (Mandatory action)*
- Where an incident necessitates activation of the **Head Office ICF**, the Superintendent of the ESG¹⁴ will attend at Head Office (as required) to provide advisory support.*
- The command structure for emergency management at the Local Incident Control Facility and Head Office ICF should follow the Australasian Inter-Service Incident Management System (AIIIMS)."*
- 5.95 The Greenough EMP summarises the AIIIMS command structure as follows: the 'Incident Controller' oversees the overall command of the incident, supported by a 'Forward Commander' (or operations commander); a 'Planning Officer'; and a 'Logistics Officer'. This is collectively referred to as the Incident Management Team and each role has a list of specific responsibilities. In large scale incidents, the team should also include a communications officer and an official 'scribe'.
- 5.96 The Review was advised that while a number of attempts were made, no formal ICF was established at Greenough. The main reasons given to the Review was the lack of available staff to allocate to a functional management structure, because the priority was to have officers at the front-line; and the need to move locations three times during the incident due to unstable conditions.
- 5.97 Initially, it is recorded that a 'forward command post' was established at Central Control within the prison, around 55 minutes into the incident. It was known that the Superintendent was the 'Incident Controller', with a team of one, being the Assistant Superintendent, who was broadly responsible for the functions of communications, operations and planning. This position was tasked with providing regular email updates to the Head Office Operations Centre every 15 minutes. From the records, the role of 'Forward Commander' is unclear until SOG arrived on site.
- 5.98 The improvised 'ICF' had to move from Central Control to the Administration building, and then moved again to the Gatehouse, because of prisoners on the roof smashing windows in these buildings. The Gatehouse functioned as an ICF of sorts, however, this area – and indeed no areas within the prison – were properly equipped to function as an ICF; for example, there were no up-to-date site maps, no modern communications technology, no directives setting out responsibilities for each role, no electronic whiteboards, nor any other supporting equipment.

¹⁴ ESG refers to the Emergency Service Group, the former name of the Special Operations Group.

- 5.99 There was also a failure to institute a formal 'Incident Management Team' functional structure. The Review identified several omissions in the prison's response, which may not have been overlooked had a functional Incident Management Team been established. There were shortcomings in recording, planning, communications and logistics brought to the attention of the Review. Had these matters been managed better, this could have resulted in a more effective emergency management response and aided recovery.
- 5.100 The shortcomings included:
- No contemporaneous formal log of events recording events as they occurred, or the planning or development of incident action plans, decisions, resource allocations and response;
 - No designated, trained 'scribe' tasked with time recording events and decisions as the incident unfolded (noting the Assistant Superintendent did provide regular email updates to the Head Office Operations Centre);
 - Ineffective communication, for example, the response vehicle was not deployed to the perimeter when the incident inside the perimeter was evolving, which was unknown to the Incident Controller at the time;
 - Non-uniformed staff were directed home when the incident erupted, when many believed they could have been tasked with administrative, communications and logistics functions on the night;
 - No off-duty prison officers were called back into the Prison, even when some phoned in to see if they were needed. The Review was advised this decision was made to preserve officers for the next day's operations and because of the limited personal protective equipment ('PPE') in the prison. Yet throughout the critical incident there was a shortage of staff to contain areas, staff felt vulnerable in some positions where they were left, and those staff on duty had to remain active for almost 24 hours;
 - There was no communication with families of staff who were on-duty, or off-duty officers; nor to prisoners' families to advise them of the incident and the safety of family members. While some individual officers took the initiative to phone family, and allowed prisoners to use phones to advise their families of their welfare, there was no structured communication process;
 - The provision of food, water, clothing and blankets to staff and surrendered prisoners was organised where it was possible, often by individual officers acting on their own initiative. There did not appear to be an organised process for the provision of these resources to support staff in areas of containment within the prison.
- 5.101 In such a large-scale, serious incident, the Review considers that the inability to establish a formal ICF and Incident Management Team, in accordance with the requirements of the EM Framework and the Greenough EMP, was a serious failing. While it is understood that the events of 24-25 July unfolded rapidly, with multiple incidents occurring causing a chaotic situation, the precise purpose of the ICF and Incident Management Team structure is to provide clarity about the lines of command and responsibilities during such an emergency, and to bring order to disorder.

Activating resources from Corrective Services Head Office

- 5.102 On 24 July 2018, the Head Office Operations Centre was alerted to the fire and riotous behaviour incidents within 13 minutes of the events unfolding at Greenough, and began notifications as required.
- 5.103 Senior executives attended the Operations Centre and a State 'Incident Controller' was nominated, but a formal Head Office ICF and a functional Incident Management Team was not established.
- 5.104 There was a team of experienced senior executives, principal response officers, three intelligence officers and a media person in attendance to coordinate the State response. A Corrections Liaison Officer was deployed to assist WA Police Force with operational advice about prisons.

- 5.105 A contemporaneous 'running sheet' was kept throughout the incident, recording the regular reports that were coming via email from Greenough every 15 minutes, but this was largely a record of what was happening at the prison. It contained little information on the planning, decision-making, authorisations and actions that were being taken by the staff in the Operations Centre, as would normally be expected in a formal 'log of events' in a properly functioning ICF, particularly given the seriousness of the events. Further context around the roles and decision-making in the Operations Centre was provided by the Department in another chronology prepared after the event, but this was not clearly recorded at the time. For the purposes of this Chapter, the running sheet and the subsequent chronology provided by the Department are collectively referred to as the **'Head Office records'**.
- 5.106 The Head Office records note that the role and functions of the Operations Centre group was as follows:
- "Throughout the incident the acting Commissioner, acting Deputy Commissioner and acting Assistant Commissioner Adult Custodial sought clarification of events, relayed information but did not take control of the incident. Their role was to support the ICF Forward Commander Superintendent.*
- The team did not establish a command structure as such, but using the usual chain of command sought clarification, relayed information. There was not a replacement team established, although the Acting DC was relieved at midnight, should a day shift be required."*
- 5.107 The staff in the Operations Centre supported the prison with the mobilisation of SOG, who were alerted to the events at 16:45hrs and had the first team on the road to Greenough shortly after. WA Police Force was alerted to the evolving incidents and established their own State ICF and immediately began activating specialist resources to deploy to Geraldton. Communications between Corrective Services and WA Police Force were supported by the strong relationships that are in place. In total, the WA Police Force deployment was around 160 personnel plus other resources to support the region.
- 5.108 The Operations Centre was not properly equipped or laid out to provide for an efficient and effective functioning of a State ICF. Examples provided to the Review included that:
- there were no up-to-date or detailed site maps of Greenough prison, making it difficult to obtain a full appreciation of the information being received; and
 - no universal information system to relay situation reports so that all involved were receiving the same messages; instead the information was being relayed by telephone and email through various sources, causing some confusion.
- 5.109 The Head Office records provide a chronology of the information received from the communication link at Greenough, including some notifications and actions made in the Operations Centre. This includes a notation of an action taken by the Acting Commissioner that he had confirmed 'section 15 powers' for police officers to assist in the response at Greenough. Section 15 of the Prisons Act permits a police officer to exercise the powers of a prison officer upon request by the chief executive officer, subject to the directions of the Commissioner of Police. There are also notes confirming orders under section 48 of the Prisons Act permitting use of force against a prisoner where a serious breach of the good order or security of a prison has occurred or appears to be imminent, and no other reasonable means of control are available at the prison.
- 5.110 The Review suggests that it would be good practice to formally confer section 15 powers on police officers in writing, using pre-prepared forms which clearly state the specific powers police officers may use, and these should be readily available in local EM Plans.
- 5.111 While the Operations Centre sent out critical incident notifications via email, the Review could find little evidence that any Statewide actions were taken as a pre-emptive response; for example, locking down all prisons to avoid 'copycat' behaviour and to ensure resources remained concentrated on Greenough. Pre-emptive arrangements were made with other prisons for the intake of prisoners from Greenough, knowing that bed capacity would likely be reduced.

5.112 As noted above, the Department's EM Framework requires that an ICF be set up in Head Office where there is a serious incident. The Head Office records state that: *"the command and control of the incident worked well, alongside the unified command at the scene which was very well done"*. However, in the Review's opinion, the scale and seriousness of the events at Greenough on 24-25 July warranted a formal Head Office State ICF.

5.113 The State ICF has overall responsibility for a number of critical functions, including:

- providing guidance and support for the local Incident Controller;
- logistics functions of mobilising resources to assist the prison respond and recover;
- liaison with WA Police Force;
- communications across multiple stakeholders;
- statewide planning to maintain stability of the prison estate; and
- freeing up capacity for additional prisoners at other prisons.

The Review understands that some of these functions were performed to varying degrees by the team in the Operations Centre, and there was multi-tasking of activities. However, as noted above, many of the supporting decisions, authorisations and actions were not formally recorded at the time. While it is accepted that the AIIMS model is adaptable and scalable, it is still difficult to understand why a properly structured, formal Head Office Incident Control Facility and functional Incident Management Team structure was not established, especially given the seriousness and scale of the events at Greenough on 24-25 July.

Community safety – protection of the perimeter

5.114 Following the quelling of the fire in Unit 2 and evacuation of prisoners, the staff efforts focused on surrender and containment of prisoners uninvolved in the riot, and the safety of staff. Their endeavours to hold the prison until the specialist responders could arrive were commendable. The defensive approach was correct given the resources, level of training and protective and security equipment available at the prison.

5.115 However, despite several requirements in the EM Framework, the Greenough Riot Action Plan, and other relevant Action Plans for Fire and Escape, the Review found that there was an unacceptable delay in securing the perimeter of the prison following the commencement of the riot.

5.116 As noted above, the Greenough Riot Action Plan was the key applicable Action Plan during the initial events of 24-25 July. It relevantly provides that, following the outbreak of a major disturbance or riot:

- the senior officer at the gate is to 'mobilise the Primary Response Unit (PRU) utilising gate staff'; and
- the Incident Controller or Officer in Charge is to 'ensure the PRU is deployed to guard the perimeter'.

5.117 The Greenough Fire Action Plan also relevantly states that:

'A fire may be part of an insurrection or planned escape, may lead to panic by prisoners or even if started accidentally, lead to spontaneous attempts at escape'.

5.118 The Greenough Escape Action Plan also notes that:

'The escape can transpire by prisoners cutting, climbing or ramming the perimeter fence without external support. This may include support from other prisoners through such actions as riot or other forms of diversion'.

5.119 The procedure contained within this Escape plan requires that:

'1 x Gate Staff and other designated: Deploy External Response Vehicle (ERV). Consider deployment of internal vehicle response'.

5.120 The Action Overview for an escape also instructs:

'Maintain CCTV coverage and monitoring of the situation and the mobilisation of PRU and Response Team'.

5.121 The Review was advised that the general procedure in these circumstances is for staff from the Gatehouse to claim two kit bags containing personal protective and restraint equipment held at the gate, and proceed to mobilise an 'external response vehicle' to protect the perimeter. The Review was unable to identify any evidence that this procedure was followed in a timely manner.

Escape

5.122 At 16:30hrs, CCTV footage shows prisoners breaching ceiling space above Unit 2 and entering the Maintenance Workshop, where there were power tools and ladders stored. This was unknown to the Greenough Incident Controller at the time. Around ten minutes later, these prisoners exited the workshop via the ground floor personnel door, carrying ladders and a battery-operated angle grinder.

5.123 Prisoners breached the internal perimeter fence 17 minutes later using the grinder to cut a padlock securing a personnel access gate, allowing them to enter the sterile zone. The workshop door, personnel access gate and perimeter zones 10 to 12, are in the same area of the prison.

5.124 It is important to note that this escape was occurring amidst the escalating chaos and disorder in Units 2 and 3. Between 16:30hrs and 16:47hrs, other prisoners were attacking the Unit 3 office; ascending the roof of Unit 2 and 3; and breaching the women's precinct. Some prison staff had donned personal protective equipment and were forming response teams, and others were carefully evacuating those prisoners that did not want to be involved in the riot and securing them in Unit 1. The Superintendent requested SOG assistance during this period (at 16:45hrs) and notified the Acting Director General and Acting Deputy Commissioner of the critical incident.

5.125 At 16:47hrs, the in-ground security detection alarms within zones 11 and 12 were triggered.

5.126 One minute later, the alarm on the prime external perimeter fence was activated. There is no record of an emergency code being called in response to the perimeter alarms and, at this time, no external response vehicle had been deployed to protect the perimeter, as is required in the emergency plans. By 16:52hrs, ten prisoners escaped the prison.

5.127 The Department provided technical advice confirming that in response to the perimeter alarms, the master control room operator acknowledged, reset and re-armed the zones during the period of alarm activations. This advice also established that the PTZ (pan-tilt-zoom) cameras had been manually controlled for some of the period the perimeter was in alarm. This confirms that the security systems on the perimeter operated as designed and the master control room was alerted to the perimeter breaches.

5.128 The CCTV footage shows prison officers (later confirmed as two 'response teams') in the vicinity of the Gatehouse in personal protective equipment at 17:00hrs. At 17:08hrs, an update was provided by Greenough to the Operations Centre reporting that 10 to 12 prisoners had escaped the prison. The update also stated that WA Police were "on site cordoning and manning the external perimeter for escapees." The Review was advised that the WA Police Force were positioned on the access road at the railway line, approximately 100 metres from the external perimeter fence of the prison. The police established a vehicle control point stopping all exiting vehicles, to ensure escapees were not on board, and any unauthorised incoming vehicles. WA Police Force were later positioned at three designated points around the prison perimeter to ensure there were no further escapees, together with marked police vehicles patrolling the external perimeter fence.

