JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	3 APRIL 2024, 5 APRIL 2024, 8 – 12 APRIL 2024, 22 JULY – 7 AUGUST 2024, 9 AUGUST 2024, 12 – 16 AUGUST 2024, 4 OCTOBER 2024, 7 – 10 OCTOBER 2024, 15 OCTOBER 2024, 18 OCTOBER 2024, 4 – 6 DECEMBER 2024, 10 – 11 DECEMBER 2024, 3 JUNE 2025
DELIVERED	**:**	28 NOVEMBER 2025
FILE NO/S	**:**	CORC 3139 of 2023
DECEASED	**:**	DODD, CLEVELAND KEITH

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Young Offenders Act 1994 (WA)
Children and Community Services Act 2004 (WA)
Children's Court Act 1988 (WA)
Corruption, Crime and Misconduct Act 2003 (WA)
Inspector of Custodial Services Act 2003 (WA)
Public Sector Management Act 1994 (WA)
Young Offenders Regulations 1995 (WA)

Counsel Appearing:

Mr A Crocker and Ms S Tyler (on 3, 5, 8 – 12 April 2024) assisted the Coroner
Mr D Leigh and Mr D Harwood, and Mr T Russell SC and Ms K Pedersen (on 30 June and 1 July 2025) appeared on behalf of the Department of Justice
Mr S Penglis SC and Ms D Levitt with Mr A Hawkes, Mr D McKenna and Mr T.W Penglis (instructed by Levitt Robinson and later Gilbert + Tobin) appeared on behalf of Nadene Dodd
Mr J McMahon SC and Ms A Harris with Mr T Lettenmaier (instructed by the Aboriginal Legal Service of Western Australia) appeared on behalf of the Aboriginal Legal Service of Western Australia
Mr G Donaldson SC (instructed by Lemonis Tantiprasut) appeared on behalf of Christine Ginbey
Mr E Heenan SC and Mr S Penrose (instructed by Thomson Geer) appeared on behalf of Andrew Beck
Ms B Burke (instructed by Belinda Burke Legal) appeared on behalf of Fiona Bain
Mr E Greaves appeared on behalf of Kyle Mead-Hunter
Mr T Pontre and Ms K McNally (instructed by McNally & Co) appeared on behalf of Douglas Coyne
Mr J Allan (instructed by Allan & Co) appeared on behalf of Dr Adam Tomison

Case(s) referred to in decision(s):

Briginshaw v Briginshaw (1938) 60 CLR 336
Re State Coroner; Ex parte Minister for Health (2009) 38 WAR 553, [2009] WASCA 165
VYZ by Next Friend XYZ v the Chief Executive Officer of the Department of Justice [2022] WASC 274
CRU by Next Friend CRU2 v the Chief Executive Officer of the Department of [2023] WASC 257
Commissioner of Police, New South Wales Police Force v the Attorney General of New South Wales [2025] NSWSC 1119
Commissioner of Police v No Respondent [2020] SASCFC 64

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Cleveland Keith DODD*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 51, 501 Hay Street, PERTH, on 3 April 2024, 5 April 2024, 8 – 12 April 2024, 22 July – 7 August 2024, 9 August 2024, 12 – 16 August 2024, 4 October 2024, 7 – 10 October 2024, 15 October 2024, 18 October 2024, 4 – 6 December 2024, 10 – 11 December 2024, 30 June 2025 and 1 July 2025, find that the identity of the deceased person was* ***Cleveland Keith DODD*** *and that death occurred on 19 October 2023 at Sir Charles Gairdner Hospital, Hospital Avenue, Nedlands, from complications of ligature compression of the neck (hanging) in the following circumstances:*

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LIST OF ABBREVIATIONS AND ACRONYMS

Abbreviation/Acronym	Meaning
the Act	*Coroners Act 1996* (WA)
ALSWA	Aboriginal Legal Service of Western Australia
AMHW	Aboriginal mental health worker
AMP	the Department's Adult Male Prisons section
ARMS	the Department's At Risk Management System
ASO	Aboriginal Services Officer
AYSO	Aboriginal Youth Support Officer
Banksia Hill	Banksia Hill Detention Centre
the Banksia Studies	a study undertaken by the Telethon Kids Institute to assess detainees in Banksia Hill for neurodevelopmental impairments
the Beijing Rules	the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (1985)
BHDC (an abbreviation used in some documents cited in this finding)	Banksia Hill Detention Centre
the Briefing Note (also referred to as the Briefing Paper at the inquest)	the Department's Briefing Note dated 12 July 2022 that was prepared for the Minister regarding the proposed temporary use of Unit 18 as a youth detention centre
the ***Briginshaw*** principle	the principle to be applied by the Court when deciding if a matter adverse in nature has been proven on the balance of probabilities
Casuarina	Casuarina Prison
the CCC	the Corruption and Crime Commission
the CCC report	the CCC's "Investigation into allegations of serious misconduct following the death of a young detainee in Unit 18 Casuarina Prison"
CCTV	closed-circuit television
cell call	a call between a detainee and the control room via the intercom system available in each cell housing a detainee in Unit 18

Cleveland's/his incident	the incident where Cleveland hanged himself from the damaged ceiling vent in his cell on 12 October 2023
cm	centimetres
the Commissioner	the Commissioner, Corrective Services
the control room	the control room at Unit 18
COPP	Commissioner's Operating Policies and Procedures
COPP 14.1	COPP 14.1: Unit 18 Placement
COPP 14.3	COPP 14.3: Unit 18 Behaviour Standards and Behaviour Management (effective from 7 December 2022)
the Court	the Coroners Court
Mr Coyne's report	the report of Mr Coyne prepared for the Court in August 2024 that set out the options for returning detainees from Unit 18 back to the repaired Banksia Hill
CRU	the Supreme Court decision of ***CRU by Next Friend CRU2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257
the Department	the Department of Justice
the Director General	the Department's Director General
the Disability Royal Commission	the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
EcHO	the Department's Electronic Health Online system for recording a prisoner's/detainee's medical information
ED	emergency department
ELTP	the Department's entry level training program for YCOs
FASD	foetal alcohol spectrum disorder
FSH	Fiona Stanley Hospital
FTE	full-time equivalent
GP	general practitioner
Hakea	Hakea Prison
hr(s)	hour(s)
ICU	intensive care unit
IEP	Individual Engagement Plan

IRR	Initial Referral Review
the ISU	the Intensive Support Unit at Banksia Hill
the joint report	the report of Professor Neil Morgan and the Hon. Denis Reynolds dated 2 October 2024
km	kilometres
the Mandela Rules	the United Nations Standard Minimum Rules for the Treatment of Prisoners (2015)
the MDT	the Multi-Disciplinary Team at Banksia Hill
Melaleuca	Melaleuca Women's Prison
the Minister	the Minister for Corrective Services
mins	minutes
model of care	a document which sets out the high-level principles for the care and management of young people in detention
Nous	Nous Group
NSSI	Non suicidal self-injury
observation cell	a cell that allows for direct visual monitoring of the detainee; in the context of Unit 18, this would be most effectively achieved through a clear cell door or a large observation panel or panels in the cell door
OICS	the Office of Inspector of Custodial Services
OOCH	out of cell hours
the Operating Model	the Banksia Hill Detention Centre Unit 18 Operating Model dated 10 July 2022
the OPSM	Banksia Hill's Operating Philosophy and Service Model dated 17 May 2022
the original IRRs	those IRRs that were before the MDT meeting on 13 July 2022
PAR	the Department's Performance Assurance and Risk Directorate
Rangeview	Rangeview Juvenile Remand Centre
Regulation 74(2)	Regulation 74(2) of the *Young Offenders Regulations 1995* (WA)
Regulation 79(4)	Regulation 79(4) of the *Young Offenders Regulations 1995* (WA)
the reworked IRRs	the original IRRs that had their contents changed after the MDT meeting on 13 July 2022

ROSC	return of spontaneous circulation
SAMS	the Department's Support and Management System
SCGH	Sir Charles Gairdner Hospital
the SMT	the Senior Management Team at Unit 18
the SOG	the Department's Special Operations Group
the SPGU	the Department's Suicide Prevention Governance Unit
SSO	State Solicitor's Office
TOMS	the Department's Total Offender Management System
TW	a detainee in Unit 18's C-Wing who self-harmed by using his cell's damaged ceiling vent on 11 October 2023
24/7	24-hours per day, seven days per week
Unit 18	the youth detention centre in the grounds of Casuarina
the video	the promotional video prepared by the Department featuring an interview with Ms Ginbey in Unit 18 that was placed on the Department's website on or about 20 July 2022
Wandoo	Wandoo Rehabilitation Prison
the WAPF	the Western Australia Police Force
YCO	Youth Custodial Officer
the YEP	the ALSWA's Youth Engagement Program
YJO	Youth Justice Officer
YJPS	Youth Justice Psychological Services
YP	young person
VYZ	the Supreme Court decision of ***VYZ by Next Friend XYZ v Chief Executive Officer of the Department of Justice*** [2022] WASC 274

SUPPRESSION ORDERS

1. **That there be no reporting or publication of the identity of any other detainee, or any information regarding any other detainee or detainee's actions, that might reasonably be anticipated to reveal their identity.**[1]

2. **Suppression of the identification of Cleveland Dodd's siblings from publication and any evidence likely to lead to their identification.**[2]

3. **Suppression of the identification of [complainant's name] from publication and any evidence likely to lead to their identification.**[3]

4. **That there be no publication of photographs of the Department of Health's East Metropolitan Unit and no reporting of what is depicted in those photographs.**[4]

5. **That there be no reporting or publication of:**
   - **(a) the number of staff currently working night shift in Unit 18;**
   - **(b) information regarding the location of keys, issuing to and carriage of specific keys by specific personnel, and unique identifiers on keys;**
   - **(c) information regarding nominated locations for emergency response procedures within prisons or detention centres;**
   - **(d) information regarding radio channels or frequencies used within prisons or detention centre; and**
   - (e) **information regarding layouts, buildings and structures within prisons or detention centres (other than C-Wing of Unit 18 and the location of the control room).**[5]

[1] This Order was dated 21 March 2024 and made pursuant to *Coroners Act 1996* (WA) s 49(1)(b)
[2] This Order was dated 27 March 2024 and made pursuant to *Coroners Act 1996* (WA) s 49(1)(b)
[3] This Order was dated 27 March 2024 and made pursuant to *Coroners Act 1996* (WA) s 49(1)(b)
[4] This Order was dated 9 August 2024 and made pursuant to *Coroners Act 1996* (WA) s 49(1)(b)
[5] This Amended Order was dated 18 July 2025 and replaced the Order made on 28 March 2024, with the only difference in the two Orders being the addition of "currently" to (a) in the Amended Order. Both Orders were made pursuant to *Coroners Act 1996* (WA) s 49(1)(b).

INTRODUCTION

"***There can be no keener revelation of a society's soul than the way in which it treats its children***."
Nelson Mandela

1 On 19 October 2023, Cleveland Dodd (Cleveland)[6] died surrounded by his family in the ICU at Sir Charles Gairdner Hospital (SCGH). This was seven days after he was found hanging unresponsive in his cell in the youth detention centre known as Unit 18 in the grounds of Casuarina Prison (Unit 18). He had never regained consciousness from that point in time.

2 Cleveland was barely 16 years old, and his death was the first death of a young person by suicide[7] in a youth detention centre in Western Australia.

3 The death of a child who has decided to end their life is an immense tragedy. That tragedy is magnified if the death occurs when the child is in the State's care. And when the death of that child occurs by suicide in a structure built to house adult prisoners within the grounds of a maximum-security adult male prison and after repeatedly saying before his death to those tasked with his care what he was going to do, it raises the question: "How was this allowed to happen?".

4 At least one member of Cleveland's family and/or a family friend attended every day of the inquest in which evidence was heard. Many of Cleveland's loved ones had travelled a considerable distance to be at the inquest, including Nadene Dodd (Cleveland's mother). I thank Cleveland's family, and particularly his mother, for how they conducted themselves with dignity throughout the lengthy inquest process; even though some of the evidence would have been very traumatic to hear.

5 Cleveland's death has undeniably had a profound impact on his family, and it is obvious they have, by far, suffered the greatest loss. However, there are also staff at the Department of Justice (the Department) who have been deeply affected by Cleveland's death. Some were unable to give evidence in person at the inquest. Others were unable to complete their oral evidence, and some broke down in the witness box as they spoke about Cleveland. A number of youth custodial officers (YCOs) who were working in Unit 18 on the night of 11 and 12 October 2023 had not been able to return to work when the inquest commenced nearly six months later.

[6] The family has requested their relative be referred to as "Cleveland" during the inquest and in this finding.
[7] I will outline later in this finding my reasons for concluding that Cleveland's death was by way of suicide: see: **CAUSE AND MANNER OF DEATH, *Manner of death***

6 This has starkly illustrated the impact Cleveland's death has had on those who knew him. But there is also an impact that should encompass the community at large in Western Australia as it grapples to understand how a young person was able to end his life, with the means to do so, in a facility that when it opened was lauded by the Department as being, "*a much safer environment*" where detainees would receive, "*really intensive support*".[8]

7 The evidence gathered by the Court at the inquest was that when Cleveland's incident occurred, Unit 18 was anything but.

The role of the inquest

8 Cleveland was detained under the *Young Offenders Act 1994* (WA). Accordingly, immediately before his death, Cleveland was a "*person held in care*" within the meaning of the *Coroners Act 1996* (WA) (the Act)[9] and his death was a "*reportable death*".[10] In such circumstances, a coronial inquest is mandatory.[11]

9 My primary function has been to investigate the death of Cleveland. It is a fact-finding function. Pursuant to section 25(1)(a)-(c) of the Act, I must find, if possible, the identity of the deceased, how the death occurred, and the cause of death. Given the known circumstances in this matter, these findings can be made without too much difficulty.

10 As Cleveland was a person held in care, I must also comment on the quality of the supervision, treatment and care of him when in the care of the Department.[12]

11 Pursuant to section 25(2) of the Act, I may also comment on any matter connected to Cleveland's death, including public health or safety, or the administration of justice. This is an ancillary function of a coroner. It is this section of the Act that is used by the Court to make recommendations.

12 Section 25(5) of the Act prohibits me from framing a finding or commenting in such a way as to appear to determine any civil liability or suggest a person is guilty of an offence. It is not my role to assess the

[8] Exhibit 68.1
[9] *Coroners Act 1996* (WA) s 3: meaning of "*person held in care"*
[10] *Coroners Act 1996* (WA) s 3, s 22(1)(c)
[11] As the Children's Court granted bail to Cleveland on the day of his death, it could be argued that he was not *"immediately before death a person held in care*" of the Department pursuant to *Coroners Act 1996* (WA) s 22(1)(a). However, an inquest is still mandatory if "*it appears the death was caused, or contributed to, while the deceased was a person held in care"*: *Coroners Act 1996* (WA) s 22(1)(c)
[12] *Coroners Act 1996* (WA) s 25(3)

evidence for civil or criminal liability, and I am not bound by the rules of evidence.

13 A coroner is permitted to make findings or comments that are adverse to the interests of an "*interested person"*.[13] Pursuant to section 44(2) of the Act, that person must be given the opportunity to present submissions against the making of such a finding before I make any finding adverse to the interests of an interested person.

14 Prior to and during the course of the inquest, letters were forwarded by the Court to the Department and some of its staff advising of the possibility that an adverse finding or comment may be made in relation to them in connection with the coronial investigation.

15 In making any findings or conclusions that are adverse in nature, I have applied the principles as to the necessary standard of proof as set out by Dixon J (as his Honour was then) in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336. This requires a consideration of the nature and gravity of the conduct when deciding whether a matter adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle):[14]

> … reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of the allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony or indirect inferences.

16 Or, as Rich J observed:[15]

> In a serious matter … the satisfaction of a just and prudent mind cannot be produced by slender and exiguous proofs or circumstances pointing with a wavering finger to an affirmative conclusion. The nature of the allegation requires as a matter of common sense and worldly wisdom the careful weighing of testimony, the close examination of facts proved as a basis of inference and a comfortable satisfaction that the tribunal has reached both a correct and just conclusion. But to say this is not to lay down as a matter of law that such complete and absolute certainty must be

[13] The Department is regarded as a "person" as the term includes "a public body": *Interpretation Act 1984* (WA) s 5
[14] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J)
[15] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 350

> reached as is ordinarily described in a criminal charge as "satisfaction beyond a reasonable doubt."

17 Where I have made an adverse conclusion from the drawing of inferences, I have applied these well-established principles:[16]

(a) Consideration of the weight to be given to the united force of all the circumstances put together.

(b) The standard of proof (as per the ***Briginshaw*** principle) is to be applied at the final stage of the reasoning process.

(c) The inference drawn from the proved facts must be weighed against realistic possibilities as distinct from possibilities that might be regarded as fanciful.

(d) Where the competing possibilities are of equal likelihood, or the choice between them can only be resolved by conjecture, the allegation is not proved.

18 Where a concession has been made by a witness, I am mindful this does not equate to a formal admission such as an admission of a pleaded point in civil proceedings. I am required to evaluate the probative value of the concession against any other relevant evidence in order to be satisfied there is not an alternative conclusion open. I must also consider whether the concession should be qualified by the benefit of hindsight.

19 I am also mindful not to insert hindsight bias into my assessment of the actions taken by the Department and its staff. Hindsight bias is the tendency, after an event, to assume that the event was more predictable or foreseeable than it really was at the time it occurred.[17]

Priority listing of the inquest

20 The day after Cleveland's death, the State Coroner directed that the inquest into his death be given a priority direction.[18] The reasons for that direction were because (i) Unit 18 had not been specifically built to house child detainees and (ii) the safety considerations surrounding the detention of children within the grounds of an adult prison.[19]

21 In accordance with a recommendation from the *1991 Royal Commission into Aboriginal Deaths in Custody*, I and Sarah Tyler (then in-house counsel

[16] ***Palmer v Dolman*** [2005] NSWCA 361 [41]
[17] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[18] *Coroners Act 1996* (WA) s 8 (read together with s 46(1)(e))
[19] Directions Hearing on 19 February 2024: Ts pp.2-3

assisting) were early allocated to conduct the coronal inquiry. That allocation also took place on the day after Cleveland's death. On that day, I and Ms Tyler attended Unit 18 and examined Cleveland's cell and the cell wing it was in. We oversaw the examination of the cell by forensic officers from the Western Australian Police Force (WAPF), including the photographing and collection of exhibits.

22 At the Court's call over in February 2024, the unprecedented step was taken to early list the inquest without a brief being finalised, and dates for the inquest were provisionally listed.

23 Although the inquest was originally listed for 23 days over two tranches commencing on 3 April 2024 and 22 July 2024, the inquest ran for a total of 40 days and involved five tranches, with the final day of evidence occurring on 11 December 2024.

24 The inquest heard oral evidence from 29 witnesses, was comprised of nearly 4500 pages of transcript and had 149 exhibits tendered. Many exhibits had numerous sub-exhibits and attachments, and the hard copies of these exhibits filled over 30 files and lever arch files. It became one of the longest running inquests ever held in this State and the longest involving a person who had died whilst in the care of the Department.

25 The Court determined that given the complexity and length of the inquest, counsel assisting would prepare written closing submissions. These submissions were filed on 25 March 2025, and included potential adverse findings that counsel assisting submitted were open to the Court to make with respect to the Department and a number of its staff. Counsel for those interested parties intending to file written submissions did so on 6 and 7 May 2025.

26 On 13 May 2025, the Court permitted the filing of supplementary written submissions from the Department regarding additional potential adverse findings as submitted by counsel on behalf of the Aboriginal Legal Service of Western Australia (ALSWA) and Nadene Dodd. These supplementary written submissions were filed on 16 June 2025.

27 On 16 May 2025, the Court permitted the filing of supplementary written submissions from Kyle Mead-Hunter regarding an additional potential adverse finding as submitted on behalf of Nadene Dodd. These supplementary written submissions were filed on 13 June 2025.

28 The Court also permitted the filing of further supplementary written submissions by counsel for Nadene Dodd (filed on 10 June 2025), counsel

for Douglas Coyne (filed on 16 June 2025), counsel for Dr Adam Tomison (filed on 16 June 2025) and counsel for Christine Ginbey (filed on 17 and 27 June 2025).

29 On 30 June 2025, counsel for the interested parties were given the opportunity to make further oral submissions.

30 On 1 July 2025, after careful consideration of the written and oral submissions from counsel assisting and counsel for the interested parties, I orally handed down some of the findings I had made and some of the recommendations I was considering.[20] The transcript of my oral findings is attached to this finding and marked as "Annexure A".

31 On 3 October 2025, the Court advised counsel for Dr Tomison of a potential adverse finding that provided greater clarity than the one proposed by counsel assisting in his written closing submissions. The Court invited further written submissions addressing that potential finding and counsel for Dr Tomison filed those submissions with the Court on 22 October 2025.

The decision by the Court to identify Cleveland

32 Initially, the Court made a non-publication order that there be no publication of Cleveland's name or any information likely to identify him, and that he was to be referred to as "Child DC". That order was mandatory due to section 237 of the *Children and Community Services Act 2004* (WA).

33 However, after that non-publication order was made, the CEO of the Department of Communities authorised the publication and use of Cleveland's first name and surname under section 237(2) of the *Children and Community Services 2004* (WA).

34 After the Court considered the provisions of the *Children's Court Act 1988* (WA) and the *Young Offenders Act 1994* (WA) that prohibit the publication of the names of children in certain circumstances, and noting that Cleveland's family wanted his name published, the Court lifted the non-publication order prior to the commencement of the inquest.

The investigation by the Corruption and Crime Commission

35 On 11 June 2024,[21] the Corruption and Crime Commission (the CCC) tabled its report in State Parliament regarding its "*Investigation into allegations of serious misconduct following the death of a young detainee*

[20] Ts pp.4465-4476
[21] This was after the inquest's first tranche had been completed.

in Unit 18 Casuarina Prison" (the CCC report). This young detainee was Cleveland.

36 The CCC had a narrow jurisdiction with respect to its investigation as it is only empowered to investigate suspected serious misconduct as defined in the *Corruption, Crime and Misconduct Act 2003* (WA). The CCC report noted:[22]

> The scope of the Commission's investigation was limited in forming opinions as to whether any public officer committed an offence punishable by two or more years' imprisonment. The purpose of the investigation was to determine whether any public officers engaged in conduct of that kind in the execution of their duties at Unit 18 at Casuarina Prison from 10 to 12 October 2023.

37 At the completion of its investigation, the CCC found no evidence to suggest any of the involved public officers committed such an offence in the execution of their duties at Unit 18 between these dates. Accordingly, the CCC was not satisfied, on the balance of probabilities, that serious misconduct had occurred and did not form any opinions of serious misconduct.[23]

38 The Court extends its appreciation to the Hon. former Commissioner John McKechnie AO KC for the assistance the CCC provided to the coronial investigation, most notably the transcript of evidence from the Department's staff who were summonsed to give evidence at the CCC. Some of those witnesses were either unable to testify at the inquest or complete their oral evidence. This meant their evidence before the CCC assumed a greater significance than would otherwise have been the case.

39 Although I must give careful consideration to the conclusions in the CCC report with respect to its investigation, I am not bound by those conclusions.

Internal investigations by the Department

40 The Department's Professional Standards Division also undertook an internal investigation into Cleveland's death and prepared an interim report for the Minister for Corrective Services (the Minister) dated 9 November 2023.

41 The Court was provided with an unredacted copy of this interim report[24] and a redacted version was publicly released by the Minister shortly after

[22] Exhibit 22, p.2
[23] Exhibit 22, p.65
[24] Exhibit 1, Volume 1, Tab 20.2

he received it. The report identified a significant number of concerns that warranted further investigations.

42 Another version of the interim report with additional information and dated 9 December 2023 was also prepared by the Department's Professional Standards Division. An unredacted copy of this version was also provided to the Court.[25]

43 As with every death in custody, the Department's Performance Assurance and Risk Directorate (PAR) also undertook an investigation and prepared a Review of Death in Custody Report.[26] That report made a number of findings arising from the night of 11 and 12 October 2023, together with recommendations designed to improve the operation of Unit 18.

44 Although I have carefully considered the contents of the two interim reports prepared by the Department's Professional Standards Division and the report from PAR, as with the CCC report, I am not bound by any conclusions these reports have made.

Applications by the interested parties during the inquest

45 The Court was required to determine a number of applications from the interested parties after the inquest had commenced. Two applications had particularly significant ramifications for the conduct of the inquest if they were successful. One of those applications was from Christine Ginbey, the Department's Deputy Commissioner, Women and Young People.[27] The other was from the Department.

Ms Ginbey's application

46 The application by Ms Ginbey was that I recuse myself from presiding over the inquest. The Court was put on notice regarding the potentiality of such an application by letter dated 30 September 2024 from Ms Ginbey's instructing solicitors (the letter). By that stage the Court had sat for 26 days and although Ms Ginbey had given oral evidence, she had been excused from completing her evidence for the foreseeable future on medical grounds. The letter advised that unless Ms Ginbey had no adverse findings made against her in the Court's ultimate finding, she would seek, "*orders*

[25] Exhibit 1, Volume 1, Tab 20.1
[26] Exhibit 29
[27] Unless otherwise stated, the cited employment positions of witnesses are the positions they held at the time of Cleveland's death.

to the effect that this inquest cease and be re-constituted" due to the perception of the Court's bias against her.[28]

47 Not surprisingly, I was unable to make a commitment part-way through an inquest that a central witness in the proceedings would have no adverse findings made against them. Ms Ginbey's instructing solicitors were advised of that obvious fact and the application was listed to be heard on 4 October 2024. Written submissions were filed by Ms Ginbey's legal representatives in support of the application. Simply put, it was submitted that the conduct of the Court (including that of counsel assisting) had given rise to a reasonable apprehension that the Court may have a closed mind or might not be open to persuasion with respect to potential adverse findings against Ms Ginbey.

48 Written submissions opposing the application were filed by counsel for the ALSWA and counsel for Nadene Dodd.

49 In his oral submissions on 4 October 2024, Mr Donaldson SC, counsel for Ms Ginbey, clarified that the application was on the basis of an allegation of apprehended, not actual, bias. Mr McMahon SC, counsel for the ALSWA, and Mr Penglis SC, counsel for Nadene Dodd, also made oral submissions. After oral submissions from these three parties, I reserved my decision.

50 On 7 October 2024, I gave extensive oral reasons for my decision to dismiss the application by Ms Ginbey.[29]

The Department's applications

51 The first part of the Department's application was foreshadowed at the start of day 28 of the inquest (9 October 2024) during the inquest's third tranche. It was an objection on the grounds of jurisdiction with respect to the foreshadowed calling of a number of witnesses and exhibit 105.2. As outlined by Mr Leigh, counsel from the State Solicitor's Office (SSO) for the Department, the submission was that (i) the coronial investigation into a death was confined to an investigation to determine the facts required to make the necessary findings in section 25(1) of the Act and for no other purpose and (ii) consequently, a coroner is not empowered to receive evidence solely or primarily in order to make comments under section 25(2) of the Act.[30]

[28] Exhibit B
[29] Ts pp.3225-3279
[30] Ts p.3417

52 Written submissions in support of this application were filed by the SSO in 11 October 2024. The Department's application also challenged a vast amount of evidence that the Court had already gathered on the basis of jurisdictional error. In so doing, it placed a very narrow interpretation of section 25(1)-(3), section 33 and section 46(1) of the Act. In essence, the Department submitted jurisdictional error had occurred and would continue to occur, regarding the manner in which the Court had received exhibits and summonsed witnesses to provide evidence that had no bearing on the findings required to be made pursuant to section 25(1) of the Act. If the application was successful, a considerable amount of evidence the Court had received and intended to receive, would be rendered inadmissible. This included a significant amount of material that had already been provided by the Department and had become exhibits.

53 As with Ms Ginbey's application, counsel for the ALSWA and counsel for Nadene Dodd filed written submissions opposing the application.

54 On 15 October 2024, the Court heard oral submissions regarding the application from the interested parties that had filed written submissions. I reserved my decision.

55 On 18 October 2024, I dismissed the Department's application and gave oral reasons for my decision.[31]

56 In dismissing the application, I noted that the Court was advised of this new position taken by the Department on 9 October 2024, more than six months after the inquest had commenced and said: "*It is regrettable that this submission was flagged after 26 days of evidence, 3400 pages of transcript, and after the Court had received approximately 30 files and lever arch files of material*."[32]

57 I also noted:[33]

> The Department's submission also directly challenges the interpretation of the Act that the Court and interested parties before it have applied to the many hundreds of coronial inquests that have been conducted since the Act came into operation nearly 30 years ago. The Department's narrow interpretation of the legislation, if correct, would significantly constrain the investigations that this Court can undertake.
>
> …

[31] Ts pp.3771-3782
[32] Ts p.3772
[33] Ts p.3773, p.3781

> I am not prepared to radically depart from the practice of this Court in the interpretation of its powers that has been in place for nearly 30 years. To do so would place an unworkable fetter on the discretion of the Court to gather evidence relevant to the comments it can make under section 25(2), and that it must make under section 25(3) of the Act.

58 This "*unworkable fetter*" would extend to limiting the evidence that could be gathered regarding the circumstances that existed before the investigated death occurred. It would also prohibit the Court from hearing evidence of any changes or improvements to polices and/or procedures that a government department had introduced following the investigated death. And it would prohibit any information the Court could receive to assist it in making recommendations under section 25(2) of the Act.

59 It was therefore difficult to understand why the Department had instructed the SSO to make the submission that it did. It would appear the Department also recognised the problems with its submission. By the time it had filed its written closing submissions in May 2025, the Department accepted that "*current practices can inform the utility of comments (or recommendations) that his Honour, the Coroner may seek in discharging his functions under ss 25(2) and (3) of the Coroners Act 1996 (WA).*"[34]

60 After my ruling dismissing the Department's application, the Department sought to record a blanket objection to any subsequent evidence received in the inquest.[35] The Court declined to permit the Department to make such a blanket objection and required it to identify the evidence to which it objected.[36]

61 Subsequently, the second part of the Department's application took place during the final tranche of evidence on two separate occasions. The first was when counsel from the SSO on behalf of the Department provided written submissions dated 3 December 2024 in support of its objection to the evidence being received from witnesses intended to be called in this tranche and a number of exhibits.[37] Those submissions repeated the submissions in support of the Department's objection which had been dismissed on 18 October 2024, and advanced a fresh objection based on relevance.[38]

[34] Written closing submissions from the Department dated 6 May 2025, p.6
[35] Exhibit 127.1 (Letter from SSO to Counsel Assisting on 6 November 2024)
[36] Ts pp.3809-3810
[37] Ts pp.3818-3819
[38] Ts p.3820

62 The last two witnesses to give oral evidence were Ms Suzanne Short (the senior person in the Department's Strategic Communications section) and Mr Gary Budge (who was the acting Commissioner, Corrective Services in mid-2022). Both had been assisted by the SSO in the preparation of their respective statements. The SSO said it did not act for either, it acted for the Department. The consequence of the Department's position was highlighted by my question to counsel for the Department on 4 December 2024:[39]

> So, on instructions, the SSO assists Mr Budge in the preparation of a statement, files it with the Court last week, and then tells me today that it has instructions to object to the contents of that statement?

63 Counsel confirmed that was the Department's position, on the basis the evidence was not relevant.

64 Given the then time constraints on 4 December 2024, I gave brief oral reasons for rejecting the latest objections by the Department:[40]

> Essentially, I've reached the position that the contents of the statements that have been provided to date with respect to Mr Marney, Ms Butt and Mr Budge are relevant to the legitimate inquiries that the Court is undertaking with respect to this inquest. I also anticipate the contents of Ms Short's statement would likewise be relevant to those matters.
>
> …
>
> Succinctly put, it is my view that if these submissions of the construction of the Act [are] correct, the examination of systemic failings connected to Cleveland's death in resourcing, structure, reporting and accountability could not be undertaken, nor could recommendations as to specific change or better resourcing or better structuring be considered. That flies in the face of hundreds of recommendations that this Court has made over a considerable period of time.
>
> Inquests will regularly examine systemic failings that are connected to the death it is investigating. So, I do not accept that construction of the Act that has been outlined in the Department's submissions that were filed last night [with] the Court.

65 On 9 December 2024, the SSO on behalf of the Department, provided written submissions to the Court objecting to the intended evidence from the final two witnesses to be called on 10 December 2024[41] and exhibit 133[42]. On 10 December 2024, I dismissed these objections, noting that my

[39] Ts p.3821
[40] Ts pp.3822-3823, corrected as indicated
[41] Suzanne Short and Gary Budge
[42] Report by A/Professor Jocelyn Jones dated 5 December 2024

reasons for doing so were the same as what I had outlined on 4 December 2024.[43] After I made that ruling, Senior Counsel for the ALSWA made an observation regarding the constraints the Department was submitting should apply to the evidence at an inquest. That observation is worth repeating:[44]

> Your Honour has already made a ruling. It seems the normal practice would be for everyone to accept the ruling and move on. [But] introducing possibly new tests, the but-for test on causation, as being the test for relevance to a coronial inquest, despite the 30-year history since the Royal Commission into Aboriginal Deaths in Custody in no way assists this process or Your Honour, or even accepts the national consensus on how coronial inquests have grown in significance and importance since the Royal Commission into Aboriginal Deaths in Custody.