5.129 While it is noted that Police were on site providing some assistance, it is very concerning that:

- 35 minutes elapsed between the initial activation of perimeter alarms at 16:47hrs, and the prison response team entering the sterile zone at 17:22hrs. The presence of the response team at the breakout site was 30 minutes after the prisoners had escaped the prison;

- the procedures required in the various Greenough EM Action Plans to deploy a 'primary response unit' and external response vehicle to protect the perimeter in the event of a fire, riot and attempted escape were not followed;
 - 45 minutes elapsed (16:02hrs – 16:47hrs) from the initial notification of the critical incidents to the time when the first perimeter alarm was triggered; and
 - the external response vehicle had not been deployed during this time.
- 5.130 CCTV footage aligned with the perimeter alarm logs reveals that:
- between 16:47hrs and 16:52hrs ten prisoners can be seen entering the sterile zone between the fences carrying two ladders;
 - the prisoners erect the longest ladder against the internal side of the external perimeter fence extending it beyond the top of the cowl drum;
 - the prisoners then convey the smaller ladder up and over the cowl to the outer side of the main external perimeter fence, however, it appears that the outer smaller ladder is too short to descend;
 - ten prisoners are seen standing on the top of the prime external perimeter fence cowl drum;
 - three of the prisoners move along the top of the cowl drum towards zone 9, adjacent to Unit 4, and it is assumed these prisoners then jumped to freedom; and
 - the remaining seven prisoners on the cowl drum lift the longer ladder from the inside of the external perimeter fence, over the top of the cowl drum, position it on the outside of the fence, and descend.
- 5.131 Using the grinder and ladders, ten prisoners defeated the internal perimeter fence and prime external perimeter fence within an estimated five minutes; and had escaped from the prison 50 minutes after the critical incident began.
- 5.132 At 16:58hrs, the multiple alarms in zone 12 are recorded in the event perimeter log and CCTV footage of this area records a further three prisoners (not the escapees) within the sterile zone; one carrying a cordless grinder.
- 5.133 Two prisoners (probably two of the three above) can be observed in the sterile zone two minutes later attempting to retrieve the ladder from the external perimeter fence using an improvised grappling hook and rope. Multiple attempts are made by the prisoners to throw the grappling hook over the perimeter cowl drum to pull the longer ladder back into the prison sterile zone.
- 5.134 After 18 minutes, the two prisoners in the sterile zone abandoned the grappling hook and retreat through the unsecured personnel access gate back into the prison.
- 5.135 At 17:22hrs, the alarm in zone 14 is activated as the primary response team entered the area and CCTV footage shows five officers securing the access gate with handcuffs. The radio traffic audit logs then report the area as all secure.
- 5.136 Again, while appreciating that the volatile events occurring inside the prison meant the focus was on containment and preservation of life; the Review found the absence of the deployment of the emergency response vehicle to protect the perimeter, and the delayed response to prisoners in the sterile zone preparing to escape, to be serious failings.

Safety of women prisoners

- 5.137 The Department's EM Framework includes a section on 'Special Needs Groups' and states:
- "Special needs groups should be considered at the local level. State level plans are cognisant of all vulnerable groups and in line with state plans prisons/detention centres and adult/youth centres are to ensure they have suitable plans and response capabilities in place prior to an emergency to cater for the needs of special needs staff/clients".*

- 5.138 Greenough ought to have had in place a dedicated safety and protection plan for women and should have provided for their safety within a male prison. The Review found that the prison failed in both regards.
- 5.139 The Greenough EM Plan is silent in respect to special needs groups. Throughout the Review period, the complex issues associated with managing women within a male prison were raised constantly. Staff described the immense effort that must be applied to avoid inappropriate attention and contact between male and female prisoners. In this environment, the Review considers that women prisoners at Greenough, who comprised 20 percent of the prison population at the time of the incident, to be a group with special needs for the purposes of emergency management.
- 5.140 As set out in the chronology in Chapter 4, male prisoners were readily able to breach the separation fence to Unit 4 and enter the women's precinct within 27 minutes of the eruption of events. At this point, 50 (out of a total count of 56) women were secured in their cells in Unit 4 and prison staff had left the Unit to assist in managing the unfolding incidents. Six women who had just returned to Greenough from an external prison activity were still at the main prison entry, and were then secured in Unit 1.
- 5.141 The men that broke into Unit 4 had power tools with them and proceeded to cut out sections of the women's cell doors. At 19:09hrs, it was reported that between 7-12 women prisoners had been freed from their cells. Some women were then observed on CCTV footage as joining in with the male prisoners in riotous behaviour.
- 5.142 The Review has subsequently ascertained that 17 cell doors had holes cut in them. These cells held a total of 24 women.
- 5.143 During the riotous behaviour in the Women's Unit, access was gained to an office where the prisoner medication trolley was kept. Staff reported that many of the pharmaceuticals were consumed by unknown prisoners.
- 5.144 There are recordings in the various chronologies provided to the Review about concerns for the women prisoners throughout the riot. At 17:24hrs, 55 minutes after male prisoners entered the unit, a response team was assembled and attempted to advance towards the Women's Unit, however, they were repelled by prisoners throwing projectiles. The Review was advised of officers requesting permission to enter via the back of the Women's Unit to defend it, and of persistent attempts to check on the women verbally through the fence. The first SOG Deliberate Action Plan developed at 22:10hrs, included advancement to Unit 4 and a reassessment of the situation. This plan had to be abandoned due to other priorities. At 00:10hrs, the SOG penetrated Unit 4, being 6hrs 46 minutes after the male prisoners had gained access to the Women's Unit.
- 5.145 Other aspects of what occurred in the Women's Unit are discussed in Chapter 7. For the purposes of this Chapter on emergency management, it is noted that while some women prisoners joined in riotous activities with the male prisoners, most did not. The Review is aware from cell call recordings that there were a number of women who experienced a great deal of fear and distress while they remained in their cells. The officer responding to cell calls was calm and provided reassurance to the callers that efforts were being made to respond to their safety needs.
- 5.146 Given that women prisoners have been a feature of the Greenough prison population since the prison opened, it is bewildering that the omission to acknowledge them as a vulnerable group has gone unnoticed. The prison ought to have had a formal 'Safety and Protection Plan' for the women prisoners, ready to be activated in the event of a large-scale emergency, especially given the known tensions within the prison between male and female prisoners and the previous attempted breach into the Women's Unit that occurred in 2015.
- 5.147 It is appreciated that in the chaos of events and with limited resources available, the evacuation and protection of women prisoners may not have been achievable until the SOG were on site. Nonetheless, without an emergency plan focusing on this vulnerable group, there was no thought given to a planned procedure for the protection of women. The Review considers this to be a serious oversight.

Special Operations Group and the multi-agency response

- 5.148 As noted previously, the operational specialist and inter-agency emergency management arrangements are governed by the EM Framework and two key MOUs:
- Service MOU between The Department of Corrective Services and Western Australia Police in relation to Major Prison Incidents Occurring in Western Australia; and
 - MOU between the Department of Fire and Emergency Services ('DFES') and Department of Corrective Services for All Hazard Emergencies Occurring at Prisons & Detention Centres.
- 5.149 The Head Office records show that at 16:15hrs, the Greenough Superintendent confirmed that the Operations Centre and DFES had been notified. The notification to WA Police Force also occurred at this time. The Review was informed that SOG was not alerted to the critical incident until 16:45hrs. During the preceding 43 minutes, there was a fire, prisoners were engaging in riotous behaviour damaging infrastructure and attacking staff posts, the separation fences and the Maintenance Workshop had been breached, and men had broken into the Women's Unit. It is recorded at this time as: 'site now major disturbance'.
- 5.150 The EM Framework details that in the event of a riot, the Emergency Support Group ('ESG') (now known as the Special Operations Group) will be mobilised on the authority of the Director Security Services. In urgent circumstances, where the Director Security Services is not immediately contactable, the Superintendent Administration or Assistant Commissioner Custodial Operations may authorise deployment of the ESG.
- 5.151 The Greenough EM Plan requires the Incident Controller to inform the ESG and other external agencies as required. It states:
- "The ESG may be notified but are only to attend at the direction of the Designated Superintendent or relevant Director in accordance with Paragraph 2 of Policy Directive 33."*
- 5.152 It is of note that the EM Framework superseded Policy Directive 33 on 6 March 2012 and there are inconsistencies between the EM Framework and the local Greenough EM Plan, again highlighting the importance of maintaining regular reviews of the authorising policy framework. The Review was unable to determine if this impacted on the activation of the SOG or if there were any other reasons for waiting 43 minutes to make the decision to notify these specialist resources.
- 5.153 SOG immediately mobilised resources and the first team including the SOG Commander, were en route to Greenough shortly after the alert, with the full emergency response of lights and sirens authorised. The SOG Commander developed an appreciation of the scale of the event en route and began structuring a planned response. The Review was advised that careful thought was given to the size of the SOG deployment to Greenough, being mindful of retaining capacity in the metropolitan area should 'copycat' events erupt.
- 5.154 The Geraldton WA Police Force's initial deployment to the prison was four officers and the Head Office records indicate that they arrived on site at 17:00hrs. As more police resources arrived on site, they patrolled the sterile zone between the inner and outer perimeter fence where the escapes had occurred, which freed up the prison officers to respond to the incident within the prison. The WA Police Force Regional Operations Group ('ROG') and Tactical Response Group ('TRG') were also mobilised in the metropolitan area, travelling under priority conditions by road. Additional police resources were recorded on the Greenough to Head Office update as entering the prison to coordinate resourcing at 18:51hrs, and the TRG arrived at 23:50hrs.
- 5.155 The DFES arrived at the prison at 18:05hrs. They were positioned outside the prison and did not enter the site. It was recorded in the logs at that time that 'fire is not a threat to buildings'. Throughout the night several fires were lit, and the Unit 3 fire in particular was reported as 'major', with smoke significantly impacting across the other units due to the shared roof space. The prison officers and SOG were required to quell the fires and rescue prisoners from smoke filled areas.
- 5.156 The Review was advised by DFES that before entering a prison during a riot they would first conduct an assessment to determine any imminent risks. The Review suggests that the arrangements between DFES and prisons warrants further exploration, examining all scenarios, risk mitigation and response options.

- 5.157 St Johns Ambulance are recorded as having been placed 'on-call' at 18:05hrs and en route to the prison at 23:09hrs where they established a triage post within the Sally port at the Gatehouse where they treated staff and prisoners for minor injuries.
- 5.158 A multi-agency briefing involving Greenough prison staff, SOG's, WA Police Force, DFES and St John's Ambulance was conducted at 20:40hrs. The SOG Commander formulated an Emergency Action Plan that was authorised by the Incident Controller, and at 21:28hrs a briefing was conducted with the State Commanders of each agency (referred to as Controller representatives in the logs). This plan was amended over time in response to the evolving incidents, attacks by prisoners and available resources.
- 5.159 'Deliberate Action Planning' took place at 22:10hrs. This involved establishing a 'unified command' model, whereby the SOG Commander developed the planned response, being the deployment of a combined force of SOG officers and police officers in a joint operation under the control of the SOG Commander. The SOG Commander consulted with the Commanders of the police units to settle and agree the plan.
- 5.160 Another SOG Emergency Action Plan was put in place at 22:45hrs due to infrastructure damage. The teams entered the prison at 23:03hrs and were met with resistance from prisoners discharging petrol bombs and chemical agents. The Emergency Action Plan had to be abandoned when the priority became the preservation of life requiring the evacuation of Unit 1 prisoners due to smoke from fires overtaking the area. The joint response team safely released panicked prisoners from the unit.
- 5.161 Following the arrival of the highly specialised TRG, an assessment was made that these specialist officers were not essential to the safe resolution of the incident. Therefore, they remained outside the prison guarding the perimeter.

What worked well

- 5.162 All reports to the Review were collectively positive in respect to the 'unified command' model that operated on the night of the riot. The multi-agency response under the unified command structure was described by all agencies as having worked extremely well. The Review was advised that there was a high level of confidence and cooperation at the site. As noted above, police officers were given the powers of prison officers under section 15 of the Prisons Act, and it was reported that because this was practiced, they were confident being under the control of the SOG Commander.
- 5.163 The cooperation and support of the WA Police Force under the direction of the Incident Controller and control of the SOG Commander is to be commended. This signifies strong, positive relationships at a local level in Geraldton and at the State level between Corrective Services and WA Police Force.
- 5.164 The 'unified command' structure is not envisaged in the Service MOU for Major Prison Incidents, although the Review was advised that the joint response model is practiced by SOG and ROG.

Emergency Management Act 2005

- 5.165 As noted at the beginning of this Chapter, the EM Act '*provides for the prompt and coordinated organisation of emergency management in the State*'. Section 9 of the EM Act specifically excludes the taking of measures directed at ending an industrial dispute or 'controlling a riot or other civil disturbance'. The EM Act does not distinguish between riots inside or outside of prisons.¹⁵
- 5.166 This is in contrast to the legislative position in some other jurisdictions. In Victoria, for example, the *Emergency Management Act 2013* (Vic) includes a 'siege or riot' within the general definition of 'emergency' (in section 3).

¹⁵ The power for police officers to control or suppress a riot is provided by section 239 of the Criminal Code (WA).

- 5.167 The events of 24-25 July at Greenough were by any definition a serious emergency. The escape of 10 prisoners put the community at risk. The fires and riotous behaviour within the prison put the lives of staff and other prisoners at risk. The events were certainly of a magnitude that required a coordinated multi-agency response. It is also noted that, although riots are excluded from the EM Act, the 2013 Banksia Hill Riot was described in a general sense as an 'emergency' by Chief Justice Martin in *Wilson v Joseph Francis, Minister of Corrective Services for the State of Western Australia* [2013] WASC 157.
- 5.168 The Review therefore suggests that consideration be given to the advantages and disadvantages of amending the EM Act to embed Corrective Services within Western Australia's broader emergency management arrangements, taking into account the geographical locations of prisons across the State and the existing emergency management structures in WA.
- 5.169 Some of the advantages of embedding Corrections within a broader State emergency management architecture are outlined in the Victorian report titled *Independent Investigation into the Metropolitan Remand Centre Riot Final Report* (December 2015)¹⁶. They include:
- greater consistency and coordination across agencies in terminology, structures, command and control arrangements;
 - better access for prisons to equipment, information, technology and support;
 - broader hazard planning within prisons;
 - more transparent risks and accountabilities; and
 - prisons bringing different views and expertise to other emergency agencies.

As was aptly noted in this report: "*Given the inherent volatility of prisons (particularly with current overcrowding issues), further incidents needing a multi-agency response are likely. Embedding [Corrections Victoria] in statewide planning and structures will improve its ability to respond.*"

Safety of staff

- 5.170 Throughout the events of 24-25 July there was a strong and effective focus on the safety of staff. Non-essential public service staff were evacuated at the earliest opportunity. Prison officers were directed to retreat to safe areas when it became unsafe to remain at their posts. There was a focus on accounting for all staff.
- 5.171 The role of prison officers at Greenough was to contain and hold the prison until the specialist response arrived. Due to deficiencies found in planning and preparedness for an event of this scale, there were insufficient trained officers, and they were ill-equipped nor properly protected for offensive action. Therefore, the decision to only take defensive action was sensible, prioritising the safety of staff.
- 5.172 Whilst the Greenough officers did the best that they could within the limitations of little recent training and available resources; the defensive action presented some risks when under attack by prisoners. Prisoners confronted officers with missiles, indiscriminate fires were lit and had to be quelled by officers; and prisoners wielded weapons and used OC (oleoresin capsicum) spray on staff. Three officers were treated for the effects but no serious physical injuries were sustained.
- 5.173 Many officers who were stationed in Units looking after secured prisoners, and those positioned on the oval safeguarding evacuated prisoners, reported feeling abandoned and left to fend for themselves, with little support or direction throughout the night. They reported spending many hours with negligible relief or food, water and warm clothing provided. As noted above, this is possibly a symptom of the failure to establish a formal Incident Management Team with functional responsibilities to manage such matters as communications and logistics. There were examples given to the Review of officers using their own initiative to meet the needs of uninvolved prisoners, and acts of decency, such as arranging for prisoners to phone family members to advise of their safety.

¹⁶ Author: Kieran Walshe, p.36.

- 5.174 The SOG applied diligence and care to the development of emergency and deliberate action plans. They delayed action until adequately trained resources were available and gave proper consideration to the safety of staff in their deployment options. The SOG Commander made decisions to retreat when faced with substantial resistance and attack from prisoners, and changed priorities when informed that prisoners were trapped in a smoke-filled area and staff needed SOG assistance.

Safety of prisoners

- 5.175 At the outset, it is evident that prisoner safety was important to the prison. When staff responded initially to quell the cell fire in Unit 2, the immediate action was to evacuate prisoners to a safe area. Throughout the night, staff did their best to attend to the needs of surrendered prisoners; and when panicked prisoners were trapped in the unit filling with smoke, the officers' priority was to rescue and release them to a safe location.
- 5.176 From the records provided to the Review, it is apparent that staff provided every opportunity for uninvolved prisoners to surrender throughout the course of the events, including for those prisoners that did not wish to be involved in the riot from the outset and were concerned for their own safety. The first surrender call was made within seven minutes of the events unfolding and staff continued to provide openings for the surrender of prisoners throughout the night.
- 5.177 Some prisoners also assisted prison staff during the course of the events. The Review heard from some prison officers, for example, that some of the older prisoners helped to calm other prisoners down and assisted in the delivery of meals. Prisoners were also seen quelling some fires their peers had started.
- 5.178 The absence of a 'Safety and Protection Plan' for women, as discussed previously in this Chapter, was a serious oversight in planning for the safety of women prisoners. While some offensive actions were attempted and observers put in place, the fact remains that male prisoners were in the Women's Unit for almost seven hours before a rescue plan could be actioned.
- 5.179 At around 22:30hrs, some eight and a half hours into the events, a major fire in Unit 3 caused smoke to significantly impact across the other units. Prisoners secured in Unit 1 were reported as suffering smoke inhalation and were panicked. In an effort to free themselves from the smoke, the trapped prisoners damaged grilles, windows, doors and other areas.
- 5.180 The SOG had to abandon the action plan they had committed to and diverted resources to the fire in Unit 3 and trapped prisoners in Unit 1. Using implements and force, SOG released the emergency escape door from the unit office and freed prisoners from the smoke-filled area. When faced with the very real risk of freeing more prisoners to join the affray by releasing them from the security of the unit; the safety of the prisoners was the priority. The ongoing containment and security of the released prisoners was then given urgent attention.

Forced surrender tactical options

- 5.181 It was reported that prisoners ignited fires in buildings, in bins and on trees, spread fuel within units and made Molotov cocktails which they threw at staff limiting SOG's options to force surrender of prisoners engaged in riotous behaviour.
- 5.182 SOG's priorities are to operate in a safe manner and to consider all tactical options available to them in a dynamic environment. Taking into account all known risks at this time, forced surrender was more difficult given limited tactical options available to them in the context of the weapons and fuel in the possession of prisoners. This caused delays in the resolution of the critical incident and increased the risks to the response teams.
- 5.183 Overall, the Review considers that the direct action was conducted as safely as possible and the delays in actioning plans were justifiable in the circumstances.

RECOVERY

- 5.184 In the context of emergency management, recovery refers to support in the reconstruction and restoration of physical infrastructure, the environment and staff wellbeing.
- 5.185 The Review found that:
- Greenough failed to comply with the EM Framework and PD41 by not conducting a formal debrief with staff after the incident, and there was an unacceptable delay in the follow-up debrief, both of which negatively impacted on staff wellbeing and recovery; and
 - the absence of an ongoing, dedicated and visible 'Recovery Team' to support Greenough to plan, action, communicate and care for all staff throughout the recovery process, was also a missed opportunity.

Initial recovery plan

- 5.186 Following the events of 24-25 July, there was an immediate process put in place to stabilise the prison, with an ICF established in the prison to control and monitor activities, noting that this was achievable under calmer conditions. The initial recovery focus was on maintaining a lockdown regime for prisoners and meeting their basic needs, cleaning up the debris and destruction of the riot and ensuring the safety and security of the environment. These matters appeared to be actioned efficiently.
- 5.187 A SOG management team remained on site for five days after the critical incident and SOG maintained an on-site presence to support the recovery operations for the following six weeks,
- 5.188 The Review was not provided with a clearly documented and timely 'Recovery Plan', and was advised that there were problems with communication and developing a shared understanding of what was to occur in the restoration of the prison. A clear recovery plan would have avoided such confusion.
- 5.189 One week after the riot, the Review observed staff in the Women's Unit which was covered in debris and the staff amenity was severely damaged. The women prisoners were secured in cells and the staff were providing medication and support through the door traps. The staff were seen approaching their tasks with professionalism and care in very difficult circumstances.

Debriefing processes

- 5.190 Section 9 of the EM Framework outlines comprehensive 'Organisational Debriefing Guidelines'. The Framework describes the aim of the debriefing as follows:
- 'For staff to be able to communicate their experiences of an incident so that lessons can be identified/learnt. A debrief should be a disciplined technique for learning, through reflection, by sharing experiences, gathering information and developing ideas for the future.'*
- 5.191 The EM Framework details two types of organisational debriefs that are typically used to promote post-incident learning: the **immediate** (or 'hot') debrief and the **formal** debrief. The 'immediate' debrief is described as normally carried out by the officer in charge of the incident immediately after an incident, to obtain immediate feedback from officers and staff participating in the incident. The 'formal' debrief is described in the EM Framework as being usually conducted following more dynamic or critical incidents. This is intended to be a very structured process, analysing the whole event in detail and how the Department performed during the critical incident.

5.192 Policy Directive 41 on 'Reporting of Incidents and Additional Notification' also sets out detailed requirements for an 'immediate' and 'formal' debrief following an incident. Section 10 provides that in any debrief, the following things should be considered:

- review of the incident and concerns;
- lessons learned;
- good practice identified;
- employee welfare; and
- any other relevant matters.

5.193 The guidelines in PD41 for each of the debriefs are as follows:

Immediate debrief – to take place immediately after the incident:

- the purpose is not to analyse or re-live the incident, nor apportion blame or pre-judge investigation findings;
- the focus is on reassurance, information sharing, normalisation and how staff can support each other;
- prison-based support staff must attend and assess the need for additional services; and
- a report is to be submitted using the 'Immediate Debrief Report'.

Formal debrief – within four weeks of the incident:

- the purpose is to examine an incident in its entirety and look at how it occurred;
- determine how the incident was managed;
- improve responses to incident management; and
- identify and address any concerns from the incident.

Immediate debrief

5.194 The Review was advised that an 'Immediate Debrief' was conducted at Greenough at 06:00hrs on the morning of the 25 July 2018, however, there was no formal report submitted. The staff had been on active duty for twenty-three hours by that time. While the debrief was conducted in accordance with the timeframes required of the guidelines, given the size and scale of the event and the expected weariness of staff, it would have been very tough trying to cover anything other than immediate support and acknowledgment of staff's efforts.

5.195 A multi-agency debrief comprising WA Police Force, DFES and Greenough prison senior management team was conducted within two weeks and an Immediate Debrief Report submitted (undated). The positives identified included: inter-relationships between agencies, comprehensive initial briefings at the site, while communications between agencies was mixed. There were a number of learnings identified, most of which should be addressed within the context of reviewing the MOUs referred to above. Shortcomings in the ICF were also identified.

5.196 Corrective Services Adult Justice Services conducted a 'hot' debrief meeting on 27 July 2018. They identified the following matters as working well: the presence of a dedicated logger in the Operations Centre (it is assumed this refers to the running sheet)); the Liaison Officer co-located with police; executive support; operational understanding of powers under the Prisons Act; support from intelligence and dual task coordination. There were a number of matters highlighted as needing improvement including: the amenity of the Head Office ICF, communication, training, some housekeeping matters and site related concerns.

Formal debrief

- 5.197 While there were staff meetings at Greenough, the formal debrief with staff did not take place until the 3 October 2018. It was reported to the Review that this debrief was attended by around 75 staff from across all service areas of the prison. Detailed and thoughtful preparation around the conduct of the debrief was undertaken. While staff were disappointed that the formal debrief had taken so long to be organised, it was reported they engaged well in the process contributing their learnings and reflections on what worked and what did not work on the night of the riot. The key themes included poor communication, the state of security and personal protective equipment and fear for the safety of women prisoners. The Review was advised that the themes arising from the debriefing process were being collated and appropriate action considered.
- 5.198 Given the apparent positive outcome of the debriefing process for Greenough staff, the Review considers the long delay in facilitating this supportive process to be poor practice and contrary to policy requirements.

Staff welfare

- 5.199 The Review was informed that the Department has provided a range of supports for the staff involved in the incident. On the morning of 25 July, the Acting Director General attended the prison to inspect the damage and held a full staff meeting.
- 5.200 Local staff support was on hand immediately following the incident. The head office Staff Welfare Officer engaged the services of the Employee Assistance Program provider, *PeopleSense*, to assist in the critical incident response. Two psychologists travelled to Greenough on 26 July and were on site for two days providing individual consultations in addition to three group psycho-educational sessions.
- 5.201 The Staff Welfare Officer was available on site for four days to coordinate the provision of *PeopleSense* services and provide informal staff consultations. Referrals and follow-up for any staff deemed necessary were made.
- 5.202 A further site visit was conducted by a *PeopleSense* psychologist on 31 July 2018. During the next week, they conducted a blanket welfare call program to all staff whether or not they were at Greenough on the night of the incident. They were provided with contact details for 194 staff, of which 98 were successfully contacted and spoken to. Voicemails were left for the remaining 96 staff inviting a return call if they wished.
- 5.203 On 3 August 2018, the Superintendent sent out an email to all staff from the Principal Psychologist reminding them of the staff support available. A further site visit was conducted at Greenough by a psychologist from *PeopleSense* on 23-24 August. The Review was informed that the Staff Welfare Officer is continually monitoring and developing a plan as required for any further intervention.
- 5.204 Notwithstanding the interventions and support detailed above, many of the Greenough staff relayed their disappointment and frustrations to the Review in respect to staff welfare on and after the events of 24-25 July. Staff were particularly aggrieved that on the night of the riot:
- no off-duty staff were called into the prison, and those at home were not contacted and left to be informed of the events from the media reporting;
 - staff meals were not provided to staff on active duty throughout the riot while prisoners were fed;
 - staff who had worked for almost 24 hours had to drive themselves home after the riot.
- 5.205 After the events of 24-25 July, from the perspectives of some staff members, the aspects they found most upsetting were:
- the absence of any meaningful debriefing process prior to 3 October;
 - the way the loss of staff personal property during the riot was dealt with, including being told at one point that personal property would not be covered by the prison's insurance – this was later rescinded;

- the process used by *PeopleSense* had felt to some like a ‘token gesture’ and the contact by phone rather than face-to-face meetings was thought to be inconsiderate of their emotional state;
 - in their view, senior management was acting like nothing had happened following the events.
- 5.206 The Review was impressed by the staff members’ care for their colleagues. The non-uniformed staff spoke highly of the support they had been given by prison officers and the response and care that had been shown towards the public service staff. Prison officers also provided examples of checking in on their fellow officers and giving them support.
- 5.207 As at 10 October 2018, 11 employees had submitted workers compensation claims in relation to injuries suffered during the critical incident. Four of those injured are still not able to attend work; three officers have returned to work on ‘Return to Work Plans’ and four have returned to full duties with ongoing support.
- 5.208 Throughout the Review process, many staff at Greenough generously shared their experiences with the Review team. While this was an emotional experience for some they did not waver in their efforts to inform the Review of their personal observations, understanding and learnings from what occurred at Greenough.
- 5.209 The Review cannot help but reflect that the ongoing level of emotion displayed by Greenough staff in interviews and submissions, may be partly because ten weeks elapsed before they had the opportunity to participate in a structured emotional and technical debrief process with colleagues. It is regrettable that the support provided by the Department described above, did not meet the expectations of many staff at Greenough who contributed to the Review.
- 5.210 This was a missed opportunity for the Department and a serious omission by the prison; particularly given the impact of the events on staff, their willingness to reflect and share, and the presence of an EM Framework and PD41 that provided a clear model for debriefing and staff support.