66 There was a degree of irony in the Department making the applications that it did to the Court. That was because the current Director General, Kylie Maj, was paying close attention to all the evidence which was emerging during the inquest. Ms Maj was receiving a written summary of the evidence each day and later, the transcript.[45]

67 Not only was Ms Maj paying close attention to what was being revealed in the inquest, she was responding to such revelations. Ms Maj told the Court that if the evidence revealed a risk which had not previously been identified, she was speaking with Mr Royce, the current Commissioner, Corrective Services (the Commissioner), and asking what can be done about it. Ms Maj expressly told the Court that she was addressing issues as they arose and was not waiting for any formal findings or recommendations.[46]

68 Such an approach by the current Director General is to be commended. It reflects well on the Department's current leadership that it is interested in the identification of what can be done better and doing something about it. By responding in this manner, Ms Maj was using the inquest as a means of identifying what needed to be addressed within the Department. As uncomfortable or confronting as that evidence may be, acknowledging such evidence and doing something about the problems being revealed is the correct response.

[43] Ts p.4190
[44] Ts p.4191
[45] Ts p.2689
[46] Ts p.2705

69 The ability and willingness of the Department's current leadership to respond in this manner can only be seen as a virtue.

70 Ms Maj gave evidence on 14 August 2024. Nearly two months later, the Department made its application concerning the scope of the inquest and how it should be limited. The good work being done by Ms Maj and Mr Royce, in responding to the issues revealed in the evidence and doing so as the inquest continued, would not have been possible if such evidence had not been obtained.

71 If the Department's application as to the scope and jurisdiction of the inquest, as advanced in October 2024 and again in December 2024, was correct and had been put earlier, much of the evidence to which the Director General was responding to would not have been received and the issues that she then addressed would never have been identified. This begs the question as to whether Ms Maj was even aware of the instructions the Department had given to the SSO to make the applications that it did in October and December 2024, and if she did, whether she was aware of the implications had the application been successful.

Scope of the inquest

72 As stated by Buss JA (as his Honour was then), an inquest is not, "*a roving Royal Commission for the purpose of inquiring into any possible causal connection, no matter how tenuous, between an act, omission or circumstance on the one hand and the death of the deceased on the other*".[47]

73 However, Buss JA also stated that section 25(1)(b) of the Act "*extends to the circumstances attending the death … which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred* ".[48] Buss JA noted that this construction, "*reflects the public interest which is protected and advanced by a coronial investigation (especially an investigation into deaths where one or more of the conditions in s 22(1) of the Act are satisfied).*"[49] As already noted, Cleveland's death fell within section 22(1)(c) of the Act.

74 Buss JA applied a similarly broad construction to section 25(1)(c) of the Act:[50]

[47] ***Re State Coroner; Ex parte Minister for Health*** (2009) 38 WAR 553, 566; [2009] WASCA 165 [46].
[48] ***Re State Coroner; Ex parte Minister for Health*** (2009) 38 WAR 553, 565; [2009] WASCA 165 [42]
[49] ***Re State Coroner; Ex parte Minister for Health*** (2009) 38 WAR 553, 565; [2009] WASCA 165 [42]
[50] ***Re State Coroner; Ex parte Minister for Health*** (2009) 38 WAR 553, 565-566; [2009] WASCA 165 [44]-[45], [47]

> The coroner in finding, if possible, "the cause of death", is not confined or restricted by concepts such as "direct cause", "direct or natural cause", "proximate cause" or the "real or effective cause". Similarly, a coroner is not confined or restricted to a cause that was reasonably foreseeable. See ***WRB Transport v Chivell*** [1998] SASC 7002; (1998) 201 LSJS 102 [20] (Lander J, Mullighan J agreeing).
>
> In ***WRB Transport***, Lander J said, in the course of considering the coroner's jurisdiction under s 12 of the *Coroners Act 1975* (SA) to ascertain "the cause or circumstances of the … death of any person …":
>
> > The coroner … has to carry out an inquiry into the facts surrounding the death of the deceased to determine what, as a matter of common sense, has been the cause of that person's death. The inquiry will not be limited to those facts which are immediately proximate in time to the deceased's death. Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of the death of the deceased. But there will be other facts less proximate in time which will be seen to operate, in some fact situations, as a cause of the death of the deceased. That is a factual inquiry which only has, as its boundaries, common sense [21].
>
> His Honour added that the coroner's jurisdiction to determine the cause of a deceased's death is in addition to his or her jurisdiction to determine the circumstances of the deceased's death [22]-[25]. See also ***Saraf v Johns*** (2008) 101 SASR 87 at [18]-[19] (Debelle J).
>
> …
>
> It will be necessary, in each inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of the death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case. See ***March v E & MH Stramare Pty Ltd*** [1991] HCA 12, (1991) 171 CLR 506, 515 per Mason CJ, 522 per Deane J; ***WRB Transport*** [21]; ***Saraf*** [18]-[19]; ***Doogan*** [29].

75 The inquest had undertaken an investigation into the facts proximate to Cleveland's death. To understand those facts and how those circumstances came to be, I examined other matters less proximate to October 2023. Such matters were very relevant to understanding how it transpired that in October 2023 a 16-year-old boy was being detained in a cell block built for high security adult male prisoners, who was often detained by himself in a cell for 22 or 23 hours each day and sometimes longer, and kept in the squalid conditions as described at the inquest by those who worked there.

76 It was while he was in such circumstances that Cleveland self-harmed in a manner which cost him his life, which the Department has not only accepted "*should not have happened while he was in the care of the Department*",[51] but has expressed regret in its failings and apologised to Cleveland's family and the community for those failings.[52]

77 What the inquest heard at the first tranche of the inquest in April 2024 from those who had worked at Unit 18 in and before October 2023 was alarming, unexpected and confronting. The evidence from YCOs, a Unit Manager and a nurse described conditions that posed grave dangers to the welfare and safety of staff and detainees alike. The Court also heard evidence of the locking up of young persons in solitary confinement for extended periods reminiscent of 19th century jails.

78 In addition, Mr Torrijos (an experienced YCO who had worked at Unit 18 for some length of time) had said that Unit 18 "*was set up to fail*" which was "*how it was perceived by a lot of officers.*"[53]

79 Accordingly, at the end of the first tranche, I announced that the Court would be gathering and hearing evidence as to how and why Unit 18 came into existence in July 2022.[54] The Court subsequently examined whether sufficient time and resources were given to converting into a stand-alone youth detention centre, a cell block that was constructed on the basis that it had the resources of the wider Casuarina estate available to the adult prisoners that it was built to house.

80 The Department has accepted that it was important for the Court's inquiry into the cause and circumstances of Cleveland's death to examine the reasons why Cleveland had the opportunity, means, and motivation to self-harm while in the Department's care.[55] However, it disagreed with the Court's decision to gather much of the evidence that it did.

81 I am satisfied, despite the objections taken by the Department during the inquest and in its written closing submissions, that the evidence received by the Court was properly admitted for four reasons.

82 First, I was satisfied these investigations fell within the reasons given by the State Coroner for an expedited inquest.[56]

[51] Written closing submissions from the Department dated 6 May 2025, p.5
[52] Written closing submissions from the Department dated 6 May 2025, p.5
[53] Ts p.66
[54] Ts p.685
[55] Written closing submissions from the Department dated 6 May 2025, p.5
[56] See [20] above.

83 Secondly, it was properly admitted for the purpose of understanding how it came to be that Unit 18 was operating in the disturbing circumstances that it was during Cleveland's last period of detention. The Court was entitled to explore when Unit 18 had started to operate in this dysfunctional manner: was it during Cleveland's final period of detention or had it always operated like that because it had been "*set up to fail*"?

84 Thirdly, this evidence was properly admitted for the purpose of determining whether and what recommendations should be made pursuant to section 25(2) of the Act.

85 Finally, and connected to the second reason, this evidence was relevant with respect to my function under section 25(3) of the Act to "*comment on the quality of the supervision, treatment and care of* " Cleveland during his last period of detention. Should those comments be adverse in nature, then the Court was entitled to explore the reasons why the quality of Cleveland's supervision, treatment and care was lacking. Was it systemic, was it cultural, was it Unit 18's infrastructure, was it funding, was it due to organisational factors, was it due to staff error on the night in question or was it because of management, and if it was due to management – at what level?

86 As the CCC report noted when pointing out its narrow jurisdiction:[57]

> Broader systemic and cultural issues within the Department of Justice may have contributed to this outcome [i.e. Cleveland's death]. In his May 2023 Inspection of Banksia Hill Detention Centre and Unit 18, the Inspector of Custodial Services, Mr Eamon Ryan found young people, staff, and a physical environment in acute crisis. In the almost 18 months leading up to his inspection, the rates of self-harm and attempted suicide among young people in custody were unprecedently high. Staffing was in terminal decline. <u>These wider considerations may form part of the coronial inquest into Cleveland's death</u> or the inquiries of other authorities.
> (underlining added)

87 In the recent New South Wales Supreme Court decision of ***Commissioner of Police, New South Wales Police Force v Attorney-General of New South Wales*** [2025] NSWSC 1119, McHugh JA determined the scope of a coroner's jurisdiction under the *Coroners Act 1960* (NSW).

[57] Exhibit 22, p.1

88 After examining five decisions in Australian jurisdictions concerning the scope of coronial enquiries, including ***Re State Coroner, Ex parte Minister for Health*** (2009) 38 WAR 553; [2009] WASCA 165, McHugh JA noted:[58]

> The five decisions discussed above largely support taking a broad approach to concepts of "manner" or circumstances of death, particularly where the death occurs in an institutional setting where the operation (or failure) of systems or practices may have been one of the important circumstances surrounding the death.

89 As I will outline in this finding, I am satisfied that the information gathered by the Court demonstrated the existence of longstanding issues at the time of Cleveland's death that concerned the failure of systems and practices. I am also satisfied that these failures were connected to his death.

90 The inquest also received evidence about how Unit 18 has operated since Cleveland's incident. Evidence of this nature is regularly considered by the Court to assess whether any meaningful changes have been made to processes and procedures to remedy difficulties, deficiencies or errors identified upon a consideration of the circumstances of the relevant death. Indeed, often the entity (including the Department) responsible for the care of the deceased is keen to have the Court understand how the current processes or procedures operate to demonstrate the learnings understood and the changes made to reflect those learnings after a death.

91 The inquest had information about several matters concerning the operation of Unit 18, often both before and after Cleveland's death, including the number of detainees, their status as being sentenced or on remand, their ethnicity, the number of staff (custodial and non-custodial) present on the day or night shifts, the use of confinement orders in the management of the detainees, the reasons for the making of such confinement orders and the nature and scope of such confinement orders.

92 This information is important because any recommendations by the Court about the future operations of the youth custodial estate in Western Australia are designed to avoid a reoccurrence of the circumstances in Cleveland's incident and thus hopefully avoid another death of a detainee in custody. Consequently, it is critical that recommendations be evidence-based and be based on the most accurate and current information available.

[58] ***Commissioner of Police, New South Wales Police Force v Attorney General of New South Wales*** [2025] NSWSC 1119, [114]

The witnesses at the inquest

93 The inquest heard oral evidence from the following witnesses:

1. Daniel Torrijos: YCO working at Unit 18 on the night of Cleveland's incident;
2. Nina Hayden: YCO working at Unit 18 on the night of Cleveland's incident;
3. Fiona Bain: nurse working at Unit 18 on the night of Cleveland's incident;
4. Christina Mitchell: unit manager at Unit 18. Ms Mitchell commenced her YCO training in March 2014. She was first deployed to Unit 18 in September 2022. For the previous four months, she had been a unit manager at the ISU at Banksia Hill Detention Centre (Banksia Hill);[59]
5. Peter Collins: Director of Legal Services at ALSWA;
6. Professor Neil Morgan: Inspector of Custodial Services from March 2009 to May 2019;
7. Eamon Ryan: current Inspector of Custodial Services who succeeded Professor Morgan;
8. The Hon. Denis Reynolds:[60] President of the Children's Court from 2004 to 2018;
9. Christine Ginbey: Deputy Commissioner, Women and Young People, at the Department from June 2022 to July 2024. Prior to then, she had been the Assistant Commissioner to Deputy Commissioner, Andrew Beck in the Women and Young People Directorate;
10. Dr Adam Tomison: Director General of the Department from May 2017 until he relinquished the position in late January 2024;[61]
11. Michael Reynolds: Commissioner, Corrective Services, from November 2020 until shortly after Cleveland's death in October 2023. He had previously trained as a prison officer in

[59] Ts pp.541-542

[60] At the inquest, this witness expressed a preference to be referred to as "Mr Reynolds". Accordingly, that is how I will identify him in this finding; although it will be "Mr D Reynolds" to distinguish him from Micheal Reynolds (who is identified as "Mr M Reynolds").

[61] He was appointed the Acting Director General of the new Department of Justice in May 2017 and the following month was substantiated in that position: Ts p.941

1987 and worked for 32 years in Corrections in South Australia before coming to Western Australia;

12. Melanie O'Connell: acting Director of Youth Custodial Operations at the Department since February 2022. She was Ms Ginbey's "right hand person" when Ms Ginbey was Assistant Commissioner and then Deputy Commissioner, Women and Young People;[62]

13. Douglas Coyne: first dedicated Superintendent of Unit 18 on 1 May 2023. Prior to then, Unit 18 had been overseen by the Superintendent at Banksia Hill. Mr Coyne remained the Superintendent at Unit 18 until 8 July 2024[63] when he became the Assistant Commissioner in the newly formed Young People Directorate;

14. Dr Gosia Wojnarowska: forensic child and adolescent psychiatrist who has worked at Banksia Hill. She was one of two psychiatrists appointed by the Court to provide evidence;

15. Andrew Beck: Deputy Commissioner, Women and Young People, at the Department. He held this position for about two years until June 2022. He then handed over to Ms Ginbey on about 20 June 2022. At the time of the inquest he was Deputy Commissioner, Offender Services;

16. Bradley Royce: current Commissioner, Corrective Services, having replaced Mr M Reynolds. He had been a police officer since 1994 in the WAPF. Shortly after Cleveland's death, he was seconded from his then position as an Assistant Commissioner in the WAPF to the position of Commissioner, Corrective Services;

17. Kylie Maj: current Director General of the Department. She succeeded Dr Tomison in an acting capacity when he relinquished the position, until her permanent appointment in late June 2024;

18. Professor Fiona Stanley: founding Director and Patron of the Telethon Kids Institute, a multidisciplinary independent research institute focusing on the causes and prevention of matters affecting children and youth. She was instrumental in establishing the Australian Research Alliance for Children and Youth, to lobby nationally for investing in children and families

[62] Ts pp.1554-1555

[63] Except from 25 June to 25 July 2023 and from 18 September to 19 November 2023 when Mr Coyne was Superintendent of both Banksia Hill and Unit 18, and from 5 March to 21 April 2024 when he was assigned tasks in relation to the Department's preparation for the inquest: Exhibit 57, pp.3-4

for a better society. For her research on behalf of Australia's children and Aboriginal social justice, she was named Australian of the Year in 2003;[64]

19. Marc O'Siochain: acting Deputy Superintendent (Operations) of Unit 18 for 2023, except for the first three weeks of January 2023. He became the acting Superintendent of Unit 18 in July 2024;

20. John Mortley: Assistant Superintendent (Operations) at Unit 18 since November 2022. He commenced his training as a prison guard in 2010 and until 2022 he worked in male adult prisons.[65] He was then brought over to Unit 18 in August 2022 due to a lack of managerial experience there;

21. Solomon Idowu: Assistant Superintendent (Security) at Unit 18. He first went to Unit 18 in August 2022. For the next three months, he and Mr Mortley performed the tasks relating to Security and Operations. In November 2022, those tasks were divided into two positions: Assistant Superintendent (Security) and Assistant Superintendent (Operations).[66] When Mr Idowu came to Unit 18 in August 2022, he became the third member of the Senior Management Team (SMT). When Mr Mortley took up the newly created position of Assistant Superintendent (Operations) in November 2022, he became the fourth member of the SMT. Those four members were the Deputy Superintendent, the Facility Manager, Mr Idowu and Mr Mortley.[67]

22. Dr Angela Cooney: experienced forensic psychologist who has worked with the Department in various positions over a lengthy period, including as Deputy Superintendent of Banksia Hill since November 2021. From April 2024, she has been Acting Superintendent of Banksia Hill;

23. Andrew MacDonald: acting Principal Psychologist (Community) at the Department;

24. David Etherington: mental health nurse for 38 years, the last 18 years in Corrective Services. He has worked at Banksia Hill and Unit 18;

[64] Exhibit 95.1
[65] Ts pp.3016-3017
[66] Ts pp.3294-3297
[67] Ts pp.3297-3299

25. Dr Marshall Watson: an indigenous man of Noongar descent and one of about 20 indigenous psychiatrists in Australia. He is the only indigenous psychiatrist who is dually qualified as a forensic and child and adolescent psychiatrist. He was a trainee and then a Senior Registrar at Banksia Hill from shortly after the closure of Rangeview in 2012 until 2014. Dr Watson worked under the supervision of Dr Wojnarowska at Banksia Hill and was the second psychiatrist engaged by the Court to provide evidence at the inquest;

26. Tim Marney: principal consultant at the Nous Group which was involved in the preparation of the model of care for youth detention in 2022. In February 2023, he was engaged by the Department to implement the model of care. After six months, his employment ceased;

27. Narelle Butt: current Program Director for implementing the model of care. She replaced Mr Marney and commenced employment with the Department on 16 October 2023;

28. Suzanne Short: Director of Strategic Communications at the Department since 2019; and

29. Gary Budge: acting Commissioner, Corrective Services, when Mr M Reynolds went on extended personal leave on 18 May 2022. Prior to then, he had been responsible for leading the COVID-19 response across Corrective Services, as well as several other projects. When Mr M Reynolds returned from leave on 4 July 2022, Mr Budge remained assisting him.

94 The Court also received written statements from three witnesses who were excused from giving oral evidence:

(a) Ms Toni Priestley:[68] one of the YCOs working at Unit 18 on the night of Cleveland's incident;

(b) Mr Kyle Mead-Hunter:[69] the acting Senior Officer at Unit 18 on the night of Cleveland's incident;

(c) Ms Joanne Jacobs:[70] an Aboriginal mental health worker (AMHW) who had been employed with the Department since

[68] This statement was read aloud in open Court on 8 April 2024: Ts pp. 244-254.
[69] In addition to receiving the transcript of the evidence he gave to the CCC (Exhibit 1, Volume 2.1, Tab 9.4), the Court received Mr Mead-Hunter's affidavit in which he provided answers on oath to written questions: Exhibit 82
[70] Exhibit 56

August 2023. She worked at Banksia Hill and Unit 18. At the time of the inquest, Ms Jacobs was the only AMHW at either site.

95 In addition, Mr Mead-Hunter provided two affidavits in response to questions from other counsel and in response to a potential adverse finding proposed by counsel assisting.[71] The Court also received affidavit evidence from Ms Ginbey which supplemented the oral evidence she had commenced, but was unable to complete. Five sets of written questions were put to Ms Ginbey in December 2024, respectively by counsel for Mr Mead-Hunter,[72] Nadene Dodd,[73] the ALSWA,[74] by her own counsel[75] and by counsel assisting.[76] Ms Ginbey provided written answers on oath to those five sets of questions.[77] In May 2025, counsel for Nadene Dodd was given leave to ask additional supplementary questions of Ms Ginbey,[78] who provided sworn answers to those questions on 27 May 2025.[79]

A BRIEF OVERVIEW OF THE ESTABLISHMENT OF UNIT 18

96 At this point in my finding, it is appropriate that I summarise how Unit 18 came to be established. This is necessary to not only understand the background of Unit 18's creation but also to understand why it was operating in the manner that it was during Cleveland's last period of detention.

Banksia Hill Detention Centre

97 Banksia Hill was opened in September 1997. It began its operation as a youth detention centre for sentenced detainees and operated in conjunction with the already established Rangeview Juvenile Remand Centre (Rangeview). As its name indicated, Rangeview only housed those detainees who were on remand.

98 As noted by Professor Neil Morgan in his written statement to the inquest, in the early years of its operation, Banksia Hill was lauded by Professor Richard Harding, the then Inspector of Custodial Services, who

[71] Exhibits 82 and 82.1
[72] Exhibit 144.1
[73] Exhibit 144.2
[74] Exhibit 144.3
[75] Exhibit 144.4
[76] Exhibit 144.5
[77] Exhibits 145.1-145.5
[78] Exhibit 144.2a
[79] Exhibit 145.2a

described it in 2006 as, "*certainly one of the best-performing institutions within the remit of the Department of Corrective Services.*"[80]

A crisis emerges at Banksia Hill

99 However, in the years that followed, Banksia Hill, "*became a different world.*"[81] One major reason for this was the decision by the State Government in 2009 to close Rangeview and have Banksia Hill as a "one stop shop". That amalgamation went ahead in October 2012 which meant that remand detainees now shared the same facility as sentenced detainees. The evidence at the inquest was universal in its agreement that this was, "*a bad decision.*"[82]

100 The difficulties associated with having only one site, a "one size fits all" approach soon became apparent after the merger of the two sites. The major disturbance at Banksia Hill in January 2013 and the subsequent need to move young people into Hakea Prison (Hakea) was a vivid illustration of the then precarious situation in the youth custodial estate. It also meant that following this disturbance, Banksia Hill's original design as a campus-style facility completely disappeared, with additional security measures and new internal perimeter fencing introduced.[83]

101 The circumstances giving rise to the disturbance in January 2013, were examined by Professor Morgan, the then Inspector of Custodial Services, in a report specifically requested by the then Minister. Professor Morgan referred to that report in his written statement to the inquest.[84]

102 The decision to move young people to Hakea was the subject of Supreme Court proceedings seeking a declaration that such a decision was unlawful.[85] The challenge was unsuccessful.

103 In June 2024, Professor Morgan said in his statement for the Court that there were significant differences between Hakea in 2013 and Unit 18:[86]

> [3.52] In 2013, the Supreme Court ruled that the transfer of detainees to Units 11 and 12 at Hakea Prison had been lawful despite those units being gazetted as a youth detention centre only after the

[80] Exhibit 28, p.3
[81] Exhibit 28, p.3
[82] Exhibit 28, p.4
[83] Exhibit 1, Volume 6.1, Tab 1, p.5
[84] Exhibit 28, p.7
[85] ***Wilson v Francis*** [2013] WASC 157
[86] Exhibit 28, pp. 20-21 (citations omitted)

transfers had started. Nevertheless, the move was unprecedented and highly problematic.

[3.53] But it is important to recognise some major differences between what happened in 2013 and what was happening at Unit 18 in 2022 and 2023:

- In 2013, the young people had to be moved to Hakea at short notice because of the damage caused in the riot, and consequential dangers on the Banksia Hill site. By contrast, moving young people to Unit 18 in 2022 was a deliberate decision, preceded by carefully crafted media announcements. So, it should have been ready in terms of staffing, regime and services.
- Both moves were badged as 'short term'. In 2013 the Department's priority was to move the young people back to Banksia Hill. It achieved this in 10 months. However, after almost two years, young people are still in Unit 18. The Department told the CCC that the aim was to close Unit 18 in mid-2023 and that this was stymied by disorder at Banksia Hill in May 2023. Looking ahead, the Department has been given extra funding to come up with a plan by the end of 2024. This suggests that Unit 18 will continue to operate for some considerable time to come.
- The regime at Hakea in 2013 was highly restricted in the early days. However, the Department did then give detainees access to fresh air and outdoor recreation (including a basketball court, an open grassed area, and a football oval). They were never locked down to anything like the extent that they have been at Unit 18. The people responsible for Units 11 and 12 at Hakea in 2023 knew that would be inhumane, totally unacceptable, and a recipe for disorder.
- Detainees at Hakea who were deemed at risk of suicide or self-harm were transferred to the CCU at Banksia Hill. They were not left in their Hakea cells. The people responsible for Units 11 and 12 at Hakea in 2013 understood that this was a completely unacceptable risk.

104 Professor Morgan identified several key themes in his statement, including that the Department failed to develop an "*operational philosophy*" or "*model of care*":[87]

[87] Exhibit 28, p.12

> [3.4] Without an operational philosophy, there will be uncertainty, confusion and inconsistency.
>
> [3.5] Time and again, my reports called on the Department to develop and implement an operational philosophy/model of care for youth custody. Time and again they agreed this was essential. Time and again they failed to deliver. Eamon Ryan repeated the same recommendation in 2021.
>
> 2013: Report on the 2013 Banksia Hill Riot
>
> [3.6] In the run-up to the 2012 amalgamation of Banksia Hill and Rangeview, the Department claimed it had developed an operational philosophy for the new Centre. But I found no clear written philosophy. In fact, there were at least three versions. New staff were being trained with 2008 material and existing staff were not aware of any new philosophy. The result was confusion. I recommended the development of a 'clear and consistent philosophy' for youth detention.
>
> [3.7] In response, the Department said this was well advanced: the Commissioner's Executive Team had already endorsed an interim 'Philosophy and Vision' and it would be further developed to ensure a more active and positive regime. The timeline for completion was three months.

105 In the subsequent decade, the Department, the State Government and Parliament were all warned, repeatedly, of the problems present and evolving at Banksia Hill. These warnings were initially made by Professor Morgan in his reports as the Inspector of Custodial Services published by the Office of Inspector of Custodial Services (the OICS). The warnings continued under the watch of his successor Mr Eamon Ryan in his reports published by the OICS.[88]

106 The Inspector of Custodial Services has a statutory obligation to inspect and report upon each custodial facility every three years. During Professor Morgan's term as Inspector, the OICS tabled in Parliament nine reports in relation to youth custody and another six background papers.[89] Mr Ryan's OICS has tabled the four reports in evidence.[90] The frequency of such reporting is itself indicative of very significant concerns and the contents of those reports articulated those concerns in great detail.

[88] Exhibits 18, 19, 20 and 20.1
[89] Exhibit 28, p.3
[90] Exhibits 18, 19, 20 and 20.1

107 Similar concerns were being expressed by the Children's Court and the ALSWA.

108 The operation of Banksia Hill continued to deteriorate. Aside from the issues created by the amalgamation with Rangeview, problems included staff shortages and disaffection, a high turnover of superintendents and senior management, excessive lockdowns and a lack of direction.[91] By 2021, the state of affairs at Banksia Hill was rapidly reaching a crisis level.

109 In December 2021, Mr Ryan took the unprecedented step of serving the Director General of the Department with a Show Cause Notice under section 33A of the *Inspector of Custodial Services Act 2003* (WA) regarding the care and welfare of detainees held in the ISU at Banksia Hill.[92]

110 From late 2021 to early 2022, staff at Banksia Hill and their unions began requesting the transfer of the cohort of the most disruptive detainees at Banksia Hill to another more secure site, "*because of the increase of critical incidents, assaults on staff, infrastructure damage and the impact the critical incidents were having on the daily operations*" at Banksia Hill.[93]

111 From the beginning of 2022, it may be open to contend that the situation at Banksia Hill did not improve, and that it continued to deteriorate. From 1 January 2022 to 30 June 2022 there were 269 critical incidents at Banksia Hill. This amounted to about 25% of the total number of critical incidents occurring in all of the State's custodial estates.[94] During this same period there had been a dramatic increase of incidents involving cell damage at Bankia Hill.[95] In addition, there was an increase in staff shortages.

The decision to create a temporary second youth detention centre

112 On 25 May 2022, Mr Beck, as Deputy Commissioner, Women and Young People,[96] convened a meeting of senior executives from across the youth and adult custodial estates. The purpose of the meeting was to consider the realistic options available to the Department if it became necessary to establish a second site to detain young people. This was referred to by many

[91] Exhibit 28, p.4
[92] Exhibit 30.1
[93] Exhibit 1, Volume 6.1, Tab 1, p.8
[94] Exhibit 1, Volume 6.1, Tab 1, p.4
[95] Exhibit 1, Volume 6.1, Tab 1, p.6
[96] Mr Beck was the Deputy Commissioner of Women and Young People until about 20 June 2022 when Ms Ginbey commenced in that role. During late May and early June 2022, they were both aware of the impending change in their respective roles.

witnesses as the need to consider "Plan B". At the conclusion of that meeting, three realistic options had been identified. These were Melaleuca Women's Prison (Melaleuca), Wandoo Rehabilitation Prison (Wandoo) or a unit in Casuarina Prison (Casuarina).

113 What occurred between this meeting on 25 May 2022 and the opening of Unit 18 on 20 July 2022, was carefully examined during the inquest. The following chronology of key events is not controversial:

(a) Following major incidents at Banksia Hill on 19 and 20 June 2022, it was clear that the Department's attempt to manage a small group of male detainees in Banksia Hill had failed.

(b) On the morning of Friday, 1 July 2022, Mr Budge and Ms Ginbey inspected the Melaleuca and Wandoo sites and concluded neither was suitable as a site for "Plan B". No such inspection had occurred in the period since the meeting on 25 May 2022.

(c) Later during 1 July 2022, Dr Tomison convened a meeting and told Mr Budge, Ms Ginbey and Ms O'Connell that Unit 18 was to be used as a youth detention centre but that such information was not to be made public until the State Government announced it.

(d) On Saturday, 2 July 2022, Ms Ginbey and Ms O'Connell met and began to consider what needed to be done to implement what Dr Tomison had told them the previous day.

(e) On Monday, 4 July 2022, Minister Johnston took the proposal to use Unit 18 as a youth detention centre to the scheduled cabinet meeting for that day.

(f) On the afternoon of Tuesday 5 July 2022, the State Government announced there would be a transfer of up to 20 detainees from Banksia Hill to a designated youth detention centre within Casuarina.

(g) On Wednesday 6 July 2022, the working group established to liaise with Mr Budge and Ms Ginbey in the preparation of Unit 18 as a youth detention centre held its first meeting.

(h) On Sunday 10 July 2022, the last of the 113 adult male prisoners were removed from Unit 18.

(i) The morning of Monday 11 July 2022 was the first opportunity for those preparing Unit 18 to receive young people to have access to the site.

(j) On Tuesday 12 July 2022, the Department provided to the Minister a Briefing Note in support of the proposal to use Unit 18 as a youth detention centre (the Briefing Note). This proposal would require a gazettal process to remove Unit 18 as part of Casuarina and then declare Unit 18 to be a youth detention centre for the purposes of the *Youth Offenders Act 1994* (WA). Such gazettal process occurred in the days following the provision of the Briefing Note to the Minister.

(k) On the morning of Wednesday 20 July 2022, 17 young people were moved from Banksia Hill to Unit 18. At the time, the Department's plan was that Unit 18 would only be a temporary measure until the necessary repairs to the infrastructure at Banksia Hill was completed. Unit 18 was expected to cease operations as a youth detention centre by mid-2023.[97]

114 There is a dispute in the evidence between Dr Tomison, and Ms Ginbey and Mr Budge as to what may or may not have occurred in the period leading up to 1 July 2022 in respect of what Dr Tomison was or was not saying to them about the need to use Unit 18 as a youth detention centre. This matter is considered later in my finding.

115 The above is a concise narrative of how Unit 18 came into existence as a youth detention centre. That process was considered at length during the inquest and such evidence will be analysed in further detail later in this finding.[98] The circumstances surrounding the decision to use Unit 18 in this manner and the very limited time within which to prepare Unit 18 for such a purpose, together with the already existing concerns about how the Department was managing its obligations to those young people at Banksia Hill, meant it may be open to conclude that Unit 18 was beset with enormous difficulties from its inception.

116 Prior to and after mid-2022, the Department faced increasing and intense scrutiny about its behaviour and conduct towards young people in detention. There was a large and vocal public outcry about the use of Unit 18 for this purpose. The Department was aware of that outcry and the outrage expressed in some quarters that young people were to be held in a building designed to accommodate adult men in a high security prison. There was evidence to suggest the messaging put out by the Department around the decision to use Unit 18 in this manner was a response to the

[97] Exhibit 1, Volume 6.1, Tab 1, p.24

[98] See: **RECOMMENDATION REGARDING THE MANNER IN WHICH UNIT 18 CAME INTO OPERATION**

awareness of the public outcry. The Department's messaging to its wide and disparate audiences is examined later in this finding.

117 The Department also had other difficulties emerging. The concerns expressed by lawyers and commentators as to the lawfulness or otherwise of the Department's conduct in managing young persons in detention through confinement in their cells were validated in two decisions of the Supreme Court in proceedings brought on behalf of particular young people in detention. The first case was ***VYZ by Next Friend XYZ v Chief Executive Officer of the Department of Justice***[99] (***VYZ***) and the second case was ***CRU by Next Friend CRU2 v Chief Executive Officer of the Department of Justice***[100] (***CRU***).

118 The proceedings in ***VYZ*** were commenced on 22 June 2022. Oral argument was heard by Tottle J on 14 July 2022.[101] Judgment was delivered on 25 August 2022.

119 The proceedings in ***CRU*** were commenced on 6 December 2022. Oral argument was heard by Tottle J on 11 May 2023. Judgment was delivered on 11 July 2023.

120 The Department's response to both decisions was considered during the inquest.

121 The haste with which Unit 18 was set up to become a stand-alone youth detention centre within Casuarina and the messaging the Department delivered to stakeholders and the wider community regarding the merits of Unit 18 are outlined in greater detail later in this finding.[102]

CLEVELAND

Background [103]

122 Cleveland was born on 18 September 2007 at Kalgoorlie Regional Hospital. His parents separated when he was very young and he was raised in Laverton by his mother in his early life.

123 Initially, Cleveland enjoyed going to primary school. He also attended the youth centre in Laverton where he participated in activities to help the

[99] ***VYZ by Next Friend XYZ v Chief Executive Officer of the Department of Justice*** [2022] WASC 274
[100] ***CRU by Next Friend CRU2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257
[101] This was in the middle of the time when the Department was attempting to convert Unit 18 from an accommodation block in a high security prison into a youth detention centre.
[102] See: **RECOMMENDATION REGARDING THE MANNER IN WHICH UNIT 18 CAME INTO OPERATION**
[103] Exhibit 137

community and its Elders. Cleveland appreciated the respective cultures of his mother and father, and valued his time on country.