Additional staff resources

- 5.211 Immediately following the riot, Greenough was supported with additional staff resources including senior personnel to assist with the recovery process. Around ten prison officers were seconded from other prisons to support the operations of the prison.
- 5.212 While the immediate recovery response at the prison was good, including the swift physical clean-up, the additional staff and the SOG presence, the Review considers that there was a need for a more holistic ongoing ‘Recovery Team’ at Greenough – to support the prison to project manage the restoration of infrastructure, the return to normal routines, and to engage with and care for all staff throughout the recovery process. The Review considered that the absence of such a dedicated and visible Recovery Team was also a missed opportunity.

Prisoner management

- 5.213 The prison population at Greenough was almost halved in the 41 days following the riot with the transfer of prisoners to other accommodation throughout the state. This was necessary given the loss of accommodation and staff amenity due to riot damage. A ‘*Strategy for the management of women currently housed at Greenough Regional Prison*’ was developed and approved on 27 July 2018. The strategy is discussed in detail in Chapter 7 – Women Prisoners.
- 5.214 There was no similar strategy developed for male prisoners involved or not involved in the riot. It is noted that those prisoners identified as being key instigators in the riotous behaviour and the escapees were transferred to other prisons.
- 5.215 The Inspector has commenced an inquiry focussing on the post-incident management of prisoners; therefore, this aspect of recovery has not been comprehensively examined by the Review.

Infrastructure

- 5.216 During the review period, the physical recovery process appeared to be progressing as swiftly as possible within a prison environment.
- 5.217 The damage in the prison was extensive and widespread with areas affected being Units 1, 2, 3, 4 and 5, workshop grilles and garden sheds. Units 1, 2 and 5 sustained damage predominantly to cells, general and control room doors and security glass, with these areas requiring significant cleaning. IT equipment and recreational items also sustained damage. The Unit 3 office was completely gutted by fire requiring some demolition and a complete refit. Unit 4 (the Women's Unit) sustained very significant security glass damage and required replacement of 29 cell doors and other wall, floor and door finish repairs.
- 5.218 Representatives from the Department's Infrastructure Team were on site at Greenough from 25 July assessing the damage, arranging the clean-up and scoping the rectification works aimed at bringing the facility back into operation as quickly as possible.
- 5.219 An insurance claim was reported to RiskCover on 25 July and an assessor allocated who inspected the site on the next day. The clean-up and repairs commenced immediately with numerous contractors on site after access was made available by WA Police Force.
- 5.220 A structural engineer undertook a preliminary assessment of the Unit 3 Control Room and identified the rear section as requiring demolition with the remainder of the structure appearing sound.
- 5.221 Work commenced on design and documentation of the significant rectification works, which was estimated to take nine to twelve months to document, tender, construct and commission.
- 5.222 An opinion of probable costs of the infrastructure rectification works was estimated at \$2.4 million. The estimated total cost of the clean-up was \$15,845 excluding repairs and rectification.
- 5.223 The Review was advised that the Department will undertake additional enhancements including security grilles to unit offices, replacement of some chain-link fence around Unit 4, and other enhancements were being considered. Advice provided to the Review was that the staff at Greenough were able to provide input into the fortification of the staff areas.
- 5.224 As at 10 October 2018, the Review was provided with a status of the infrastructure works detailing that:
- Cell door replacements were completed with the exception of three doors;
 - Officer Post security grilles in units 1, 2, 4 and 5 were commencing progressive installation the week of 15 October;
 - Installation of escape doors in units 2 and 3 Senior Officers' office were to be undertaken in conjunction with security grille works (above);
 - Razor wire installation to the Unit 2 and 3 dividing fence was completed; and
 - Unit 3 rebuild was currently in the design stage.

Update on general purpose beds

- 5.225 As a result of the events of 24-25 July and the damage to infrastructure, the Review was advised that the number of general purpose beds available at Greenough has been revised down to 176 (170 male beds and six female beds); along with six male and one female special purpose beds.

CHAPTER 6

CAUSES AND CONTRIBUTING FACTORS

OVERVIEW

- 6.1 The terms of reference directed the Review to examine the causal and contributing factors that led to the critical incident on 24-25 July 2018. As stated in the OICS 2013 Review into the Riot at Banksia Hill Detention Centre: *“riots in closed institutions rarely involve a simple ‘cause and effect’ relationship; instead they reflect a complex interplay of factors.”*¹⁷
- 6.2 In an attempt to establish why prisoners at Greenough rioted and escaped, the Review looked at the operating environment generally and, more specifically, what had changed in the preceding months leading up to the critical incident that may have contributed to the events.
- 6.3 The Review found that there was no specific ‘spark’ or catalyst that triggered the riot or the escapes on the day of the incident. Rather, there was a strong element of opportunism when prisoners had to be evacuated to safety because of the initial fire in cell 22; some then began throwing projectiles at staff and others quickly joined in, and the uncontrolled behaviour then escalated rapidly. It is important to note that the majority of prisoners chose not to become involved in the riotous behaviour and there were examples of prisoners acting responsibly trying to quell fires and later assisting staff.
- 6.4 The Review also found that there were a number of inter-related factors that are likely to have contributed to an unstable prison environment; and other factors that amplified the scale and seriousness of the events.
- 6.5 As evidenced by previous reports by the Inspector of Custodial Services, Greenough is a prison that has long been under pressure. The Inspector’s November 2016 Report identified a number of problems at Greenough, many of which do not appear to the Review to have been properly addressed in the intervening period.
- 6.6 To summarise, the Review found that the following factors contributed to the critical incident.
- **First**, the increasing frequency of lockdowns from March 2018 and implementation of the ‘Adaptive Routine’ following the signing of Standing Order E6 and the Daily Staff Deployment Agreement at Greenough. This resulted in constant uncertainty and disruption to normal routines for both staff and prisoners; increasing limitations on access to work, recreation and services; which led to frustration, disengagement and boredom among prisoners.
 - **Secondly**, the underlying reason for the increasing frequency of lockdowns under the Adaptive Routine from March 2018 was increasing staff shortfalls within a tight fiscal environment. This included a cap on the number of overtime shifts the prison could use to fill vacancies on the roster, noting that exceptions could be made if there were grounds to believe the prison was unsafe or adversely affected. The adequacy of staffing levels at Greenough and ongoing vacancies on the roster was a recurring theme throughout the Review, and this issue underpins many of the other contributing factors. The question of how many staff it takes to run Greenough safely and securely is ultimately a matter for the Department and the Superintendent to determine in consultation with staff and the Union.

¹⁷ p.34

- **Thirdly**, a decline in attention to infrastructure and security at Greenough also directly contributed to the scale and seriousness of the critical incident. This issue is covered in detail in Chapter 5 – Emergency Response – in the context of prevention. The prisoners’ ability to easily breach the fences between Unit 2 and Unit 3, and the fence into the Women’s Unit, allowed the initial disturbance to escalate rapidly into a full-scale riot. The prisoners’ ability to access an unsecured battery-operated angle grinder and ladders from the maintenance workshop inside the prison directly facilitated the escape of ten prisoners. Once the rioters had the run of the prison and access to fuel and improvised weapons, this severely constrained the emergency response options. These are all examples of poor physical and procedural security and require serious attention at Greenough.
 - **Fourthly**, a lack of engagement with Aboriginal prisoners may also have contributed to the events of 24-25 July. Given that 70% of the total prisoner population at Greenough were Aboriginal, their needs should have been at centre of the prison’s operating model in accordance with the Department’s values and expectations.
 - **Fifthly**, the absence of a robust risk management process and governance framework at Greenough meant that not enough was being done to monitor the impact of the increasing lockdowns and the potential risks this posed to the security of the prison. Communication with staff and prisoners in this time of major change was also not as good as it should have been, with concerns about the rising tensions in the prison not receiving enough attention. There was also an absence of any active monitoring of the recommendations from previous reports by the Inspector or departmental audits at the local level.
- 6.7 Each of the above factors played a part in the events of 24-25 July; and also accord with the perceptions of staff and prisoners interviewed by the Review team.
- 6.8 It is equally true, however, that responsibility for the critical incident also lies with the prisoners themselves. Those prisoners that chose to instigate or become involved in the riot, destroy property, trash units, set fires, attack staff and/or escape, are individually responsible for their own unlawful actions and must be held to account. Because of the ongoing police investigation, it was not possible for the Review to interview the main instigators of the riot to determine individual motivations for their behaviour.
- 6.9 Finally, the Review notes that the population at Greenough had not substantively changed and the prison’s capacity had remained substantially the same for the past three years. As noted in Chapter 2, the Review has therefore concluded that the question of whether Greenough was ‘over-crowded’ was not a direct cause or contributing factor to the critical incident.
- 6.10 The rest of this Chapter examines each of the above contributing factors in detail:
 - the increasing frequency of lockdowns under the Adaptive Routine;
 - the impact of the Adaptive Routine on service delivery, including:
 - education;
 - pre-release services;
 - therapeutic programs; and
 - health services;
 - a lack of engagement with Aboriginal prisoners and commitment to improving quality of life outcomes for Aboriginal prisoners; and
 - poor governance and risk management around the major changes taking place in the prison.
- 6.11 In addition, this Chapter also details the staff, prisoner and external agency perceptions and observations about the causes of the incident.

INCREASING LOCKDOWNS UNDER THE ADAPTIVE ROUTINE

- 6.12 The background regarding the implementation of the Adaptive Routine is set out in detail in Chapter 3 – Significant developments at Greenough in 2017-2018. This part of the Report seeks to further elucidate the impact that the Adaptive Routine had on both prisoners and staff.
- 6.13 The Review was advised that the practice of the cancellation of structured activities, prisoners secured within Unit wings and systematic lockdown of prisoners in cells during the normal unlock periods, has been a longstanding but infrequent response to managing staff shortages at Greenough. However, this practice appears to have become the normal routine after the signing of Standing Order E6 and the Daily Staff Deployment Agreement ('**Agreement**') on 8 March 2018, as detailed in Chapter 3.
- 6.14 From March 2018, the implementation of the Adaptive Routine created an environment where staff were unsettled because of the constant changes. Staff routines were disrupted and they felt constantly under pressure, being unable to manage prisoners in the way they were used to. Staff were displeased with the negative impact this was having on their working day. Standards were not being maintained with the absence of an Assistant Superintendent of Security and Prosecutions Officer, and in the view of staff, this was undermining the safety of the prison.
- 6.15 Most prisoners are familiar with a prison operating model that is structured, consistent and focussed around a routine of constructive activities. From the viewpoint of the prisoners at Greenough that were interviewed, the constant uncertainty and increasing limitations on access to work, recreation and services led to disengagement, boredom and frustration.
- 6.16 Healthy prisons are grounded in supportive and respectful relationships between staff and prisoners; and prison officers must work hard to create an environment where this is fostered. The Adaptive Routine undoubtedly reduced the opportunity for meaningful engagement between officers and prisoners; resulting in strained staff, closed workshops, limitations on purposeful activities and daily confinement of prisoners. For many prisoners this did not culminate in behaviour that showed a blatant disregard for the prison and its people, but for a group of prisoners, it did.
- 6.17 Notwithstanding that the changes across the prison were discussed and recorded, Greenough should have taken more proactive steps to address the growing disquiet about the 'new normal'. The 'balance' of the prison was upset and the prison should have been more alert to the risks posed to the good order and security of the prison and the potential consequences.
- 6.18 The task of quantifying the frequency and duration of lockdowns across the prison was difficult. Although there is a central repository for this information in the custodial information management system, commonly referred to as 'TOMS'¹⁸, local information sources were also maintained and the two were sometimes inconsistent. Most importantly, while lockdowns in cells was generally properly recorded, confinement to Units was not.
- 6.19 At Greenough, there was little difference between the impact on the routine of prisoners and their structured day regardless of whether they were confined to their Unit or their cell. The observations of the Review were that for most of the accommodation Units at Greenough (other than Units 5 and 6), the Unit wings contain very little amenity or reasonable space for activity; for example, prisoners in Unit 2 could only access a hot drink through the security grille.
- 6.20 In attempting to measure and quantify the impact of the Adaptive Routine on prisoners, the Review examined data from the Department's approved reporting source, the Reporting Framework¹⁹. However, the Review notes that some Greenough lockdown information was either alternatively captured in Microsoft Excel workbooks, or first captured therein and later entered into the custodial system. Accordingly, there were minor inconsistencies between these two repositories. Thus, the Reporting Framework records – summarised in Figures 1 and 2 – may under-report the time out-of-cell.

¹⁸ Total Offender Management Solution.