124 As he got older, Cleveland played the guitar and liked listening to and making music. He was a talented artist who enjoyed painting and drawing. He also played a number of sports, with his favourite being basketball.

125 Cleveland was known to be a person who recognised unfairness and would stand up for someone if he saw them being treated the wrong way.

Cleveland's life from 10 years of age [104]

126 By the time he was 10 years old, Cleveland was spending time between Laverton with his mother and his father in Meekatharra. When he was living in Meekatharra, Cleveland experienced a lack of supervision within the home, and he was exposed to substance misuse and family feuding. He was also spending time with older children, some of whom regarded criminal offending as normal. It was not long before Cleveland came to the attention of Child Protection authorities and then the police.

127 On 12 April 2020, at the age of 12, Cleveland was held in custody for the first time in Banksia Hill. Although he was only detained there for less than two weeks, I am satisfied the impact of detention at such a formative age would have been significant.

128 Cleveland began using cannabis in about 2020 and by then, his refusal to attend school had become entrenched. He was also engaging in threatening behaviour towards his mother and younger siblings.

129 On 11 September 2020, one week before his 13th birthday, Cleveland made threats to hang himself from a fan. Child Protection authorities again became involved, and consideration was given to move Cleveland to live with relatives in Meekatharra. By the end of 2020 this move had occurred.

130 Unfortunately, Cleveland's life did not improve with the move. Police alleged he had committed further offences in Meekatharra and he was returned to Banksia Hill on 24 March 2021. During that period of detention (which lasted for less than a month), Cleveland attempted self-harm on multiple occasions by tying items of clothing or bedding around his neck. During a mental health review following one of those incidents, Cleveland said he was frustrated about being in detention and that he did not want to suicide, rather it was his way of expressing his level of distress.

[104] Ts pp.12-14; Department's EcHO records for Cleveland

131 After his release from Banksia Hill, Cleveland returned to Laverton to live with his mother. Although he saw a clinical psychologist for counselling on one occasion, scheduled fortnightly sessions did not take place as he had moved back to Meekatharra.

132 Cleveland was arrested in Meekatharra for alleged offending in December 2021 and January 2022. On each occasion, he attempted self-harm in police custody and was taken to the Meekatharra Hospital by police who held concerns about his wellbeing and challenging behaviour. On each occasion, he required sedation to manage his behaviour in the ED.

133 During his detention in Banksia Hill from 21 January 2022 to 23 March 2022, Cleveland attempted self-harm on no less than seven occasions by using clothing to strangle himself, placing a metal rod in his mouth, chewing on wires he had pulled from a cell wall, using a screw to cut his arms, tying electrical wire around his neck and placing strips of clothing into his mouth.

134 On 18 April 2022, Cleveland was taken by police to the ED of Kalgoorlie Regional Hospital when he threatened to kill himself after his arrest. He had earlier attempted to hang himself at his mother's home by using a fan.

Cleveland's assessment by a neuropsychologist [105]

135 Following an order from the Children's Court, Cleveland was assessed by a clinical neuropsychologist on 19 May 2022. As part of that assessment, Cleveland's mother raised concerns about his emotional state, his anger and ongoing cannabis use.

136 Sadly, Cleveland had difficulty identifying to the neuropsychologist any goals for the future or personal strengths that he felt he had. When asked how he spent his days, Cleveland responded he did not know and that he just sat around.

137 The neuropsychologist expressed the opinion that Cleveland's emotional and behavioural difficulties were likely caused by many factors, including:

- early life trauma;
- limited receptive and expressive language abilities;
- lack of communication skills to express his needs or communicate his emotional state;

[105] Exhibit 17

- the developmental impact that exposure to family and domestic violence may have had;
- poor role modelling;
- low levels of adult supervision in his life;
- cannabis withdrawal symptoms; and
- associations with an antisocial peer group.

138 The neuropsychologist diagnosed Cleveland with a major depressive order, cannabis use disorder, and a likely language disorder which required further assessment.

139 In her comprehensive report dated 30 May 2022, the neuropsychologist made a number of recommendations. They included that Cleveland engage with drug and alcohol services, obtain mental health support, undertake psychological therapy (particularly if he reduced or ceased using cannabis), regularly see a GP, see a paediatrician or child and adolescent psychiatrist, be assessed by a speech pathologist, undertake regular recreational activities to give structure to his days, and be encouraged to return to education or commence vocational training.

140 Although he was not yet 15 years old when this assessment was made, it is clear that Cleveland required significant intervention to address the many challenges he was facing. From the information available to me, it appears that few, if any, of these recommendations occurred.

141 Soon after Cleveland saw the clinical neuropsychologist, he returned to live in Meekatharra. It is unclear whether any of his family members in Meekatharra or Laverton were told about the clinical neuropsychologist's recommendations.

The period before Cleveland's final detention

142 For the balance of 2022, Cleveland continued to be arrested by police. He was detained in Banksia Hill on three separate occasions and during two of those detentions he was sent to Unit 18. The first occasion he was detained in Unit 18 was from 3 September to 5 October 2022 (32 days) and the second was from 2 – 20 December 2022 (18 days). There continued to be episodes of misbehaviour and incidents involving self-harm when he was in detention.

143 On 16 March 2023, Cleveland appeared in the Carnarvon Children's Court via video link from Meekatharra after he had been arrested by police.

He was remanded in custody and taken to Banksia Hill the next day, 17 March 2023.

144 On 18 April 2023, Cleveland was moved to Unit 18 for a third time where he remained until 16 June 2023 (59 days).

Cleveland's final detention [106]

145 Cleveland's final period of detention began on 12 July 2023 after he had been arrested and charged with further offences. He was remanded in custody by the Carnarvon Children's Court on that date after no application for bail was made. He was taken to Banksia Hill on the same day.

146 On 14 July 2023, Cleveland was involved in a critical incident which resulted in damage to fencing and assaults on staff at Banksia Hill.

147 On 17 July 2023, Cleveland was discussed at the Multi-Disciplinary Team (MDT) meeting. MDT meetings discuss potential transfers for detainees at Banksia Hill to Unit 18 and make recommendations to the Superintendent of Banksia Hill who ultimately decides whether a young person should remain at Banksia Hill or be moved to Unit 18.

148 At the MDT meeting on 17 July 2023, Cleveland was noted to be a detainee who would climb onto the roof, was a prolific spitter, had assaulted staff in the past, and was said to have a disability (described as a communication disorder). The recommendation was made that he be placed at Unit 18 because of his extensive history of absconding out of bounds, assaulting staff, damaging property, and for the good order and security of Banksia Hill. The representative from Banksia Hill's mental health services was recorded as stating: "*I have known him for a while. He is oppositional, defiant, very angry. If you talk to him slightly wrong, he loses his temper. He has no consequential thinking about what he does; he doesn't care. He is extremely violent and aggressive when he wants to be. He needs to be in Unit 18.*"[107]

149 The Superintendent of Banksia Hill ordered that Cleveland be moved to Unit 18, and this took place on the same day as the MDT meeting. Cleveland remained in Unit 18 until he was taken to Fiona Stanley Hospital (FSH) in the early hours of 12 October 2023. This represented a period of 87 days, which was the longest continuous time Cleveland had been detained in either Banksia Hill or Unit 18.

[106] Exhibit 1, Volume 5, Tab 2.7; Exhibit 29
[107] Exhibit 29, annexure 5

150 Four days after he arrived in Unit 18, Cleveland struck his head on a wall during an altercation with another detainee. He was taken to FSH where the injury was sutured.

151 On 26 July 2023, Cleveland was placed on the Department's Youth At Risk Management System (ARMS). ARMS is the Department's primary suicide prevention strategy for prisoners and detainees. There is a manual (the ARMS Youth Manual) specifically for young persons in detention which provides all detention centre staff with clear guidelines to assist with the identification and management of detainees deemed to be at risk of self-harm or suicide.[108] When a detainee is placed on ARMS, they are monitored through a three-tier system of observations at either level 1 (uninterrupted, constant observation), level 2 (observations between two and five minutes) or level 3 (observations between five and 15 minutes).[109]

152 There is also a level 4 ARMS which can be implemented to allow a detainee previously on ARMS observations and who is no longer considered at an acute or imminent risk of self-harm or suicide to transition safely from intensive monitoring back to standard monitoring.[110] Observations for level 4 ARMS are to take place every 15 minutes.[111]

153 Between 26 July and 3 October 2023, Cleveland was managed on ARMS on three separate occasions. The first was when he threatened to stab himself with a needle that he said he had stolen from FSH. He was later removed from ARMS on 2 August 2023.

154 The second occasion was on 17 August 2023 when Cleveland threatened self-harm by hanging himself after not being provided with the breakfast he wanted. He was placed on ARMS after a mental health nurse noted Cleveland had chronic neurological issues driving his behaviours. He remained on ARMS until 13 September 2023.

155 The third and final time Cleveland was on ARMS began on 16 September 2023 after he had cut himself with a piece of plastic from a broken light switch in his cell. He also threatened self-harm, saying he was stressing out. Cleveland remained on ARMS until 3 October 2023.

156 During these three occasions, Cleveland's ARMS observation levels fluctuated between level 1 ARMS and level 4 ARMS.

[108] Exhibit 29, Tab 13
[109] Exhibit 29, Tab 13, p.54
[110] Exhibit 29, Tab 13, p.53
[111] Exhibit 29, Tab 13, p.54

157 On 28 September 2023, 13 days before Cleveland's incident, the ALSWA wrote to Ms Ginbey, on behalf of Cleveland, requesting that he be urgently transferred from Unit 18 to Banksia Hill. The letter conveyed Cleveland's instructions about several issues and sought information from the Department. It was marked as "***URGENT***". The letter was received by the Department on 29 September 2023.

158 The full text of the letter is set out:[112]

> Dear Ms Ginbey
>
> **Request for urgent transfer to Banksia Hill Detention Centre – Master Cleveland Dodd (DOB: 18 December**[113] (sic) **2007)**
>
> The Aboriginal Legal Service of Western Australia Limited acts for Master Cleveland Dodd.
>
> Cleveland has instructed us to request that he be transferred from Unit 18, Casuarina Prison ('Unit 18') to Banksia Hill Detention Centre. Cleveland has been held in Unit 18 since July 2023.
>
> **Conditions in Unit 18**
>
> Cleveland instructs that the conditions in Unit 18 are negatively impacting his wellbeing. Cleveland instructs that since his transfer to Unit 18, he has generally not received more than one hour out of his cell per day, and on some days, no time out of his cell at all. He instructs that on most days, he usually tries to sleep through the day in his cell. He instructs that on 24 August 2023, he was let out for one hour during the morning, and 20 minutes during the evening to make a phone call. He received dinner in his cell that day, which he threw away because it was cold. Cleveland instructs he had received cold dinners on a number of days since his transfer to Unit 18. He instructs in early September 2023, he was not let out of his cell at all for four consecutive days.
>
> Cleveland instructs that he still generally has not been able to access programs or education, and though he has received one or two programs since arriving, these have only been for one hour each day and were the only time he was allowed out of his cell on those days.
>
> In addition, it appears from the Department's statistics that the average time out of cell each day for children in Unit 18 is decreasing, from two hours and 27 minutes in June 2023 to two hours and seven minutes in August 2023. It is concerning that Cleveland and other children's time in cells seems to be increasing despite consistent instructions that he and others are generally still spending at least 23 hours in cell each day, and still on some days not being allowed out of cell at all.

[112] Exhibit 91, attachment CG 131
[113] Cleveland's date of birth was 18 September 2007.

Decision to transfer Cleveland

ALSWA lawyer [practitioner's name deleted] was told during her tour of Unit 18 on 12 July 2022 that the young people moved to Unit 18 would be chosen on the basis of recommendations from the multidisciplinary team, which would include mental health workers, health workers and Aboriginal Welfare Officers. She was also informed that the young person's wishes would be considered. Similarly, on 6 October 2022, Commissioner Reynolds informed the Royal Commission into the Violence, Abuse, Neglect and Exploitation of People with Disability ('Disability Royal Commission') that each young person transferred to Unit 18 is considered for suitability by a multidisciplinary team. In light of this, please advise the grounds on which the Department of Justice chose to move Cleveland to Unit 18 and provide to us the report made by the Department in regards to his suitability for transfer.

Pursuant to section 7(i) of the *Young Offenders Act 1994* (WA), the detention of a young person in custody is to be in a facility that is suitable for a young person. In light of Cleveland's significant and unlawful lockdown hours at Unit 18, both previously and currently, and the lack of education or programs, it is our view that Unit 18 is not a facility suitable for the detention of a young person. Given the impact of these conditions on Cleveland's wellbeing, ALSWA requests that the Department reconsider its decision to detain him at Unit 18 and instead return him to Banksia Hill Detention Centre.

[Some contact details are provided]

We request that Department staff do not discuss this matter with our client without an ALSWA staff member present.

Yours faithfully,

[Name and title of the author]

159 This was clearly a letter which required an urgent response by the Department to the various issues raised. On 29 September 2023, Ms Ginbey sought information to respond to the letter in an email to Mr Coyne, Mr O'Siochain and Ms O'Connell. She also acknowledged receipt of the letter in an email to the ALSWA on that date.[114]

160 The ALSWA never received a response to its letter as Cleveland's incident occurred a matter of days later. Tragically, the concerns raised in the letter were a chilling portent of what was to occur on the night of 11 and 12 October 2023.

[114] Exhibit 91, [188]-[189]

161 Throughout Cleveland's final period of detention in Unit 18, the four most senior Department executives responsible for his care were:

(a) Dr Tomison was the Director General, and he gave evidence at the inquest over five days early in the second tranche of the evidence. Towards the end of that tranche, he was recalled and gave evidence again for several hours.

(b) Mr M Reynolds was the Commissioner. He gave evidence during the second tranche and was recalled during the fourth tranche.

(c) Ms Ginbey was the Deputy Commissioner for Women and Young People. She was in her third day of oral evidence when she was not able to continue. Ms Ginbey was stood down until the third and fourth tranches of evidence. Unfortunately, at the conclusion of the fourth tranche, she was still unable to complete her oral evidence. As noted above, Ms Ginbey did subsequently provide sworn written answers to written questions from counsel assisting and counsel for some of the interested parties.

(d) Mr Coyne was the Superintendent of Unit 18 during Cleveland's final period of detention there. He gave evidence over a three-day period during the inquest's second tranche.

EVENTS LEADING TO CLEVELAND'S INCIDENT

Background [115]

162 As from 7.15 pm on 11 October 2023, there was an acting Senior Officer, four YCOs and one registered nurse on duty at Unit 18. Sixteen detainees were at Unit 18 at this time. All were First Nations, with 14 of them having been diagnosed with intellectual disabilities.[116]

163 Each cell in Unit 18 had an intercom system that enabled detainees to communicate with a YCO stationed in the control room at Unit 18 (the control room). These are known as "cell calls" and they are audio recorded. Cell calls are only supposed to be made for an emergency, which explains why YCOs would answer a cell call asking the detainee to explain their emergency. Detainees would frequently use cell calls for non-urgent reasons. I am satisfied that being locked in a cell by themselves for up to 23 or 24 hours a day would be an obvious reason for detainees wanting to simply talk to another person.

[115] Exhibit 22
[116] Exhibit 46, annexure PC-01

164 There is also a CCTV camera in each cell which is supposed to provide a live feed to monitors located in the control room.[117] I say "supposed to" as these CCTV cameras were frequently covered by detainees which prevented the YCO in the control room tasked with viewing the monitors from seeing anything within the cell. There are also CCTV cameras located in various common areas of Unit 18. The CCTV cameras in the cells and common areas do not have sound.

165 The time stamp on all CCTV footage for Unit 18 on 11 and 12 October 2023 was four minutes 30 seconds behind Perth standard time. The time recorded when cell calls were made was four minutes 16 seconds behind Perth standard time.[118] The times referred to in my finding for CCTV and cell calls are actual Perth standard times, and not the time stamp displayed on CCTV footage and documented for the commencement of cell calls. I have not always recorded these times by identifying the precise second in which an event occurred as I have determined that this degree of specificity is not necessary in those instances. However, where I do regard that precision as important to distinguish, for example, the time between two events, I have identified the exact times.

166 On 11 October 2023, Cleveland was one of eight detainees in C-Wing of Unit 18, which is an upstairs wing. Each of these eight detainees had their own cell. Cells in the upstairs wings of Unit 18 had their air vents in the ceiling. In contrast, the cells on the ground level had their vents affixed to the wall.[119]

167 At 9.06 am on 11 October 2023, the base radio in the control room was switched off. The base radio allows Unit 18 staff to communicate, and listen to, communications from Casuarina which operate on a different channel from Unit 18. The base radio remained switched off until 11.40 pm on 11 October 2023.