¹⁹ The Reporting Framework applies agency counting rules to data from multiple Departmental systems, including TOMS.

- 6.21 Figure 1 shows the number of lockdowns at Greenough for the period 1 January to 23 July 2018 (the day before the riot) and the frequency with which lockdowns occurred.
- 6.22 Figure 2 shows the overall impact on time spent out-of-cell. To aid understanding, the out-of-cell hours data in Figure 2 is expressed as a percentage of the scheduled out-of-cell hours that prisoners ought to have had in accordance with their Unit Plans.
- 6.23 Lockdowns and time spent out-of-cell²⁰ are inversely related. As the number of lockdowns (Figure 1) increases, the percentage of available time out-of-cell (Figure 2) decreases.

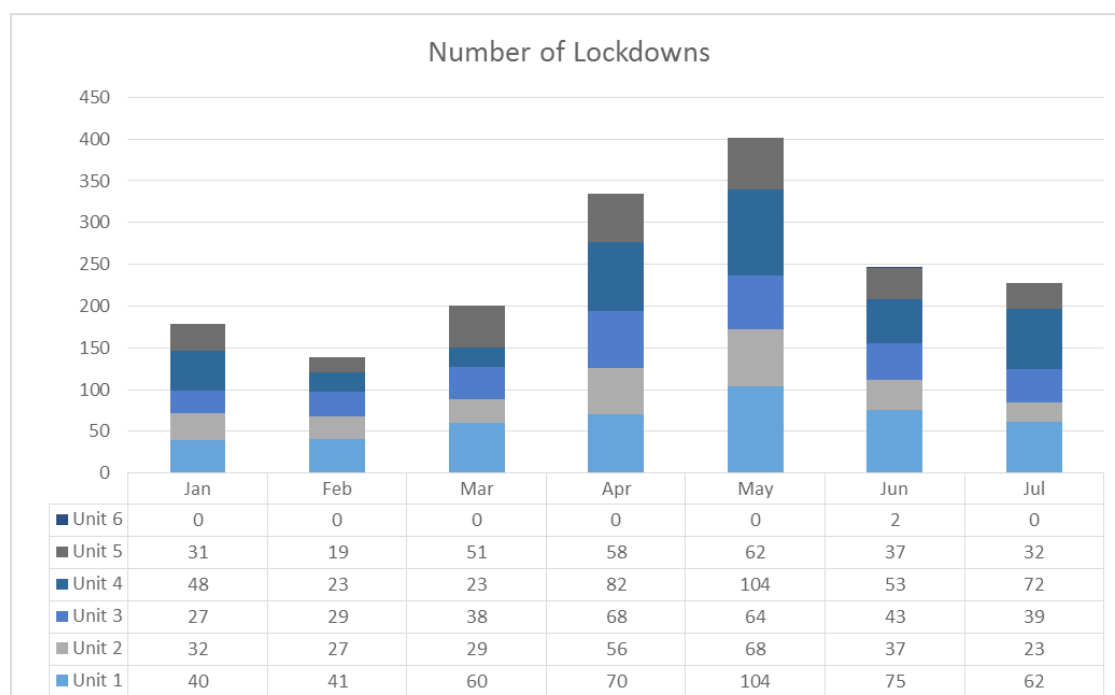


Figure 1: The number of lockdowns at Greenough for the period 1 January to 23 July 2018.

- 6.24 Notably, Figure 1 shows an increase in the number of lockdowns commencing in March 2018 and increasing through April and May. The timing of this increase corresponds with the more rigid implementation of the Adaptive Routine, following the signing of Standing Order E6 and Staff Deployment Agreement on 8 March.
- 6.25 In contrast to the six months prior to December 2017, the first six months of 2018 revealed a 36% increase in the total number of lockdowns. The lockdowns were primarily attributed to staff shortages or for the “good order” of the prison. Data for the first three weeks of July show the trend continuing. Some of this increase may also have been partially influenced by a push to improve the recording of lockdowns across the Department in March 2018, following qualified audit opinions on KPI data in 2016, 2017 and 2018 by the Auditor General relating to the Department’s data keeping in this area.
- 6.26 Greenough’s local Microsoft Excel workbook records also confirmed this trend. The Review found that according to these records, Greenough implemented a ‘modified routine’ on 107 out of 139 days reported on during the period 1 March – 24 July 2018 (a total of 77%), and was using lockdowns and rolling lockdowns²¹ to manage staff shortages on these days.

²⁰ Out-of-cell hours data were extracted from the Department’s Reporting Framework database prior to the end of September. Any subsequent changes to source data are not reflected in this report.

²¹ ‘Rolling lockdown’ refers to a sequence of lockdowns across Units.

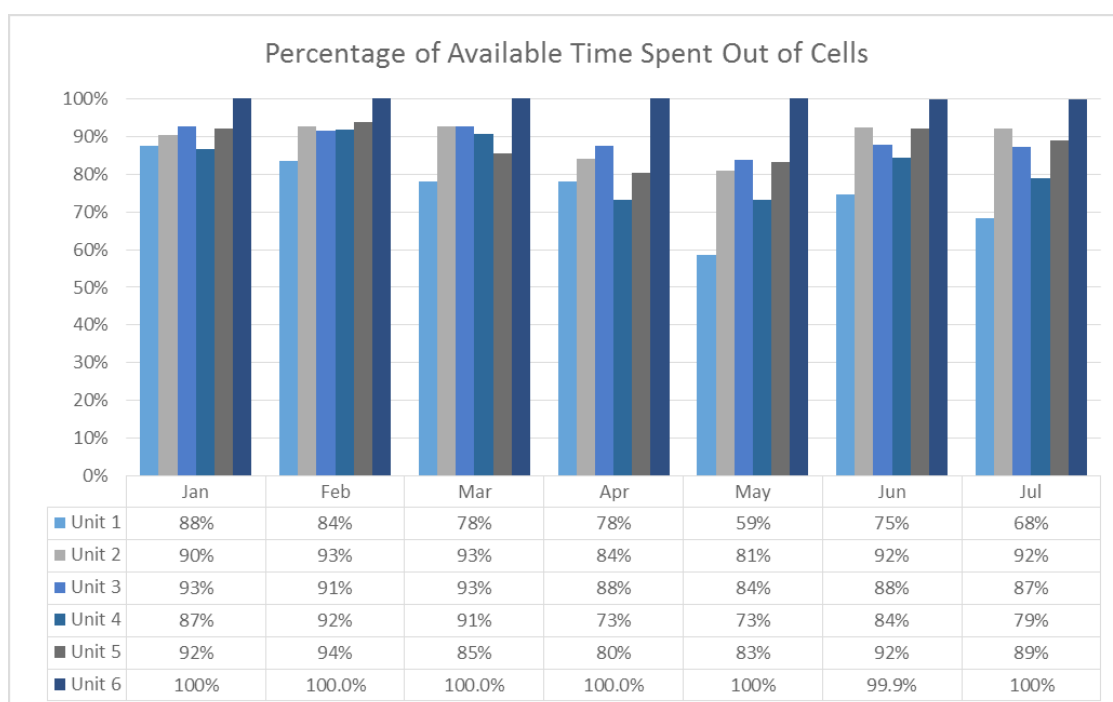


Figure 2: The percentage of time out-of-cells at Greenough for the period 1 January to 23 July 2018.

- 6.27 Greenough has, on average, a scheduled unlock period of 11.5 hours inside of the main secure perimeter section of the prison (Units 1-5). The minimum security section (Unit 6), located outside of the main prison, has a longer scheduled unlock period of 15 hours. These hours are presented here as an approximation, as there are small differences between weekday and weekend unlock and lockup times.
- 6.28 Figure 2 shows that for the period January to June 2018, Unit 1 prisoners had the least available time out-of-cells, at 77% of the available unlock hours, whilst male prisoners in Units 2, 3 and 5 had freedom of movement for closer to 90% of the available unlock hours. Female prisoners in Unit 4 were able to move outside cells for 83% of the available unlock hours.
- 6.29 The Department reports time out-of-cells in accordance with the National Corrections Statistics Group (NCSG) Data Collection Manual, which states: “*The annual average time out-of-cells is the average number of hours per day that prisoners are not confined to their cells or units*”. The Review understands that lockdowns at Greenough are recorded for cell confinement only. As such, the lockdown frequency and durations would be even higher if captured consistent with the national counting rules.
- 6.30 As noted above, given the potential under-reporting of both the number of lockdowns and the duration of time-out-of-cell that the data presented in Figures 1 and 2 provides a “best case” scenario of time spent out-of-cell by Greenough prisoners.
- 6.31 It is evident from the data above that a modified routine, frequent lockdowns and a reduction in out-of-cell activity had become everyday practice at Greenough in 2018.

What changed after March?

- 6.32 The strict adherence to the Adaptive Routine is what substantially changed at Greenough in March 2018. The Review understands that prior to March, staff and the local WAPOU branch had been more flexible regarding the precise numbers of officers positioned in in each Unit while prisoners were unlocked. However, from March, the flexibility stopped. If the required number of staff under the Daily Staff Deployment Agreement ('**Agreement**') were not present, then confinement to wings and lockdowns were implemented. It is important to note that the Agreement had the authority of an Order and therefore must be followed.
- 6.33 The redeployment of VSOs to cover vacant prison officer roles further added to the problem. For example, if the Gardens Officer VSO was redeployed to cover a prison officer role in one of the Units, then gardening work would be cancelled, and prisoners employed in this party had no work to attend even if they could be unlocked.
- 6.34 The Review was advised that there were a number of reasons for staffing shortfalls during this period, including ongoing vacancies on the roster, staff transfers, retirement, personal leave, workers compensation and other leave entitlements.
- 6.35 In particular, a significant impact on the prison's capacity to cover the roster was the transfer out of eight supernumery officers between March and 24 July 2018. By way of example, in the roster period 3-23 March, there were nine supernumerary officers and by the 29 June roster this had reduced to one.
- 6.36 Supernumery officers are assigned to a prison above the agreed staffing level. At Greenough, however, these officers were routinely used to cover a range of positions such as Recovery Officer, Assessment Writers, Prosecutions, Cognitive Skills and other support roles. Their transfer further depleted the prison's staffing resources after March.
- 6.37 While there was a six-week non-leave period from 18 May to 28 June 2018, the prison's records show the prison was on a modified routine for 41 of the 42 days during this period, when there were surplus staff available to fill the roster. The Review was advised that during this period while there were surplus staff available, the priority was to deliver mandatory training to officers.
- 6.38 In the view of many who contributed their thoughts to this Review, the implementation of the Adaptive Routine and the Agreement had been undermined by the constant presence of vacant lines on the roster; as it had been premised on an agreed staffing profile and roster lines covered by a full complement of staff. If this were the case as intended, the Adaptive Routine would then only have been applied as the exception – rather than the norm.
- 6.39 A stark example of the above is the period of 13-19 July – the week before the riot – when seven roster lines were vacant and a further eight staff were known to be absent on workers compensation. Notably, the measures to cover the roster did not take into account any daily unplanned absences due to personal leave.
- 6.40 The staffing requirements for the week were 180 shifts to cover the roster. There were available staff to cover only 118 shifts (or 66% of the roster); leaving a shortfall of 62 shifts (or 34% of the roster).
- 6.41 The routine that was to be implemented for the week to cover rostered positions was:
- coverage of 55 of the 62 vacant shifts by the daily redeployment of four VSOs (20 shifts);
 - weekly approved overtime allocation (28 shifts); and
 - seven approved additional overtime shifts.
- 6.42 Even with the above measures, the prison started the week with seven shifts vacant; and during the week a further 12 vacancies occurred due to unplanned personal leave. To manage this staff shortfall, the routine of the prison was to operate with further restrictions – rolling lockdowns and industry closures on a day-to-day basis.

- 6.43 Staff reported that they were constantly changing positions and facing aggravated prisoners because of the ambiguity and restrictions (as evidenced by the Independent Visitor Reports discussed in this Chapter).
- 6.44 While the deployment of VSOs into Units allowed some prisoners to be unlocked at different times, it also meant that these staff were not performing the duties they were engaged to do, such as instructing and managing prisoners for vocational training outcomes and education, as well as workshop requirements, such as maintenance management.
- 6.45 Significantly, the Review also found that when a VSO was redeployed to undertake prison officer duty there was a gap in shift and duty coverage. VSO positions are generally employed for eight hours per day, whereas a prison officer position is for 12 hours per day. This meant that some positions were not covered for up to four hours, creating a further source of strain within the prison.

IMPACT OF THE ADAPTIVE ROUTINE ON SERVICE DELIVERY

Education

- 6.46 From March 2018, education staff were reporting an increase in the “rolling lockdowns” and the effect this was having on their students. Comments from the Aboriginal Education area noted: *“when students were locked up due to staff shortages, the students would be visibly affected and show some frustration when they had education next... this would happen for both males and females”*. This area also commented on the amount of times that officers were being redeployed and that this added to the prisoners’ frustration.
- 6.47 Education Centre staff also reported that as the lockdowns increased, a tension had developed between the prisoner work areas in the prison (managed by VSOs) and the education area. It was noted that the prison work areas had become very “territorial” and did not want to release workers to attend education due to the limited access they had to prisoners. Prisoners were caught in the middle of this situation and when they did manage to attend education sessions, they presented as being “very unsettled”.
- 6.48 The Review was advised that for the first 6 months of 2018, in comparison to the same period in 2017, there was a 50% reduction in education unit completions at Greenough and a 51% reduction in student enrolments.
- 6.49 The reduced ability to plan prisoner education contact hours also had a fiscal implication. The Review was advised by the Department that Greenough had *‘24,000 student contact hours for the year which is approximately \$360,000 of training allocation’*. The Review was further advised that if this allocation is not used, TAFE can be penalised, and this penalty may be passed on to the Department.
- 6.50 The Review observes that Education, Employment and Transitional Services has developed a comprehensive model which clearly defines how education, training and transitional services are provided to prisoners at Greenough. This model advises on specific service delivery for women, Aboriginal prisoners, remand and short term sentenced prisoners, and applies to all state-run prisons. It is operationalised at Greenough (and all other prisons) via a local Service Level Agreement between the Greenough Campus Manager and the Superintendent.
- 6.51 Such a model aims to ensure that all prisoners have a clear direction on education and training options which in turn can form part of the prisoner’s individual management plan and future post-release planning.

Pre-release services

- 6.52 Another function of Greenough prison is to operate as a re-integration and pre-release facility to prepare sentenced prisoners for a successful re-entry back into the community. The Transitional Manager and the Employment Coordinator support this function. These two key positions support prisoners in working toward achieving a successful outcome with the Parole Board by demonstrating they have taken active steps toward reducing their likelihood of re-offending.
- 6.53 Both areas reported experiencing an impact on service delivery to prisoners due to increased frequency of lockdowns and also an impact on external service providers. For example, prisoners were advised at very short notice of the cancellation of appointments for driver training, OSH training, career advice or pre-release community employer interviews.
- 6.54 It was reported to the Review that, since February 2018, there was a 30 percent reduction in the delivery of transitional and employment services.

Therapeutic programs

- 6.55 Greenough prisoners' individual therapeutic treatment requirements are determined in line with *Adult Custodial Rule 18 – Assessment and Case Management of Prisoners*.
- 6.56 All prisoners with an effective sentence of greater than 6 months must have an Individual Management Plan ('IMP') developed, within 28 days of sentencing. The IMP provides information regarding their custody and containment, care and wellbeing, rehabilitation, reintegration and reparation needs.
- 6.57 Specific therapeutic program needs are identified through the application of a Treatment Checklist and the prisoner's program needs should then be placed into a treatment planning schedule for delivery at their prison.
- 6.58 Prisoners generally have considerable input into the development of their IMP and are encouraged to actively work toward achieving their identified treatment requirements. Non-completion of assessed treatment programs will influence not only a parole board decision, but also the potential for a minimum-security rating and placement. The treatment needs checklist and any specific program delivery must be administered by suitably trained staff.
- 6.59 In the 2017-2018 financial year at Greenough, four programs were cancelled which affected 39 prisoners. Cancellations were due to insufficient qualified staff to deliver a particular program and staff shortages. Greenough's staffing level for program assessment and delivery is three FTE. However, one position has been vacant for some time and has been affecting the delivery of programs.
- 6.60 It was also noted during staff interviews that when a program was scheduled to be delivered, there was often daily uncertainty for staff and prisoners alike as to whether the program would occur. Staff also reported that prisoners expressed anxiety about not being able to complete their IMP requirements, knowing the impact this would have upon their potential release date.

Health services

- 6.61 The prison's Health Centre staff reported that while an Adaptive Routine had been operating at Greenough for some time, from March 2018 they noticed this was beginning to have a significant impact on their work area and their capacity to deliver essential health services to prisoners.
- 6.62 If a prisoner was required at the Health Centre, the normal procedure was to call the Unit and request a prisoner's attendance. However, if the Unit was under a modified routine, the prisoner would not be available. Nursing staff reported that there were times that the telephone would simply ring out as there were no staff in the Unit having been redirected to other duties. The Review was advised that prisoner appointments were continually having to be rescheduled and this resulted in an increase in aggression and abuse being directed toward nursing staff.
- 6.63 Nursing staff also reported that on the weekends, the prison officer assigned to the Health Centre was frequently redeployed. This directly affected the ability of nursing staff to interview and undertake health induction procedures for newly admitted prisoners. It is a Statewide requirement that this process is undertaken within 24 hours of admission and it is an important part of the risk management process within a prison.

Recreation

- 6.64 During March 2018, access to recreation and the length of time prisoners were able to be outside on the oval was raised by male prisoners as an issue with the Independent Prison Visitor. During the OICS quarterly liaison visit in April 2018, prisoners again raised their concerns about not being able to get out to the oval to engage in physical recreation activities such as playing football.
- 6.65 The Review notes that when the disturbance commenced on 24 July in Units 2 and 3, these Units were on "unit-based" recreation. Of the 138 men living in this area, 25 percent were young men aged between 18-23 years and the majority of the men were under 30 years of age.
- 6.66 Although not directly relevant as a cause of the critical incident, it is important to note that the women prisoners' access to recreation was also affected. During the interviews with female prisoners, most of the women were very disgruntled about how the Adaptive Routine had been impacting on their recreation time. They were particularly unhappy about not being able to access the oval on a regular basis or being able to participate in the Zumba classes which were regularly cancelled. As an alternative, women's recreation time was often replaced by "in Unit" activities. Women said that they wanted more structure during their recreation time and had requested activities such as painting and storytelling, but had been told that there was no money available to fund these activities.

ABORIGINAL ENGAGEMENT

- 6.67 The majority of male and female prisoners at Greenough are Aboriginal people. On the day of the critical incident, 70 percent of the total prison population were Aboriginal. The proportion of Aboriginal people is consistent with the OICS 2016 Report on Greenough (dated November 2016), where it was reported that 74 percent of the population were Aboriginal.
- 6.68 The Department's Reconciliation Action Plan ('**RAP**') for 2018-2021, launched during NAIDOC week in July this year, is described as:
- "a core part of the new Department's business demonstrating our commitment to improving justice services and outcomes for current and future generations of Aboriginal people. This RAP aims to identify actions and targets that are equitable, responsive and relevant to Aboriginal people and communities".*
- 6.69 The former Department of Corrective Service's RAP required that each public prison establish and maintain an Aboriginal Services Committee ('**Committee**') to provide a focus on the appropriate management and delivery of services to Aboriginal prisoners. The maintenance and enhancement of the Committee arrangements is an important action of the Department's RAP for 2018-2021.
- 6.70 The operational requirements for the Committees advise on the service areas prisons need to consider and report on in regard to the management of Aboriginal prisoners. These areas are clearly defined and are designed to report on the quality of life for Aboriginal prisoners. Any operating model for Greenough should ideally include these required outcomes.
- 6.71 The 2016 Aboriginal Committee Guidelines require that:
- Superintendents must convene quarterly Committee meetings pursuant to their performance agreements;
 - the Committee must comprise representatives from each functional area within the prison and, at a minimum, include the Superintendent, Assistant Superintendent Offender Services, Prisoner Support Officer, Aboriginal Visitors Scheme ('**AVS**') representative, Education Campus and Transitional Managers and Prisoner Employment Coordinator;
 - a written report must be submitted to the Commissioner addressing Aboriginal engagement and quality of life measures including:
 - rates of individual management plans;
 - access and participation in industries, training and education and access to gratuities;
 - safety of Aboriginal people and visits,
 - drugs and alcohol; and
 - may also include staff cultural competency developments.
- 6.72 In the 2017-2018 reporting year, Greenough Prison did not convene a single Aboriginal Services Committee, nor did they submit a report. The result was evidenced in the Capability and Development performance framework where the prison failed this measure in each quarter for the year. Indeed, Greenough has only conducted one meeting and submitted minutes for June 2016, since the structure was established in the first half of 2016.
- 6.73 On a more positive note, the Review was provided with two sample Committee Reports, one from Bunbury for August 2016, and the other from Eastern Goldfields Regional Prison for September 2017. These quality reports demonstrated the focus on services to Aboriginal people in those prisons and the thorough monitoring of engagement and quality of life measures for Aboriginal people.
- 6.74 Greenough had held a NAIDOC Week function at the prison in the week prior to the events of 24-25 July and this was attended by around 98 people of which 72 were Aboriginal people.

- 6.75 The Department also has an initiative whereby Aboriginal prisoners can participate in the production of art for NAIDOC Week and National Reconciliation Week. The aim of this funded program for Aboriginal people is to provide an opportunity to create and display culture through art. Greenough prison did not participate in this program in 2016, 2017 or 2018.
- 6.76 The Review found little evidence of programs specifically designed to meet the needs of Aboriginal prisoners. Greenough did provide the Review with a table ostensibly detailing Aboriginal programs, but the majority of programs listed were one-hour activities and information sessions open to all women with a few targeted to Aboriginal women. There had been two programs run in 2018 (with a duration of 4.5 hours and 6 hours each) targeting family violence and women's physical health, open to all women but attended by Aboriginal women.
- 6.77 Greenough does have an AVS, however, the Review understands that there were frequent delays seeing prisoners, usually attributed to operational priorities. AVS suggested that staff at Greenough may benefit from cultural competency training, as they sometimes misinterpret the cultural dynamics among Aboriginal prisoners in the prison. AVS also noted that following the riot, they were advised to stay away from the prison for one week, and that this inhibited their efforts to provide support and to assist the prisoners' recovery process.
- 6.78 While it is not possible to measure the effects of the lack of specific services to meet the needs of Aboriginal prisoners, given they comprise the majority at Greenough, the absence of targeted services represents a real deficiency in the overall operating model for the prison. It is reasonable to deduce that without culturally designed services, or any active monitoring of outcomes, it is inevitable that Aboriginal prisoners in this environment would be disengaged and disconnected from the prison.
- 6.79 Given that the Department has displayed a strong strategic commitment to improving justice services and outcomes for Aboriginal people, and seven out of ten prisoners at Greenough are Aboriginal, the Review found that the prison was seriously failing to meet its obligations in this regard. The needs of Aboriginal people should be at the centre of Greenough's operating model, not the periphery.

STAFF PERCEPTIONS

- 6.80 The Review was fortunate to receive a number of detailed written submissions from staff employed at Greenough, many of whom were on duty the night of 24 July. The Review also conducted a number of one-on-one meetings with staff and group forums to gain an understanding of what occurred during the incident and the underlying contributing factors.
- 6.81 It was clear to the Review that all staff at Greenough have been deeply affected by the events of 24-25 July, even those that were not on duty on the night. Staff said they were still suffering high degrees of stress, anxiety and anger many weeks after the event. The Review is very grateful for the time taken by individuals to share their thoughts and concerns, whether in writing or in person, and acknowledges that for some people, the consultation process may have been emotional and difficult.
- 6.82 The staff members consulted included the senior management team, VSOs, Prison Officers, Senior Officers, Principal Officers and public service staff including program delivery, health and administration staff.
- 6.83 A number of common themes emerged from the staff submissions and interviews, and there was a high degree of consistency among submissions.
- 6.84 Staff did not identify any particular precipitating cause or 'spark' that triggered the beginning of the riot on 24 July and the subsequent escapes. Rather, staff pointed to several contributing factors and systemic problems that they believed had been 'brewing' over a number of years and may have culminated in the riot.

- 6.85 A common comment the Review heard from staff members of Greenough was: *“it was not a matter of if, but when.”*
- 6.86 Without exception, every staff member identified staff shortages as a key contributing factor to the riot. Staff believed the increasing levels of stress and strain within the prison were also compounded and exacerbated by:
- increasing lock-downs leading to prisoner boredom, frustration and aggression;
 - lack of effective leadership and a breakdown in relations between staff and management;
 - VSOs being routinely re-deployed to cover prison officer shifts;
 - a general lack of consistency in the management of the Units;
 - lack of appropriate disciplinary action against difficult prisoners, including no prosecution of charges against prisoners due to the absence of a Prosecutor;
 - a perception that management were not supporting the officers in dealing with difficult prisoners, for example, by not approving transfers of difficult prisoners to other prisons;
 - management not communicating well with staff and not listening to their concerns about the rising tensions within the prison; and
 - ageing and inadequate infrastructure and poor maintenance.
- 6.87 Notably, staff did not identify the co-location of women prisoners within Greenough as a contributing factor. They did note, however, that the special measures needed to manage women moving to and from the women’s precinct (for example, the need to lockdown male prisoners when escorting women to medical appointments) was an additional strain on staff when short staffed.
- 6.88 The issues identified by staff generally correlate with those identified by the Review outlined in this Chapter and Chapter 5 – Emergency Response.

PRISONER PERCEPTIONS

ACCESS complaints

- 6.89 ACCESS is a dedicated service within the Department that handles complaints, compliments and suggestions from prisoners, staff and members of the public.
- 6.90 Complaints for Greenough from 1 January 2018 to 24 July 2018, indicate a spike in prisoner complaints received in April 2018 regarding lockdowns and staff shortages, and the impact these were having on the prisoner’s ability to get to recreation, telephone calls with their families and work.
- 6.91 On 14 April 2018, for example, five prisoners contacted ACCESS complaining about the amount of time they were in lockdown. The complaints were from both male and female prisoners, with one woman claiming that she did not have access to a shower.

Interviews with male prisoners

- 6.92 The Review met with both Aboriginal and non-Aboriginal male prisoners at Greenough. The men were asked to share their views about life at Greenough including any experiences during the riot. All of the men had been living at Greenough for a period of three months or more and were asked for both positive and negative reflections.
- 6.93 The common themes raised were:
- some prison officers were disrespectful towards prisoners, although they are in the minority;
 - lockdowns were occurring frequently which was affecting their physical, mental and emotional wellbeing;

- visits were not impacted by the lockdowns but showering before a visit is important and could not always be facilitated due to lack of time;
 - there was a perception amongst some prisoners that the reason for the frequent lockdowns was that prison management was unwilling to pay prison officers overtime. Others, however, said that prison officers told them they didn't know why they were locking prisoners down;
 - prisoners wanted to know why they were being locked down;
 - the prison routine and day-to-day stability is poor; and
 - a stable prison routine is desirable even if it involves frequent lockdowns.
- 6.94 The Review spoke with several male prisoners whose peers identified them as having a 'senior standing' in the prison. These men were of the view that there was a group of around ten 'troublemakers' who were creating trouble amongst the prisoners and with staff in the lead up to the riot. Two of these prisoners the Review spoke to, including an Aboriginal Elder, considered themselves as generally in tune with all prisoner happenings at Greenough, but on this occasion, they were unaware of any planning involving the individuals in the troublemaker group.
- 6.95 Individual prisoners also spoke about how they genuinely felt their lives were in danger when they were confined to Units affected by smoke during the critical incident. Overall, prisoners were satisfied that staff reacted to the best of their abilities given the circumstances they were operating in.