168 At about 9.30 pm, electrical contractors attended Casuarina to conduct pre-planned electrical works. At about 11.29 pm, all staff at Casuarina were advised by a broadcast on the Casuarina radio channel that Units 15 to 18 were to prepare to transfer over to emergency power. Unit 18 did not acknowledge this radio call, and power was then transferred from normal operation to these units to essential power only. As a result, from 11.37 pm, only electrical equipment such as computers, CCTV cameras, monitors,

[117] For privacy reasons, those areas in a cell where the shower and toilet are located are blanked out on the monitor.
[118] Exhibit 1, Volume 1, Tab 20.1
[119] Exhibit 1, Volume 1, Tab 48.1, p.10

and lighting connected to essential power were operating inside Unit 18. Other equipment on non-essential power such as televisions within cells ceased to operate. Although this was a pre-planned event, Unit 18 staff were unaware it was going to happen.

169 The staff on duty at Unit 18 on the night of 11 and 12 October 2023 were acting Senior Officer Kyle Mead-Hunter (Mr Mead-Hunter), YCO Daniel Torrijos (Mr Torrijos), YCO Toni Priestley (Ms Priestley), YCO Nina Hayden (Ms Hayden), YCO Christopher McClennan (Mr McClennan), and the registered nurse was Fiona Bain (Ms Bain).

170 Although all these staff gave oral evidence at the CCC investigation, Mr Mead-Hunter, Ms Priestley and Mr McClennan were excused from their summonses to be called as witnesses at the inquest due to health reasons. Ms Priestley's signed statement that had been prepared for the Court was read out at the inquest on 8 April 2024[120] and Mr Mead-Hunter provided an affidavit dated 2 August 2024 in which he gave answers on affirmation to written questions from counsel for the interested parties. After obtaining consent from the Court, he filed a second affidavit dated 2 May 2025 that he affirmed. This affidavit was in response to a potential adverse finding advanced by counsel assisting in his written closing submissions.[121]

171 As set out below, I am satisfied Cleveland's incident inside his cell occurred sometime between 1.37 am and 1.49 am on 12 October 2023.

Cleveland's movements on the day of 11 October 2023 [122]

172 At about 8.05 am, breakfast was delivered to detainees' cells in C-Wing by YCOs and they ate their breakfast while remaining inside their cells. After breakfast, staff training took place which finished at about 10.45 am. During that time, all detainees were locked in their cells.

173 At about 12.00 pm, lunch was delivered to the detainees by YCOs. Again, these meals were eaten by the detainees in their respective cells.

174 At about 2.10 pm, Cleveland was removed from his cell to attend a video link appearance regarding a bail hearing in the Children's Court. He was handcuffed behind his back as he made his way to the room used in Unit 18 for video link court appearances. At 2.21 pm, Cleveland's hearing was

[120] Ts pp.244-254
[121] Exhibits 82 and 82.1
[122] Chronology of Events: Exhibit 1, Volume 1, Tab 6; Audio from the recorded cell calls from Cleveland to the control room: Exbibit 1, Volume 1, Tab 40; Vision captured by CCTV cameras in the common areas of Unit 18; Aide-memoire provided to counsel

called and his application for bail was adjourned for eight days so that further information could be obtained.

175 During Cleveland's absence from his cell, two YCOs entered the cell and searched it. During that process they removed toilet paper that was covering the cell's CCTV camera.

176 Shortly before 2.30 pm, Cleveland was escorted back to his cell after his video link appearance. Again, his hands were handcuffed behind his back for this escort.

177 At 2.49 pm, Cleveland made a cell call to the control room asking why he was not getting out of his cell as he had anticipated. He was advised there was a delay because another detainee had set off a sprinkler.

178 At about 3.00 pm, Cleveland covered his cell's CCTV camera by using wet toilet paper and sticking it to the front of the camera. The CCTV camera remained covered with no vision on the monitor in the control room, other than for a very brief period,[123] until a YCO removed it during CPR on Cleveland nearly 11 hours later. No Unit 18 staff attempted to remove the toilet paper from the CCTV camera during this period.

179 At 3.16 pm, Cleveland made another cell call to the control room asking when he was getting out of his cell. At 4.40 pm, he was removed from his cell in handcuffs and escorted downstairs to A-Wing for his recreation. The handcuffs were removed once he was in A-Wing. During this time, he unsuccessfully attempted to contact his mother through three telephone calls at 4.55 pm, 5.12 pm and 5.23 pm. Only the first of these calls was connected and it only lasted 20 seconds.[124] At 5.49 pm, Cleveland was escorted back to his cell in handcuffs.

180 At about 6.15 pm, Cleveland was handed his medication by the nurse, his dinner and three cups of water by YCOs. From CCTV footage, it would appear he was also handed a Nintendo device by staff. I note that custodial staff made no attempts to uncover the cell CCTV camera. Cleveland ate his dinner in his cell.

[123] At 12.33 am on 12 October 2023, the toilet paper fell from the CCTV camera and vision can be seen of the cell. However, Cleveland replaced the toilet paper about 23 seconds later which, as before, obscured the vision.
[124] Exhibit 1, Volume 8.3, Tab 1.1.26, p.64

Cleveland's behaviour during the night of 11 and 12 October 2023 [125]

181 Cleveland made multiple cell calls to the YCOs who were allocated to answer cell calls during the night of 11 and 12 October 2023. These cell calls included asking for water, asking for the nurse and making threats of self-harm. The chronology and description of those cell calls outlined in this section of my finding are taken from the recordings of these cell calls. The movements of YCOs within Unit 18 are taken from the CCTV cameras in various common areas.

182 Cleveland's cell had no running water as he had damaged the taps in his cell to such an extent that water to his cell had to be isolated. He needed to be taken to another cell for showering.

183 Between 7.08 pm and 8.20 pm on 11 October 2023, Cleveland asked during cell calls to be provided with cups of water or said he was thirsty on six occasions. He was not provided with water at any time during the night of 11 and 12 October 2023.

184 At 8.03 pm, Cleveland made a cell call answered by Ms Priestley and asked for water. That request was declined because, as Ms Priestley explained to Cleveland, she had been told he was given four cups of water with dinner. Cleveland then said, "*Well, I'm slicing my throat open*". This was the first of Cleveland's threats of self-harm that night. After he said that, Ms Priestley asked Cleveland to uncover his camera so she could monitor him from the control room. He replied, "*Nup*".

185 After being informed of Cleveland's requests for water, Mr Torrijos went to the utility room next to Cleveland's cell at 8.24 pm and attempted to turn the water on in Cleveland's cell, However, this was not successful.

186 At 9.07 pm, Cleveland made a cell call answered by Ms Priestley and asked her to turn off the power in the cell of his neighbouring detainee who continued making banging noises.

187 At 9.14 pm, Cleveland made another cell call to Ms Priestley and said that if the neighbouring cell's power was not turned off, he was going to, "*slice myself*" and "*hang myself*". This was the second time Cleveland had threatened to harm himself.

[125] Chronology of Events: Exhibit 1, Volume 1, Tab 6; Audio from the recorded cell calls from Cleveland to the control room: Exbibit 1, Volume 1, Tab 40; Vision captured by CCTV cameras in the common areas of Unit 18; Aide-memoire provided to counsel

188 At 9.31 pm, Cleveland said in a cell call to Ms Priestley that if his neighbour's power was not turned off, "*I'm gonna hang myself in a minute*". This was the third threat of self-harm Cleveland had made.

189 Cleveland then made two cell calls in quick succession at 9.46 pm and 9.47 pm. On both these occasions he said he was slicing himself up as his neighbour's power had not been turned off. These were the fourth and fifth times Cleveland threatened to self-harm.

190 At about 10.20 pm, Ms Hayden replaced Ms Priestley for the task of answering cell calls. Cleveland had contacted Ms Priestley via cell calls on 13 occasions.

191 At 10.42 pm, another detainee made a cell call and said he was going to kill himself. At 11.25 pm, this detainee made another cell call and told Ms Hayden he had tied a ligature around his neck and that he could not breathe. Custodial staff responded to that incident.

192 At 11.39 pm, Cleveland made a cell call to Ms Hayden asking what had happened to his power. He made repeated calls for this purpose and received no explanation as Unit 18 staff were not aware of the pre-planned power outage. Cleveland said he was being lied to and ignored.

193 At 12.26 am on 12 October 2023, Cleveland called Ms Hayden and asked for the nurse (a request that he had previously made at 12.12 am). The following conversation then took place:

> Cleveland: I'm gonna slice my throat.
>
> Ms Hayden: No, don't do that.
>
> Cleveland: Why? I can do that.
>
> Ms Hayden: Why, why would you want to?
>
> Cleveland: Because of the power.
>
> Ms Hayden: Slicing your throat's not going to bring the power back, okay?
>
> Cleveland: I'll slice my throat cos I've got a headache.
>
> Ms Hayden: And that's not going to stop your headache either, it's going to make it worse.

194 This was the sixth time Cleveland threatened to harm himself.

Events within the hour before Cleveland's incident was discovered [126]

195 As stated above, the chronology and description of the cell calls outlined in this section of my finding are taken from the recordings of these cell calls. The movements of YCOs within Unit 18 are taken from the CCTV cameras in various common areas.

196 At about 1.00 am on 12 October 2023, Mr McClennan took over the answering of cell calls from Ms Hayden.

197 At 1.08 am, Cleveland made a cell call to Mr McClennan asking for the power to be put back on. Mr McClennan explained to Cleveland: "*Half of Casa is out man … it's not us turning it off. Trust me, we don't want to turn it off. It's heaps, everyone's out*".

198 At 1.14 am, Ms Priestley approached Cleveland's cell and shone a torch through the hatch of the cell door. She had a conversation with Cleveland before moving away after about 90 seconds.

199 At 1.17 am, Cleveland made another cell call to Mr McClennan. This conversation was short and involved Cleveland adding up numbers. It would appear he was calculating the time he had spent in detention.

200 At 1.19 am, Ms Priestley and Ms Hayden attended C-Wing and Ms Priestley briefly looks into the Cleveland's cell through the cell door hatch.

201 At 1.31 am, Cleveland made another cell call to Mr McClennan as follows:

> Mr McClennan: What's your emergency?
>
> Cleveland: Hey, oi.
>
> Mr McClennan: Yeah mate.
>
> Cleveland: Chris
>
> Mr McClennan: Yes mate.
>
> Cleveland: How long I been locked up?
>
> Mr McClennan: I don't know, what do you…
>
> Cleveland: Check.
>
> Mr McClennan: … mean from since, what how long you been at Unit 18 for?

[126] Chronology of Events: Exhibit 1, Volume 1, Tab 6; Audio from the recorded cell calls from Cleveland to the control room: Exbibit 1, Volume 1, Tab 40; Vision captured by CCTV cameras in the common areas of Unit 18; Aide-memoire provided to counsel

> Cleveland: Since I was locked up, how long have I been locked up for?
>
> Mr McClennan: I wouldn't have a clue mate.
>
> Cleveland: Check.
>
> Mr McClennan: Alright, I'll check and I'll get back to ya.
>
> Cleveland: I'm hanging myself, tell Danny to come here.[127]
>
> Mr McClennan: What's that sorry, mate?
>
> Cleveland: I'm hanging myself, tell Nina or um Toni[128] to come here.
>
> Mr McClennan: Alright, will do mate.
>
> Cleveland: I'm hanging myself.

202 This was the seventh occasion Cleveland threatened to self-harm.

203 Mr McClennan's evidence at the CCC was that he told Mr Torrijos what had happened and that he should go and talk to Cleveland.[129] At 1.34 am, Mr Torrijos left the control room to attend C-Wing.

204 As Mr Torrijos was doing that, Cleveland made his final cell call to Mr McClennan at 1.35 am. That conversation was very short:

> Mr McClennan: What's your emergency?
>
> Cleveland: I'm hanging myself.
>
> Mr McClennan: Cleveland don't be talking like that mate, Danny's gonna come up and see ya, I've just spoken to him okay?
>
> Cleveland: I'm through. I'm gonna put that[130] in my vent, I'm gonna hang myself.

205 This was the eighth and final time Cleveland threatened to self-harm during the night of 11 and 12 October 2023.

206 At 1.36 am, Mr Torrijos entered C-Wing and went to the door of Cleveland's cell where he interacted with Cleveland through the viewing window of the cell door for about 60 seconds. At the CCC, Mr Torrijos described what he saw and the conversation he had with Cleveland on this occasion:[131]

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[127] Referring to Mr Torrijos.
[128] Referring to Ms Hayden and Ms Priestley.
[129] Exhibit 22, p.48
[130] What is said by Cleveland at this point is difficult to determine. However, when placed in the context of Cleveland then saying, "*in my vent*", it does sound like: "*I'm gonna put that*".
[131] Exhibit 1, Volume 2.1, Tab 5.3, p.29

> What could you see? --- I spoke to Cleveland, and I – everything looked in order in his cell. Like, I – what I was looking at was Cleveland, and he was just saying, 'Well, why haven't I got the TV on?' And I said, 'Well, it's not just you Cleveland. I've already told you that', and I tried to – just said, 'Look' – he was going off a bit, and that's why, I think, I walked off, and said, 'Look, I'll come back to you, Cleveland'.

207 Shortly after Mr Torrijos moved away from Cleveland's cell door, the CCTV camera in Cleveland's cell showed the movement of a shadow from a less obscured part of the toilet paper fixed to the camera.

208 Mr Torrijos also said at the CCC that he saw no ripped t-shirt or material in the cell and that he did not notice any material attached to the ceiling vent or anything at all about the ceiling vent.[132]

209 After he had spoken to Cleveland, Mr Torrijos then walked to the neighbouring cell and spoke to that detainee through the cell door for about 40 seconds.

210 At 1.37 am, Mr Torrijos attended another cell in C-Wing and spoke to the detainee in that cell for about 11 minutes, which was longer than Mr Torrijos had expected.[133] This detainee (identified in my finding as TW) was on level 1 ARMS. This was because he had attempted to hang himself on the afternoon of 11 October 2023 by using the damaged ceiling vent in his cell as the anchor point. Mr Torrijos then went to the door of the neighbouring cell to Cleveland's and again spoke briefly to this detainee.

211 At 1.49 am, Mr Torrijos looked through the hatch of the door to Cleveland's cell and observed him to be hanging unresponsive with a ligature around his neck that had used the damaged ceiling vent as an anchor point (Cleveland's incident). This was 12 minutes 47 seconds after the shadow movement in Cleveland's cell was detected from the cell's obscured CCTV camera.

Response to Cleveland's incident [134]

212 Mr Torrijos banged on Cleveland's cell door twice and also looked through the hatch for a second time at a different angle. He then left C-Wing, went down the stairs, and began walking in a hurried pace directly to

[132] Exhibit 1, Volume 2.1, Tab 5.3, pp.29-30
[133] Ts pp.124-125
[134] The following descriptions of movements by Unit 18 staff is from vision captured by CCTV cameras in the common areas of Unit 18.

Mr Mead-Hunter's office so he could get the keys to open Cleveland's cell door. As Mr Torrijos explained at the inquest:[135]

> That's all I had on my mind. I don't know. I just was on a mission to get the keys. It mightn't have looked I was going quick but that was as quick as I could go'.

213 The speed at which Mr Torrijos was moving, as depicted on the vision from CCTV cameras, reflects the fact that he has arthritic knees.[136] I am satisfied that Mr Torrijos was moving as fast as he could.

214 Vision from the CCTV cameras showed Mr Torrijos going past the control room and the nurse's office on his way to Mr Mead-Hunter's office. He did not stop or call out to anyone in the control room or to the nurse.

215 When asked at the inquest why he did not raise the alarm with the YCOs in the control room or the nurse who was in her office at the time, Mr Torrijos said:[137]

> I was just focused on getting the keys. I was focused on getting the keys. I just knew. That was all I was focused on. Just getting the keys and once I had got them off Kyle, I just assumed he would follow and say something. I don't know. But I – I can't truthfully say why I didn't say anything. Whether I was just in shock or I don't know.

216 When Mr Torrijos got to the doorway of Mr Mead-Hunter's office, it was in darkness and Mr Torrijos turned on the light. Mr Torrijos said he spoke to Mr Mead-Hunter and said: "*Cleveland's fucking hanging. I need the keys*".[138] Mr Torrijos gave evidence at the inquest that Mr Mead-Hunter responded by placing the keys on the table in his office.[139]

217 When asked whether Mr Mead-Hunter said anything to him, Mr Torrijos said: "*No. I don't think I gave him a chance to say anything. I just grabbed them and straight out*."[140]

218 CCTV vision from another camera showed Mr Mead-Hunter standing from a reclined position. The interaction between Mr Mead-Hunter and Mr Torrijos lasted for about 10 seconds. As Mr Torrijos retraced his steps back to C-Wing, Mr Mead-Hunter appeared to put on his duty belt and then sat down to put on his boots, before leaving his office to follow Mr Torrijos.

[135] Ts p.130
[136] Ts p.132
[137] Ts p.134
[138] Ts p.136
[139] Ts p.136
[140] Ts p.136

As Mr Mead-Hunter walked down the passageway from his office towards C-Wing he did up some of his shirt buttons, and as he made his way to Cleveland's cell, he had his hands in his pockets at some stages. I have assessed his walking pace as normal, with no sense of urgency.