Return to custody escapee interviews

- 6.96 Return to Custody Interviews with the escapees were conducted by corrections staff in line with Departmental policy. The Review has considered the content of the interviews and notes that the escapees would have a high degree of self-interest when providing their responses. Given the criminal justice process is not finalised the content of the interviews has not been included in this Report.

Interviews with women prisoners

- 6.97 The Review spoke with ten women prisoners who were at Greenough on the night of the 24 July and who had subsequently been transferred to Bandyup Women's Prison and Boronia Pre-release Centre for Women. The views of the women regarding life at Greenough are discussed in Chapter 7.

EXTERNAL AGENCY OBSERVATIONS

Independent Prison Visitor (IPV) reports

- 6.98 The Independent Prison Visitor ('IPV') Reports for February, March and April 2018, and the prison's response to these reports, suggest there was information available indicating an unsettled environment in the prison during this period.
- 6.99 The Inspector of Custodial Services appoints members of the community to undertake the role of IPV.²² The IPV is required to visit and inspect the prison for which they have been appointed at least once every three months. After each visit, the IPV must provide a report to the OICS on their observations or concerns about the general wellbeing of prisoners and staff.
- 6.100 Prior to leaving the prison, the IPV usually meets with the Superintendent or their delegate to discuss their findings and work toward a resolution as informally and promptly as possible.

²² Section 39 of the *Inspector of Custodial Services Act 2003* (WA) permits the Inspector to appoint an independent prison visitor to attend prisons.

6.101 The IPV then formally provides their report and the prison's initial response to the Inspector, who may then request follow-up information from the prison. The Inspector regularly meets with the Minister to discuss the Office's activities.

6.102 Some of the observations recorded by the Greenough IPV for February, March and April 2018 are recorded as follows:

"Uniformed staff are very disgruntled about all aspects of their work environment. Staff consider the morale at Greenough Regional Prison is 'Lower than a snake's belly'. This sentiment is echoed by all staff spoken to."

"Medical staff considers prisoner management is more challenging now than it was in the past twelve months. They would like to see the extremely difficult prisoners moved to facilities where their mental / medical issues can be better addressed."

"General complaint by prisoners. Insufficient time available for activities on the football oval."

"The issue of staff morale continues to be the biggest concern at Greenough Regional Prison."

"The following comments were made by some 25 prisoners in Units 2 and 3. No one person did all the talking. No names were taken. Prisoners claimed there was no lock down that day because of the Prison Visitors being on site. Each and every other day there was a series of lock downs. Why?"

"I asked the question: On a scale of one to ten. One being very good and ten being really bad. How do you rate the morale amongst the prison population? THE ANSWER WAS UNANIMOUS... the rating was between seven and eight. They further added it may not be them that will destroy this place but any prisoner with a "short fuse" will trigger a chain reaction. Two prisoners claimed, they believe some staff feel the same way as they do."

6.103 The Review noted that prison's responses recorded in the IPV reports were somewhat dismissive of the matters being raised by the IPV. In March 2018, the IPV noted that there were general complaints from prisoners about the time they had to access recreation which was linked to the rolling lockdowns happening at the Prison. In April 2018, IPV report notes that approximately 25 prisoners from Units 2 and 3 relayed their concerns about the number of lockdowns that were happening at Greenough.

6.104 On 8 October 2018, the Inspector shared a letter with the Review received from a male prisoner dated 4 September 2018, about his experience at Greenough during and after the events of 24-25 July. The letter raised a number of serious matters in respect to post-riot living conditions at Greenough when the prison was in recovery mode. The Review understands that this will be considered as part of the Inspector's inquiry into the post-incident management of prisoners.

GOVERNANCE FRAMEWORK

- 6.105 Greenough did not have a recent or up-to-date Risk Register. The Review found this to be a significant gap, particularly given the major changes that were taking place within the prison. The implementation of the Adaptive Routine had severe impacts across the prison – on the operating model, the staffing arrangements, the budget, prisoners' structured day and access to services, to name a few.
- 6.106 All of the aforementioned impacts were not without risk and that risk should have been identified, mitigated, monitored and controlled at the site.
- 6.107 Prison operations are subject to numerous types of internal and external performance and compliance inspections and audits. These audits and inspections advise on and make recommendations for improvements regarding a prison's compliance with legislation, Departmental policies and procedures; performance outcomes required under the prison's CAD agreement; and Occupational Safety and Health and Health Department food handling requirements. Prisons are also required to ensure various operational instructions and orders issued from Adult Custodial Services are implemented and operationalised.
- 6.108 While Corrective Services does have a central 'Performance and Risk' Committee that is responsible for overseeing various recommendations, Greenough advised that it did not have a coordinated and inclusive **local** governance model in place to manage recommendations arising from these wide-ranging reviews. The Review was provided with a local 'Action List' from the OICS 2016 Report showing the recommendation status, however, there was no formal process at the prison for monitoring progress against such important recommendations.
- 6.109 Chapter 5 of this Report makes note of the Department's internal compliance/security audit of Greenough, undertaken in January 2016, where several significant security shortcomings, all very relevant to the riot and escape, were identified and improvement actions were recommended. Once again, the Review could find no local plan or a governance mechanism to monitor implementation of those recommendations.
- 6.110 A local 'Risk and Audit Committee' at Greenough would, for example, help to:
- Develop a 'risk register' and provide local oversight of risk management;
 - Coordinate leadership to monitor and improve performance;
 - Ensure local compliance with legislation and operational standards and procedures;
 - Oversee the implementation of new standards and procedures at the prison;
 - Ensure that OICS recommendations are tracked and actioned; and
 - Monitor performance against CAD.
- 6.111 Robust local governance mechanisms are required to ensure a prison has the capacity to respond to procedural changes within an accountable and proactive framework. This would also provide assurance that the prison has the capacity to respond to procedural changes within this accountable framework and in a timely manner.

CHAPTER 7

WOMEN PRISONERS AT GREENOUGH

OVERVIEW

- 7.1 On 24 July 2018, 56 women were housed in Unit 4 at Greenough Regional Prison. As noted previously, while still inside Greenough's secure perimeter, this Unit stands alone from the general male accommodation area. The Unit is situated in an area referred to as the 'women's precinct', which also contains a number of small buildings which serve as staff offices and program delivery rooms. The offices and service buildings are physically separated from the main women's accommodation unit by a mesh fence.
- 7.2 Of the 56 women at Greenough on 24 July, 41 (73%) were sentenced prisoners and 15 (27%) were women on remand. 57% of the women were from the local mid-west region or northern regions.
- 7.3 Of the 22 (39%) women who were not from the local or northern regions, six women had been placed at Greenough to participate in a treatment program and 16 were there at their own request. No women were being housed at Greenough due to insufficient metropolitan beds. This is contrary to the situation at the time of the OICS 2016 Report, whereby the Women's Unit was housing a number of women who had been transferred from Bandyup Women's Prison ('**Bandyup**') due to insufficient bed space in the metropolitan area.

EFFECT OF ADAPTIVE ROUTINE ON WOMEN

- 7.4 The Adaptive Routine and increased lockdowns from March 2018 had a significant effect on living conditions and service delivery to women prisoners at Greenough. Records for the first six months of 2018 show that as a collective, except for prisoners on restrictive management regimes, women prisoners in Unit 4 were receiving the least amount of out-of-cell hours per day across the whole Greenough prison population.
- 7.5 The staffing model for the women's precinct consists of a Coordinator Regional Women's Services ('**Coordinator**') and a Prison Officer dedicated from Monday to Friday. This is in addition to the day-to-day rostered Unit staff who are responsible for managing the women's accommodation Unit. In February 2017, the job description for the Coordinator's position was reviewed and shortly after the current staff member was appointed. The job description notes that this position "*plays a pivotal role in the delivery of women's specific services...is an advocate for all female prisoners...they enhance life skill service delivery, identify any new and additional services required for women, ensure consistency and equity...*"
- 7.6 Modified routines, rolling lockdowns and the loss of the dedicated Prison Officer (due to extended leave) in the services area of the Women's precinct had a direct impact on how the Coordinator was able to perform their role and responsibilities. While Unit 5 staff were enabling some programs to be facilitated, without the presence of a dedicated Prison Officer, the Coordinator could not have prisoner contact and women were unable to attend activities that were scheduled to occur in the services area such as education, therapeutic and life skills programs. In addition to this, the uncertainty of staff availability impacted on the capacity for the Coordinator to plan and coordinate service delivery with other women's services areas. It was reported during staff interviews that this uncertainty had an unsettling effect on the women; in particular, those who were working towards goals set in their Individual Management Plans which were linked to achieving positive outcomes for consideration by the Parole Board.

- 7.7 At Greenough, the delivery of education services for women is overseen by the main Education Centre and operates as a satellite service. From the beginning of 2018, reports from the Education Centre were expressing concerns about the increasing number of lockdowns and the impact they were having upon the women. These concerns were also echoed by the Transitional Employment and Aboriginal Education areas who advised that the services being affected were Driver Training, Occupational, Safety and Health training, Career Advice and Pre-Release interviews.
- 7.8 Examination of ACCESS records (the Departmental mechanism for receiving and responding to complaints, compliments and suggestions) shows that from April 2018, there was an increase in women expressing their concerns about the number of lockdowns they were being subjected to, not receiving recreation time out of their cells, as well as not being able to access showers, services and ablution facilities. On 10 April 2018, ACCESS noted that a female prisoner was one of five prisoner complaints from Greenough on the same day regarding these issues.

MALE AND FEMALE INTERACTION AT GREENOUGH

- 7.9 The OICS *Female Prisons in Western Australia and the Greenough Women's Precinct No. 91* (July 2014) report expressed concerns in relation to how Greenough was managing male and female prisoner interactions. It noted that while interaction was occurring, it was not interaction that promoted positive and respectful behaviour, and that the language used between males and females was troubling.
- 7.10 In October 2015, a group of male prisoners staged a roof-top protest causing extensive damage. During this incident they also tried, without success, to enter the women's precinct. As noted in Chapter 5 on Emergency Response, this should have been a warning that a dedicated safety and protection plan for women prisoners was required.
- 7.11 The OICS 2016 Report noted that little had changed in relation to how Greenough was managing interaction between male and female prisoners, and that during this inspection staff had approached the inspection team to express concerns about potential victimisation of women by male prisoners.

MALE PRISONERS BREACH INTO THE WOMEN'S UNIT ON 24 JULY 2018

- 7.12 As detailed in Chapter 5 – Emergency Management – male prisoners began rioting just after 16:00 hrs. They were first observed within the women's precinct in less than 30 minutes, and inside the accommodation Unit 15 minutes later. It was not until after midnight, at 00:41 hours on 25 July, that the SOG confirmed that they had accounted for the safety of all 56 women (7 hours and 30 minutes later).
- 7.13 After the critical incident, it was reported by other female prisoners that some of the women had been involved in sexual activity with some of the male prisoners, following the breach into the Women's Unit. The Review was not able to corroborate these reports. When the Review team met with a group of women prisoners at Bandyup after the incident, it was not considered appropriate to question the women about this aspect of the events at Greenough, nor did the women volunteer any information on this topic. At the time of writing, no reports of sexual assault had been made to WA Police Force and no charges had been laid in relation to any sexual conduct occurring during the riot.
- 7.14 On Friday, 27 July, after the incident, the prison Health Service at Greenough spoke with the women about their health and welfare, including their sexual health. It was reported that the conversation was difficult as the prison was in recovery mode and several women were being held in the one cell which was not conducive to such a private and sensitive discussion. While at that time no woman requested access to the morning-after-pill, the Health Service purchased a supply, should a private request be made.

MANAGEMENT OF WOMEN PRISONERS POST-INCIDENT

- 7.15 Given the extensive damage to infrastructure caused during the critical incident and the inability to provide suitable and safe accommodation for the women prisoners, women could not continue to be accommodated at Greenough. Infrastructure damage had also severely restricted Greenough's capacity to provide the intensive post-incident support services required to meet the needs of the women.
- 7.16 On 27 July, the Department developed and approved a 'Strategy for the Management of Women Currently Housed at Greenough Regional Prison' ('**Strategy**').
- 7.17 The Strategy was developed in line with trauma-informed practice to provide direction and a shared understanding in relation to the immediate and longer-term management of the women who had been at Greenough during the riot.
- 7.18 In accordance with the Strategy, immediate preparations commenced for all women to be transferred to Bandyup. The first group of women were transferred out on Saturday, 28 July, and the final group arrived at Bandyup on Wednesday, 1 August.
- 7.19 Women were informed that after their transfer, they would be advised of vacancies at other prisons and offered an option to transfer onwards to that prison if they chose.
- 7.20 Bandyup was assessed as being the most appropriate placement for the women as the staff are highly experienced in managing female prisoners and women's services, and relationships with external support services are well established.
- 7.21 Keeping the women together in the one location also allowed women's support services to be redirected to this one location and ensured that all women had equal access to services. The Strategy also took into consideration that there was going to be a small number of women who may need to stay at Greenough to facilitate a court appearance or who were due for imminent release.
- 7.22 On arrival at Bandyup, the women were advised of the services they could access and were informed that their requests would be given priority. The women were also advised that accommodation options for onward placement to other prisons would be provided and their request for transfer would also be prioritised.
- 7.23 At the time of writing, Greenough was only housing a limited number of female prisoners who had local court appearances, were being received directly from WA Police Force, or were onward transiting to another prison. In light of the damage to the Women's Unit, women were now being housed in Unit One. While they are being held separately from male prisoners, this area is within the main male accommodation area of the prison and is barely suitable for very short-term stays.