219 CCTV vision showed Mr Mead-Hunter attending Cleveland's cell about 40 seconds after Mr Torrijos and about 67 seconds after Mr Torrijos had left his office with the keys.

220 Mr Mead-Hunter did not give oral evidence at the inquest. He had given oral evidence at the CCC investigation,[141] and provided a signed written statement and two affidavits to the inquest.[142] From those materials, Mr Mead-Hunter's account of what he thought was happening and to what he was responding can be ascertained. This account is dealt with in more detail later in this finding.[143]

221 At this stage, it is relevant to note that Mr Mead-Hunter went into his office at about 12.55 am and did not leave again until after Mr Torrijos had attended at about 1.50 am. There is no doubt about these facts. When asked at the CCC what he was doing in that period of just under an hour, Mr Mead-Hunter said, "*I would have been on my break.*"[144]

222 Mr Mead-Hunter said that he was permitted two 30-minute breaks during the shift, and it was quite common for staff on night shift to put the two break periods together and have a one-hour break.[145]

223 Mr Mead-Hunter told the CCC that he had put his feet up on his desk to get some relief for his tail bone and to relax. He had turned off the lights as was his usual practice when having a break, he thought he may have untucked his shirt because of the heat and could not remember whether his shoes were on his feet.[146]

224 The office for the on-duty nurse was next door to Mr Mead-Hunter's office. Ms Bain was in that office at the relevant time and her office had the lights turned off. She was attempting to reboot her computer after the power outage.[147]

[141] Exhibit 1, Volume 2.1, Tab 9.4
[142] Exhibit 1, Volume 2.1, Tab 9.1; Exhibits 82 and 82
[143] See: **ADVERSE FINDINGS, *Mr Mead-Hunter,*** *2. Response to Cleveland's incident*
[144] Exhibit 1, Volume 2.1, Tab 9.4, p.47
[145] Exhibit 1, Volume 2.1, Tab 9.4, p.48
[146] Exhibit 1, Volume 2.1, Tab 9.4, pp.48-49
[147] Ts p.437

225 Ms Bain heard someone walk past her door before hearing Mr Torrijos say: "*I need the keys. I think Cleveland is hanging*".[148] Ms Bain left her office about 25 seconds after Mr Mead-Hunter had left his office as she was thinking: "*This is a bit weird. Like, what is going on?*".[149]

226 Ms Bain came out of her room, looked up towards C-Wing and walked over to the stairs. She subsequently returned to collect her equipment. When asked why she had gone to the stairs without any of her equipment, she said: "*Because I didn't know what was going on. No code was called. No one said anything when they went past my room*."[150]

227 Ms Hayden was in the control room and observed Mr Torrijos going to and from Mr Mead-Hunter's office. She described Mr Torrijos as being in a hurry.[151]

228 Ms Hayden saw Mr Torrijos go up the stairs to C-Wing, and after she saw Mr Mead-Hunter go past the control room and up to C-Wing as well, she stood up to get a better view. When she saw Cleveland's door was open, Ms Hayden said to Mr McClennan (who was also in the control room) words to the effect: "*Something's not right, I think we need to go up there.*"[152]

229 Mr McClennan agreed and they both went to the stairs to go up to C-Wing. While they were on the stairs, Mr Mead-Hunter instructed them to get the nurse. Ms Hayden returned to do that and then saw that Ms Bain was in fact following them up the stairs already.[153]

230 Ms Hayden was also asked by Mr Mead-Hunter to call triple zero and that call was made by her at 1.55 am.[154] Ms Hayden had Ms Priestley call a Code Red medical emergency to Casuarina which alerted the Nursing Response Team from Casuarina to attend Unit 18 to provide assistance in the resuscitation efforts.[155]

The resuscitation of Cleveland

231 At 1.51 am, the door to Cleveland's cell was unlocked by Mr Torrijos. He immediately lifted Cleveland to take his weight and removed the ligature from around Cleveland's neck. The ligature was a t-shirt issued by the

[148] Ts p.438
[149] Ts p.440
[150] Ts p.439
[151] Ts p.301
[152] Ts p.303
[153] Ts pp.302-304
[154] Ts pp.306-307
[155] Ts p.308

Department for detainees in Unit 18. Mr Torrijos placed Cleveland onto the floor of the cell.

232 Resuscitation of Cleveland was commenced immediately thereafter by Mr Torrijos and continued by Mr Mead-Hunter when he arrived.

233 Following the triple zero call by Ms Hayden, paramedics arrived at the entrance to Casuarina Prison at 2.06 am and "first had eyes on" Cleveland at 2.15 am. The paramedics immediately took over the resuscitation attempts being made by the staff with a return of spontaneous circulation (ROSC) achieved at 2.17 am, shortly before Cleveland was removed from Unit 18.

234 I am satisfied that from the moment Cleveland was taken down, and his resuscitation was commenced by Mr Torrijos and then continued by other Unit 18 and Casuarina staff, everything that could have been done to revive Cleveland was done. I am therefore satisfied that these efforts by the Department's staff were appropriate.

235 I must stress there is no evidence that there would have been any difference to the ultimate outcome if Mr Mead-Hunter had behaved differently by arriving sooner at Cleveland's cell.

Cleveland is taken to hospital

236 At 2.32 am, Cleveland was transported from Unit 18 by ambulance under Priority 1 conditions to the ED at FSH, arriving at 2.52 am. After being assessed, the decision was made by medical staff at FSH to transfer Cleveland to SCGH. This took place at 6.10 am.

237 Extensive investigations were undertaken in the ICU at SCGH, and all necessary care was provided. Sadly, however, Cleveland's condition worsened. Scans revealed that he had sustained a hypoxic brain injury which was deemed to be non-survivable. On 18 October 2023, medical staff at SCGH met with Cleveland's family and the decision was made to change his medical treatment to palliative care.

238 Cleveland was kept comfortable before he was certified as life extinct at 10.14 pm on 19 October 2023.[156]

[156] Exhibit 1, Volume 1, Tab 8

239 I am satisfied that Cleveland received all appropriate medical care from the moment the paramedics arrived at Cleveland's cell, through the time of his hospitalisation at FSH and SCGH, and until the time of his death.

CAUSE AND MANNER OF DEATH

Cause of death [157]

240 On 25 October 2023, Dr Reimar Junckerstorff, a forensic pathologist, conducted a post mortem examination of Cleveland's body.

241 The examination found a ligature mark to Cleveland's neck, multiple healed scars on his left forearm and signs of medical intervention that included CPR resuscitation.

242 Microscopic examination of Cleveland's heart found areas of scarring (fibrosis), focal inflammation and slight coronary artery disease (atherosclerosis). Cleveland's lungs showed changes of bronchopneumonia and inflammation in the airways (acute bronchiolitis and bronchitis).

243 A neuropathologist performed an examination of Cleveland's brain which found probable swelling of the brain and global cerebral ischemia. Dr Junckerstorff noted that global cerebral ischemia may be seen following severely reduced or absent blood supply to the brain, as can happen following a resuscitated cardiac arrest.

244 A toxicological analysis of blood and urine samples from Cleveland detected medications used in his hospital treatment.

245 At the conclusion of Dr Junckerstorff's post mortem examination, he expressed the opinion that the cause of death was complications of ligature compression of the neck (hanging).

246 I accept and adopt the opinion expressed by the forensic pathologist as to the cause of Cleveland's death. Accordingly, I make that finding.

Manner of death

247 Given the evidence I heard at the inquest from the YCOs and the registered nurse who were working at Unit 18 before and at the time of Cleveland's incident, I am satisfied that the conditions of the cells, particularly those cells in C-Wing with no access to running water, were nothing short of

[157] Exhibit 1, Volume 1, Tabs 10.1-10.3, Tabs 11.1-11.2, Tabs 12.1-12.2

deplorable and completely unhygienic. Mr Torrijos described the cell conditions as "*unliveable*".[158] Ms Bain said they were "*disgusting*".[159]

248 To make matters worse for detainees, they were repeatedly kept locked in their cells under confinement orders for 22 or 23 hours or more a day. As they were kept in single-person cells, that was akin to solitary confinement. Those detainees in C-Wing ate all their meals locked in their cells. Mr Idowu accepted it was cruel to require a detainee to eat every meal on his own in his cell, day after day, week after week, month after month and that to do so would necessarily increase the suffering of that detainee.[160]

249 It is hard to imagine the despair and despondency Cleveland would have felt living in these appalling conditions.

250 In Cleveland's case, he was enduring other hardships. His final period of detention in Unit 18 was by far the longest he had been there, and there was a prospect of a further lengthy period of detention in Banksia Hill and/or Unit 18 given the seriousness of his outstanding charges. In addition, he was detained 1000 km from his mother's home and 800 km from where his father's family lived, with the consequence that there was little to no chance of close family members being able to visit him.

251 On 9 October 2023, Cleveland asked for a referral to see a psychologist.[161] However, this did not occur as the psychologist was seeing another detainee.[162] On 10 October 2023, he made two cell calls asking to speak to the psychologist.[163] This did not take place as custodial staff were not available to facilitate a meeting taking place.[164] This aspect of Cleveland's care is dealt with later in my finding.[165]

252 On the afternoon of 11 October 2023, Cleveland's bail application in the Children's Court was adjourned for another eight days.[166] Later that day, he was unable to speak by telephone to his mother (whose birthday was on that day) during the only other time he had out of his cell.

253 On the night of 11 October 2023, Cleveland was kept awake by the detainee in the neighbouring cell deliberately making loud noises to prevent him

[158] Ts p.82
[159] Ts p.423
[160] Ts p.3379
[161] Exhibit 24
[162] Exhibit 1, Volume 8.2, Tab 1.1.14
[163] Exbibit 1, Volume 1, Tab 40
[164] Exhibit 45, p.62
[165] See: **ADVERSE FINDINGS, *The Department,*** *9. Cleveland's lack of access to mental health services*
[166] Exhibit 1, Volume 5, Tab 2.12

from sleeping. I am satisfied from the information before me that his stress levels were magnified when the power outage occurred shortly after 11.30 pm. In two of his three final cell calls, Cleveland was despairingly trying to work out the number of days he had spent "*locked up*".

254 Given all these circumstances, it is unsurprising that Cleveland threatened to self-harm so many times on the night of 11 and 12 October 2023 before taking the tragic action that he did.

255 The Court requested an independent psychiatric report from Dr Gosia Wojnarowska, a respected and experienced psychiatrist specialising in Forensic and Child and Adolescent Psychiatry. She had previously worked in youth detention. At the inquest, counsel for the Department asked Dr Wojnarowska these questions:[167]

> One of the central issues here, obviously, the details of the death. And I am wondering if you have any views on whether or not, having regard to his age and also his cognitive abilities and developmental disabilities, whether, in your view, he had the capacity to form an intention to end his life and to understand the consequences of that?--- Well, given the fact that Cleveland announced on eight occasions that he was going to hang himself, I think he did. I think he intended to end his life at that time.
>
> …
>
> My question is, is there any possibility that the behaviour was done other than the intention to end his life, for example, in the hope that somebody might discover what he was doing?--- In my opinion, even Cleveland probably didn't know at that time. He was incredibly distressed, he was a very impulsive young man, and he wanted, in my view, to finish the suffering that he was experiencing at that time. There was accumulation of all those stressors that led to his attempted suicide and then death. He did cover the camera. He was help-seeking, - appropriately help-seeking. So in my view, it was definitely not attention-seeking, as such. Whether he had a concept of permanency, I'm not sure. I'm not sure how much time Cleveland spent before thinking about [what] it meant to kill himself. So I can't answer the question in terms of permanency, but I do believe he wanted to end his suffering at the time he decided - well, it was a deliberate act, and he - it required quite a lot of manipulation to put a rope[168] through the vent and to make a noose around his neck which could sustain him. So we also have a strong planning prior. It wasn't something that - for example, he did not cut himself. He would have known that hanging is a very serious attempt. It is that kind of common knowledge for everyone. So I don't think that this was just a reckless behaviour on his part.

[167] Ts pp.1947-1948

[168] Although it was a torn t-shirt and not a rope, I am satisfied that does not undermine the point being made by Dr Wojnarowska.

> And to be clear there, is that - do you hold the view that that's certainly the case, or it's your suspicion that that's the most likely probability - or possibility?--- Well, I can't be sure a hundred percent of Cleveland's' act, but a strong possibility, yes.

256 I accept that evidence from Dr Wojnarowska. I also accept Dr Wojnarowska's diagnosis that given his behavioural and emotional difficulties at the time of his last detention, Cleveland had complex post-traumatic stress disorder that was characterised by low mood, irritability and difficulty regulating affect. Dr Wojnarowska noted that this disorder can be associated with negative perceptions about self, and suicidal ideation and attempts.[169]

257 In light of what I have outlined above, I am satisfied to the required standard that Cleveland had formed an intention to end his life when he tore up his t-shirt so it could be used as a ligature and placed it through the gaps in the two corners of the ceiling vent in his cell that were damaged by being folding back. I am satisfied Cleveland had previously caused that damage; most likely by using a broken sink tap that was wrapped in clothing or a sock to lessen the noise when striking the corners of the vent with it.[170] He was able to reach the ceiling vent to do that by standing on the toilet bowl or the waist-high partition at the end of the bed.[171] With the ligature placed around his neck that he had fashioned from the t-shirt, Cleveland stepped off either the toilet bowl or the partition in the cell, thereby suspending himself. This occurred after Mr Torrijos spoke to him at 1.37 am and before the next time he checked Cleveland's cell at 1.49 am.

258 Cleveland knew he could achieve all these preparatory steps undetected as he had obscured the vision from the CCTV camera in his cell.

259 Accordingly, I find that death occurred by way of suicide.

THE OPERATION OF UNIT 18 DURING CLEVELAND'S FINAL PERIOD OF DETENTION

The custodial and non-custodial staffing situation was dire

260 This subject as it related to custodial staff is dealt with later in this finding.[172] It is sufficient to note at this point that Mr Coyne's evidence at the inquest was that during the entire time he was Superintendent at

[169] Exhibit 24, p.12
[170] Exhibit 1, Volume 2.1, Tab 13, p.29
[171] Exhibit 1, Volume 1, Tab 47.4
[172] See: **ADVERSE FINDINGS**, ***The Department***, *12. The failure to have adequate staffing numbers and staff with appropriate experience at Unit 18*

Unit 18 (i.e. from May 2023), he had never been provided with enough custodial staff for both the day shifts and night shifts. He understood this inability to get an adequate number of custodial staff for these shifts had existed since Unit 18 opened.[173]

261 The Department approved "Commissioner's Operating Policies and Procedures 14.3: Unit 18 Behaviour Standards and Behaviour Management" (COPP 14.3), effective from 7 December 2022.[174] Clause 6.1.4 of COPP 14.3 states:[175]

> Under legislation and common law, all young people in Unit 18 are entitled to access certain conditions, services, activities and items (minimum entitlements) (Appendix C).

262 Appendix C of that document describes these minimum entitlements to include:[176]

> (a) Young people must be provided with purposeful and planned activities.
>
> (b) Young people must be provided adequate educational services.
>
> (c) Daily socialisation with other young people.

263 During her examination at the inquest, propositions were put to Ms Mitchell based on these minimum entitlements. The propositions were that during the time Ms Mitchell was the Unit Manager at Unit 18 (which included Cleveland's last period of detention) (i) it was not possible for young people to be provided with purposeful and planned activities, (ii) the young people were not provided adequate educational services, and (iii) the young people did not have daily socialisation with each other. Ms Mitchell agreed with each of those propositions.[177]

264 Counsel for the Department questioned Ms Mitchell about her acceptance of those propositions. She confirmed that her acceptance of those propositions indicated her view of Unit 18 as at October 2023. She agreed with counsel for the Department that she was making no comment about the current state of Unit 18.[178]

[173] Ts p.1908
[174] Exhibit 1, Volume 7, Tab 4.1.2
[175] Exhibit 1, Volume 7, Tab 4.1.2, p.10
[176] Exhibit 1, Volume 7, Tab 4.1.2, p.18
[177] Ts p.590
[178] Ts p.675

265 I am satisfied a primary reason for the failure by the Department to comply with this clause in COPP 14.3 would have been "*operational reasons*" i.e. the commonly used euphemism by the Department for lack of staff.

The evidence of those who were working on the floor of Unit 18

266 The inquest heard evidence from the staff who worked on the floor of Unit 18. That evidence was not challenged by any counsel. I accept that evidence and will make findings consistent with such evidence.