WOMEN PRISONERS' PERCEPTIONS

- 7.24 As at 17 September 2018, of the 56 women that transferred to Bandyup, 24 women had transferred on to other prisons or have been released to freedom or on parole.
- 7.25 The Review met with a group of women prisoners at Bandyup. The women were asked to share with the interviewer an account of their lived experience as a female prisoner at Greenough Prison. All of the women had been living at Greenough for a period of three months or more and were asked for both positive and negative reflections and for their views on any future improvements.
- 7.26 A diverse group of women agreed to be interviewed. This did not include any persons of interest to WA Police Force. 70% of the women were Aboriginal, from regions extending from the Kimberley to various areas in the mid-west region. This was representative of the overall population of women at Greenough at the time of the incident. The women were diverse in their sentence length and engagement in prison programs.

- 7.27 During the discussion, there was general agreement among the women that they had generally liked living at Greenough. They commented that they felt the staff showed compassion toward them, particularly when having to action the rolling lockdowns, often apologising for having to lock the women in their cells.
- 7.28 When asked if Greenough should once again house women when the infrastructure was repaired, all the women agreed in a general sense. However, half of the women interviewed added that while they came from the northern region, they personally would not return to Greenough as they would not feel safe there. They felt that when the incident started, they had been abandoned.
- 7.29 The women all provided suggestions on how living conditions should be reviewed and improved upon before women returned.
- 7.30 All the women shared the perception that compared to the men, they were being disadvantaged in relation to access to structured recreation activities. None of the women interviewed criticised the prison for the use of lockdowns. They were, however, critical of the uncertainty of the lockdowns and the impact this had on their structured day. Women stated they wanted to work, attend education and programs, and all had experienced difficulties in these areas.
- 7.31 One woman noted that the lockdowns had directly affected her access to her health appointments.
- 7.32 Women stated they also felt disadvantaged over the men in their capacity to personally purchase private goods from the canteen. The men were able to attend the canteen in person to select their private purchases, however, the women had to order on a paper system and could not review the actual products. They also noted that their goods were packed by the male prisoners in the canteen and then delivered to them in the Women's Unit.
- 7.33 Women were critical that no activities were provided for them to keep them occupied during the lockdowns. They noted that while some women were able to do handicraft there did not seem to be any system to advise the women of what options were available to them. They stated that they were often bored and occupied their lockdown time by watching TV.

FUTURE MANAGEMENT OF WOMEN PRISONERS AT GREENOUGH

- 7.34 The terms of reference directed the Review to make recommendations for the management of offender cohorts, particularly women going forward. The following section provides the Review's suggested approach.
- 7.35 As noted above, there has been long-standing concern about the management of women prisoners at Greenough with regard to the lack of opportunities for structured, meaningful interaction between male and female prisoners. The OICS 2016 Report emphasised the importance of these interactions for out-of-country Aboriginal prisoners with family members who were also housed at Greenough.
- 7.36 Given these concerns, during interviews with the female prisoners, the Review asked for their views on whether Greenough should operate from a more integrated (yet supervised) model, or if women should be accommodated in a completely separate place away from the men's accommodation area with limited contact with the men.
- 7.37 Women stated that the location of the Women's Unit within the prison was a problem as it encouraged some women to engage in inappropriate and disrespectful behaviour in the areas of the fence where communication and visibility of the men was possible; and men could be heard calling out to the women.
- 7.38 Women also reported that they felt it very demeaning that in order to attend appointments or interviews, they had to be under escort by an officer, and male prisoners had to be locked down or secured in a specific area such as the kitchen. The women noted that this did not stop the men shouting out inappropriate and unwanted comments towards them.

- 7.39 However, all women who were interviewed stated that women should be housed at Greenough and the prison should have more supervised, integrated activities between men and women prisoners, and the women should be given a choice if they would like to attend. Choice was seen as critical because cultural considerations may make interaction inappropriate in some circumstances.
- 7.40 Women who had been at Greenough on several previous occasions, also stated that in the past they had always participated in more activities with the male prisoners, however this had now reduced to only about twice a year, citing NAIDOC week and a 'sing-a-long' at Easter.
- 7.41 A successful and well-managed integrated model in delivering education services for male and female prisoners can be seen at Eastern Goldfields, West Kimberley and Roebourne prisons. These prisons have been providing combined education classes for several years with the Prisoner Education, Training and Employment area, reporting that this model was achieving positive results for both learning outcomes and social interactions.
- 7.42 There is also a well-considered approach in managing women and men at the West Kimberley prison. Here the type of accommodation provided for the women and the supporting infrastructure used to ensure their privacy and decency, along with the level of risk-assessed joint activities, is noteworthy.
- 7.43 The women's responses essentially supported recommendation 10 of the OICS 2014 Women's Report where it was recommended that "male and female prisoners at all of the state's mixed gender prisons should be allowed regular, voluntary, meaningful and respectful interaction with each other."²³

DEFINING A NEW MODEL

- 7.44 In light of what occurred at Greenough on 24 July, and the impact of the riot on the women, the Review found that the overall arrangements at Greenough for the safety, security and wellbeing of the female prisoner population at Greenough were inadequate.
- 7.45 In the past, in order to support an increase in the female population at Greenough, modifications had been made to existing infrastructure, however, this was from a male-based operational practice model. Repairing current infrastructure damage to the existing Women's Unit will make the unit habitable again but only to this pre-existing standard. The development of a dedicated safety plan for women will provide some confidence in this area. However, a more holistic and gender-informed model should be developed for the future long-term management of women at Greenough.
- 7.46 This model must be guided by, and work toward, the full implementation and realisation of the philosophies and goals set out in the *Mandela Rules*²⁴, the *Bangkok Rules*²⁵, the *Tokyo Rules*²⁶ and the Department's own *Western Australian Women in Prison, Prison Standard* dated 5 January 2016.
- 7.47 These basic guidelines for the humane and decent management of women in custody should underpin the development of the new strategy for women at Greenough, including:
- an accommodation area that is still within the secure perimeter but has complete and secure separation from the male prison; a separate 'prison within a prison' where women can be accommodated in cottage-style shared accommodation;
 - a culturally considerate design acknowledging women being housed at Greenough are predominantly Aboriginal people;
 - provision of employment within the women's prison that is meaningful and linked with accredited training;

²³ p.104

²⁴ UN General Assembly. *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)* (29 September 2015)

²⁵ UN General Assembly. *United Nations Rules for the Treatment of Women Prisoners and Non-custodial measures for women offenders (the Bangkok Rules)* (21 December 2010)

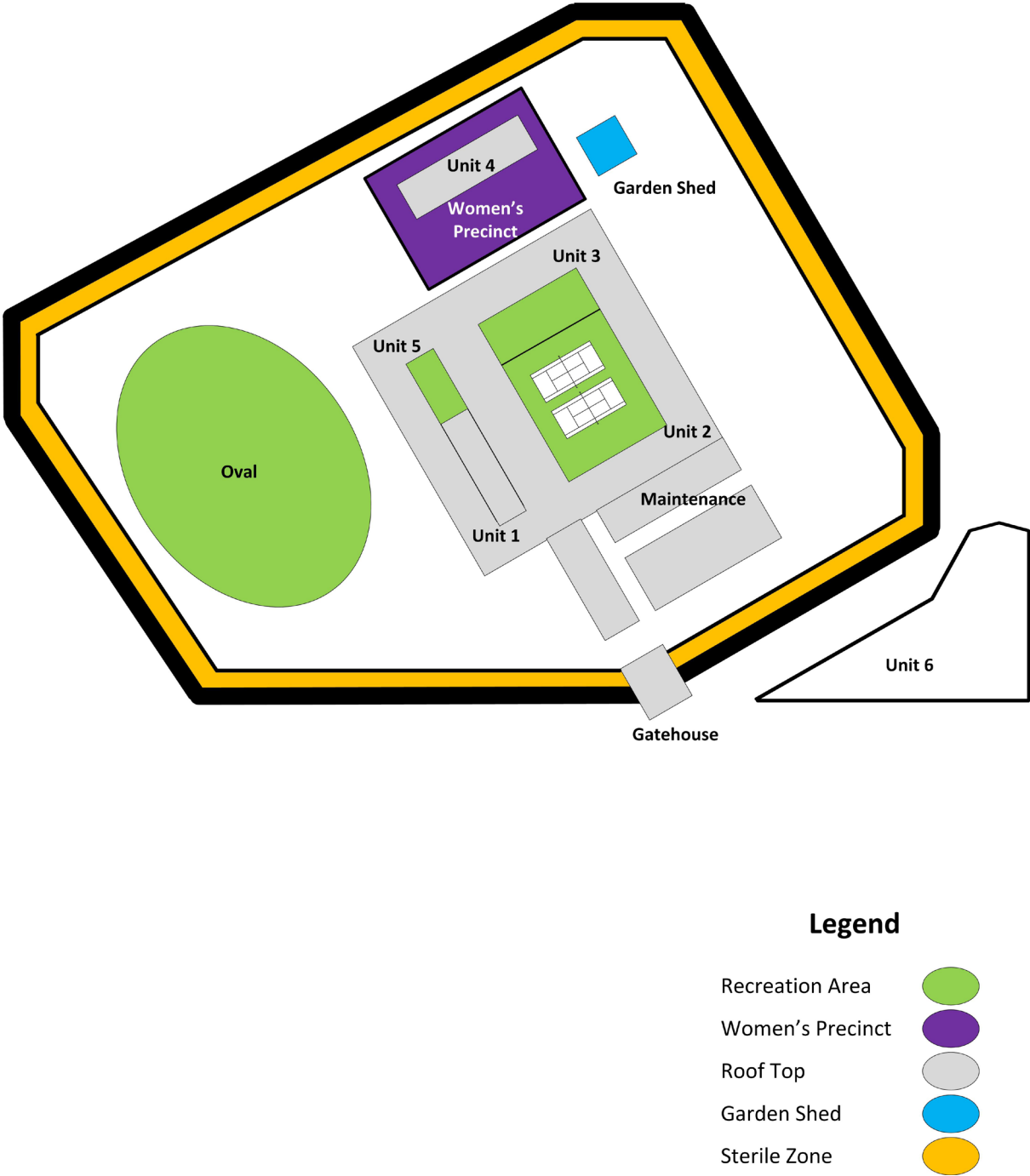
²⁶ UN General Assembly. *United Nations Standard Minimum Rules for Non-custodial measures (the Tokyo Rules)* (14 December 1990)

- the capacity for services to come to the women and not the women having to be taken to services within the male section of the prison;
- identification of supervised, integrated activities between male and female prisoners with a risk assessment process to support these interactions;
- a canteen annex located in the women's prison that is stocked with gender appropriate items with women being employed in this area;
- a dedicated child-friendly area that supports a residential 'mother and child' program, extended day visits between children and their mothers or primary carers within this safe women's space, and supervised visits where child protection agencies are working toward post-release reunification of families; and
- provision of a safe and appropriate space for pregnant women and women who are received at the prison directly from police custody who may have a baby with them. It is noted that at the time of the critical incident there were two pregnant women housed at Greenough.

7.48 The above are only a few aspects for consideration in providing an appropriate model of care for women at Greenough and further direction should be taken from the references in paragraph 7.46 of this chapter.

APPENDIX 1

MAP OF GREENOUGH REGIONAL PRISON ON 24 JULY 2018



APPENDIX 2

GLOSSARY

TERM	DEFINITION
Adaptive Routine	This refers to the implementation of Standing Order E6 and the Daily Staffing Deployment Agreement at Greenough on 8 March 2018. The Agreement prescribed the type of modifications to prisoners' normal daily routines that could be implemented in response to staffing shortfalls, including the use lockdowns.
AVS	Aboriginal Visitors Scheme
CAD Report	Capability and Development Report
Department	Department of Justice
DFES	Department of Fire and Emergency Services
EM Act	<i>Emergency Management Act 2005 (WA)</i>
EM Framework	Emergency Management Framework (March 2009)
External Perimeter Fence	The outermost of the two barrier fences surrounding the prison and encompassing the prison grounds.
Greenough	Greenough Regional Prison
FTE	Full-Time Equivalent
Greenough EMP	Greenough's local Emergency Management Plan
ICF	Incident Control Facility
IMP	Individual Management Plan
Inspector	Inspector of Custodial Services
Internal Perimeter Fence	The innermost of the two barrier fences surrounding the prison and encompassing the prison grounds.
IPV	Independent Prison Visitor
LCC	Local Consultative Committee
OICS 2016 Report	Office of the Inspector of Custodial Services. <i>Report of an Announced Inspection of Greenough Regional Prison No. 107</i> (November 2016)
PCC	Prisons Consultative Committee
PPE	Personal protective equipment
Prisons Act	<i>Prisons Act 1981 (WA)</i>
RAP	Reconciliation Action Plan
ROG	WA Police Force Regional Operations Group
SOG	Corrective Services Special Operations Group
TRG	WA Police Force Tactical Response Group
TOMS	Total Offender Management Solution - the Department's custodial information management database.
VSO	Vocational Support Officer
WAPOU	WA Prison Officers Union