267 Ms Bain, the registered nurse, said there was no space which was a dedicated clinical nursing area in Unit 18. She had worked at other sites operated by the Department and at those sites there is a dedicated nursing area.[179]

268 Ms Bain said Unit 18 did not have a dedicated mental health team. The mental health facility that was available for Unit 18 was on-site at Banksia Hill which was only available during business hours, Monday to Friday. It was not available on weekends or at night after business hours for those detainees in Unit 18.[180]

269 Ms Bain described the arrangement of one of the interview rooms being the nursing office as "*pretty unsatisfactory*".[181]

270 When Ms Bain was asked to comment on the hygiene or healthiness of the cells in Unit 18, she described them as "*disgusting*".[182]

271 Ms Bain confirmed some of the cells did not have running water. She agreed it was "*an appalling state of affairs*" that detainees used the toilet in their cell, ate their meals in their cell and those without running water could not wash their hands before eating or after toileting. She agreed such conditions were "*inhumane*".[183]

272 Ms Bain kept a personal journal from February 2023.[184] It makes for harrowing reading. She described Unit 18 as "*like a war zone*",[185] "*a very chaotic place*" [186] and that the staff were "*on the front line of a war*".[187]

[179] Ts p.415
[180] Exhibit 1, Volume 2.1, Tab 10.1, see also Ts p.416
[181] Ts p.421
[182] Ts p.423
[183] Ts pp.424-425
[184] Exhibit 1, Volume 2.1, Tab 10.6
[185] Exhibit 1, Volume 2.1, Tab 10.1, p.11
[186] Ts p.406
[187] Ts p.430

273 Ms Bain said it was a regular occurrence before Cleveland's incident when she was on a night shift, that a Senior Officer was advised a detainee was on level 1 ARMS, but the camera was covered, and custodial staff could not see the boy.[188] Ms Bain said she had heard the Senior Officer respond by saying words to the effect of: "*There's nothing we can do. Just leave it.*"[189]

274 Ms Bain recalled that shipping containers were brought into the larger recreation area at Unit 18 so that D-Wing (which had housed the SMT) could become available to receive more detainees from Banksia Hill.[190] Ms Bain was asked by Mr O'Siochain, the Assistant Superintendent at the time, for her thoughts on the proposal. She told the Court, that wearing her health professional hat, she said to Mr O'Siochain it was not a good idea. She did not feel he listened to her. The containers remained in the recreation area for quite some time.[191]

275 Mr Torrijos told the Court that prior to Cleveland's incident, his description of Unit 18 was "*chaos*". He said, "*it was unsuitable for housing detainees who were young people*". He said that Unit 18 could definitely be best described "*as a powder keg*".[192]

276 Mr Torrijos said that the cells "*have been, probably, unliveable the whole time.*"[193]

277 Mr Torrijos described cells having no running water and toilets not flushing.[194]

278 Ms Mitchell described her work at Unit 18 as "*it was traumatic, and it was soul destroying*".[195]

279 In his evidence to the CCC, Mr Mead-Hunter was of the view "*no young person should be housed in Unit 18 in my opinion. So, we literally just had to do the best we could with what we had.*"[196]

[188] Ts p.411
[189] Ts p.413
[190] Ts p.431
[191] Ts pp.433-435
[192] Ts p.144
[193] Ts p.82
[194] Ts p.85
[195] Ts p.569
[196] Exhibit 1, Volume 2.1, Tab 9.4, p.24

The evidence from a member of the SMT at Unit 18

280 Mr Idowu was brought to Unit 18 immediately after the major incident on 30 July 2022. He was able to describe how Unit 18 had been set up in the first 10 or 12 days after it became operational. He said there was not a lot of space for staff to work in Unit 18. He described the five rooms running off the passage or spine on the ground floor of Unit 18. The largest of those rooms was used by the Deputy Superintendent. One of the rooms was the medical centre, another was an interview room used by the psychologists, the other two rooms were described by Mr Idowu as rooms with "*hot desks*" used by YCOs, mentors and teachers for their documentation.[197]

281 Mr Idowu said his understanding was the face-to-face teaching was being delivered in the wings and the day room areas.[198]

282 Mr Idowu said that the practice of the detainees having their meals together in the day room area ceased after the incident on 30 July 2022. That remained the case until the commencement of the structure of different privileged wings.[199]

283 Mr Idowu described the period of the first five months or so after he commenced in August 2022 and said there was not enough staff in Unit 18. He said it operated "*in a very distressful way*".[200]

284 He said there was an inadequate delivery of programs during this time.[201]

285 Mr Idowu considered that he was being asked to undertake too many responsibilities when he went to Unit 18.[202]

286 Mr Idowu spoke about his observations of how Unit 18 functioned in the first 10 months of 2023, up to the time of Cleveland's incident. He described the operations as very difficult. He said there were not enough YCOs to operate the facility. It was necessary for members of the SMT to fill in and undertake other roles. He was aware custodial staff would refuse to work in Unit 18. He was also aware there were times when inexperienced YCOs would be required to work as the Unit Manager or Senior Officer, because no one more experienced was available. He agreed that his perception of what was happening in this 10-month period was: "*That you*

[197] Ts pp.3303-3305
[198] Ts p.3306
[199] Ts pp.3309-3310
[200] Ts p.3310
[201] Ts p.3310
[202] Ts p.3299

don't have sufficient staff or sufficiently experienced staff, and you are having to make do with what is made available to you."[203]

Use of confinement orders

287 As noted already, Ms Mitchell had been working continuously in Unit 18 since September 2022 as the Unit Manager. She explained the daily ritual of going from cell to cell to advise each detainee that a confinement order was in place.

288 She said the requests for such orders and the reason given for the making of such orders would be the same each day. Watching Ms Mitchell give this evidence, it was apparent the effect this process had on her. She said it was "*soul destroying*" for her to read out these confinement orders every day.[204]

289 Ms Mitchell said she could understand why these teenage boys misbehaved if they got the opportunity and agreed there were not sufficient health and allied health professionals "*who could help these boys cope with the situation they were in – there weren't sufficient numbers of them to devote the time that's necessary to help those boys*."[205]

290 Ms Mitchell said there was a difference in the level of input by psychologists and counsellors at Banksia Hill compared to the level of input of those people with detainees at Unit 18. She said it was much easier for the allocated psychologist to see a particular detainee in Banksia Hill, than it was in Unit 18.[206]

291 Ms Mitchell said that after the Supreme Court cases of ***VYZ*** and ***CRU***, the message from the SMT was all the detainees must be up for an hour a day and there was a particular detainee that needed to be out for an hour in the morning and an hour in the afternoon.[207]

292 Mr Torrijos was aware of the Supreme Court litigation. He said that he was told that one of the things that had to change after those cases was "*that there was a detainee that we had to get out of the cell for at least two hours*"[208] and "*that we were more or less forced to get one detainee out for two one hourly things, even if he had assaulted an officer*."[209]

[203] Ts pp.3311-3312
[204] Ts p.572
[205] Ts p.566
[206] Ts p.601
[207] Ts pp.566-567
[208] Ts p.169
[209] Ts p.170

293 If a detainee was out of their cell during the day, that did not necessarily mean they were able to go outside into the fresh air. Ms Mitchell said that the presence of the sea containers in the recreation yard, and the resultant restriction in space in the yard, meant that the one hour of out of cell time might be spent with the detainee walking up and down in the cell wing, without ever leaving the wing.[210]

294 Mr Idowu said he issued confinement orders both before and after the Supreme Court decisions of ***VYZ*** and ***CRU***. The principal things he took into account when asked to issue a confinement order were: "*Do we have enough staff?*" and "*Is the area safe?*".[211]

295 Mr Idowu said that after the Supreme Court decisions, he received further direction or instruction about confinement orders, but such directions were not very different from what he had received before those decisions, other than in one respect. That respect was there were two particular individuals for whom it was mandated they must have a certain period of time out of their cells.[212]

296 Mr Idowu said that in the 10 months leading up to Cleveland's incident, confinement orders were used daily in Unit 18.[213] That is consistent with the documentary material received by the Court which shows that barring an occasional isolated day, confinement orders were imposed daily on all detainees.

297 Mr Idowu said he was familiar with the practice of Ms Mitchell as the Unit Manager going from cell to cell reading out the confinement order to each young person. Like Ms Mitchell, he said this was distressing for him.[214]

298 Mr Mortley was asked what he understood to be the effect of the Supreme Court decisions in respect of out of cell time. He told the inquest that:[215]

> The message we got was that one particular detainee had to get two hours because of the Court injunction and the other detainees, we had to do the best we could to try and get them as much time out of cell, but it was one hour for every six.

[210] Ts p.572
[211] Ts p.3324
[212] Ts pp.3323-3324
[213] Ts p.3325
[214] Ts p.3325
[215] Ts pp.3006-3007

299 Mr Mortley said he had read nothing from the Supreme Court or the Children's Court on the question of whether the amount of time the young person is locked up can be causative of critical incidents. He said he had read nothing on this topic from OICS.[216]

300 In relation to confinement orders, Mr Mortley was unaware the Supreme Court had said they should only be used rarely and exceptionally.[217] He said he was comfortable with the practice of making confinement orders that were relatively similar.[218]

301 In his written statement to the inquest,[219] Mr Mortley said: "*In my opinion the SMT in Unit 18 is the most effective custodial management team I have observed or encountered in my career*."

302 Senior Counsel for the ALSWA put to Mr Mortley the undisputed fact that for almost every day of Cleveland's last two periods of detention in Unit 18, he had been locked down for at least 22 or more hours a day for most of that time. Mr Mortley was aware this would generally be correct.[220] It was put to Mr Mortley that, "*it's bordering on the incredulous to describe a scenario where Cleveland spent so much time in lockdown, as I've just described, to describe that as something illustrative of an efficient management team*." Mr Mortley disagreed with that proposition.[221]

303 Mr Mortley said he was aware "*there are regular occasions where boys spend between 0 and 60 minutes out of a cell in a day*."[222] He said he was unaware the Supreme Court had said this was completely unacceptable and must not happen.[223] In these circumstances, it is apparent Mr Mortley, contrary to what he asserted in his statement, had not addressed all the requirements which needed to be addressed when making confinement orders. This proposition was squarely put to him by Senior Counsel for ALSWA.[224]

304 I am satisfied that Mr Mortley's evidence demonstrated an acute lack of understanding of how the youth custodial estate is supposed to operate. That a member of the SMT displayed such unawareness does not reflect well on the Department. I am satisfied the most likely explanation for Mr Mortley's

[216] Ts p.3028
[217] Ts p.3030
[218] Ts p.3029
[219] Exhibit 59, [13]
[220] Ts p.3019
[221] Ts p.3020
[222] Ts p.3031
[223] Ts p.3031
[224] Ts p.3031

lack of knowledge is twofold. First, he came from the adult custodial estate after 12 years there. Secondly, the Department provided no training to those custodial officers transitioning from the adult estate.[225]

305 Mr Coyne accepted that when he was Superintendent of Unit 18, he realised the Department was failing to comply with the law in terms of getting detainees up out of their cell for the minimum daily time. The data which demonstrated this failure was sent on a daily basis from Unit 18 to Ms Ginbey. He would speak with Ms Ginbey about this problem and Ms Ginbey would tell him what he already knew, namely the detainees needed to get out for at least one hour a day.[226]

306 Mr Coyne was taken to the detention management reports.[227] He agreed the data in these reports indicated Cleveland was not receiving the minimum out of cell time required by law.[228] Mr Coyne agreed that if this inquest had not uncovered this information, it would have remained unknown to the public:[229]

> So, the fact that the Department knew it was acting unlawfully would remain unknown to the public but for Cleveland's inquest? --- The public, yes.
>
> Because the Department knew, didn't it? --- Yes.

307 Mr Coyne agreed that a stage was reached where the Minister and the Director General just had to be told of this matter and that it could not be kept a secret anymore. He now deeply regrets his failure to escalate this knowledge of the unlawful practice of the Department "*into the sunshine*".[230]

308 Mr Coyne accepted the proposition that he, Ms Ginbey and the Department knew Unit 18 was operating unlawfully.[231]

309 Mr Coyne agreed it was very uncomfortable in his examination at the inquest to be asked about the failure to provide the lawful minimum out of cell hours to detainees. He agreed that it was uncomfortable because it was

[225] This matter is addressed later in this finding: **RECOMMENDATIONS*, The lack of training for prison officers who move to the youth custodial estate***
[226] Ts pp.1986-1989
[227] Exhibit 1, Volume 5, Tab 4
[228] Ts pp.1989-1998
[229] Ts p.1999
[230] Ts p.1999
[231] Ts p.2001

"*patently obviously that the right thing to have done was for the Department to come clean with this [and to tell the Minister]*".[232]

310 I make no finding or comment as to the accuracy of Mr Coyne's evidence that Unit 18 was acting unlawfully with respect to the use of confinement orders and, if so, who had that knowledge. To do so would infringe the provisions of section 25(5) of the Act. As the Department has submitted, that determination can be made "*at another time and in another place.*"[233]

Failure to uncover cell CCTV cameras

311 The absence of any dedicated observation cells[234] in Unit 18 meant the use of cell CCTV cameras as a means of observing detainees in their cells had an elevated importance.

312 The ability of staff in the control room to observe the detainees was compromised because the cameras were covered or scratched to affect the quality of any image conveyed to the bank of monitor screens in the control room.

313 The operational staff on the floor were aware of these limitations and reported to their Unit Manager or Senior Officer as the case may be. These people then reported to the SMT.

314 Ms Mitchell said that during her time in Unit 18, the average number of detainees was about 16, of which somewhere between four to six would be on some sort of ARMS.[235]

315 Ms Mitchell said that every day she worked in Unit 18 there would always be one or more cameras covered.[236]

316 Ms Mitchell explained that as the Unit Manager she felt "*hopeless*" because the facilities in Unit 18 for high level ARMS supervision did not enable her to "*give them the supervision that they required*".[237]

317 When Ms Mitchell gave evidence at the CCC, she described how she expressed her concerns to her Senior Officer and the SMT. This was done in an informal, rather than formal way. She received a response that her

[232] Ts p.2005
[233] Written closing submissions from the Department dated 6 May 2025, p.7
[234] When I refer to observation cells in this finding, it means cells that allow for direct visual monitoring of the detainee. In the context of Unit 18, this would be most effectively achieved through a clear cell door or large observation panel(s) in the cell door.
[235] Ts p.556
[236] Ts p.557
[237] Ts p.560

concerns were understood but there was not a lot that could be done and that: "*We have what we have, and we just have to find other ways around working within what we have here at Unit 18*".[238]

318 Dr Tomison said that he became aware of the practice of the detainees covering the cameras, but he was never told that led to a need for extra night staff.[239]

319 Mr Idowu said that from the time he arrived in Unit 18 until the time of Cleveland's incident, he was aware of the practice of detainees covering the CCTV camera in their cells. Specifically, in the period January 2023 to the time of Cleveland's incident, Mr Idowu said his observation was that the cameras were covered most of the time and they sometimes got uncovered, but most times they remained covered.[240]

320 Mr Idowu said that he and all members of the SMT to his knowledge, were aware of the practice of the cameras being frequently covered. He specifically mentioned this to Mr O'Siochain, the Deputy Superintendent at Unit 18. He said the staff were spoken to and told the requirement was to go into the cell and uncover the camera. Mr Idowu said that was a very difficult task, particularly at night. He said Unit 18 did not have enough staff to be constantly breaching cells and removing the covering from the cameras.[241]

321 Mr Coyne's knowledge regarding the extent of the cell CCTV cameras being covered is dealt with later in this finding.[242]

322 After Cleveland's incident many more resources by way of staff were provided to Unit 18 and there was a clear change in the direction as to how staff responded to cell CCTV cameras being covered.

323 As I mentioned above, the importance of keeping the cameras uncovered is accentuated by the absence of observation cells.

324 Ms O'Connell said Mr Coyne had discussions with her and Ms Ginbey after Cleveland's incident and he was trying to rectify the situation. In response to questions from me, Ms O'Connell provided the following answers:[243]

[238] Ts p.596
[239] Ts p.1490
[240] Ts pp.3316-3317
[241] Ts pp.3316-3320
[242] See: **ADVERSE FINDINGS, *Mr Coyne,*** *1. The failure to adequately address the covering of cell CCTV cameras prior to 11 October 2023*
[243] Ts p.1698

> Now, I hear all the time at inquests about entities, including government departments being reactive to an event such as a death. And so, these discussions have all been reactive? --- Unfortunately, yes.
>
> Yes. And looking back on it now, these discussions ought to have occurred prior to an incident such as Cleveland's? --- Unfortunately, your Honour, there's a lot of lessons that are being learnt and it's a little too late.
>
> Yes, it's just that the Department would only be too well aware that those detainees being placed in Unit 18 were the most vulnerable of an already highly vulnerable group of detainees? --- Correct.
>
> And that, therefore, it was absolutely essential? --- That's correct.
>
> To have proper, effective … observation cells in Unit 18 at all times? --- Correct.

Potential ligature anchor points

325 At the inquest, Mr Mortley agreed that on the night of Cleveland's incident there was more than one cell with an anchor point from a damaged ceiling vent. When asked why he did not do everything possible to force his superiors to change that status quo, he said that he did.[244]

326 Following Cleveland's incident, all detainees in C-Wing were immediately moved and it was still empty when I visited Unit 18 on 20 October 2023 (the day after Cleveland's death). After examining the cell in which Cleveland had been placed, I asked that the other cells in C-Wing be unlocked for me to inspect.

327 Upon inspection, seven of the 16 cells in C-Wing had damage to their ceiling vents with the metal of at least one of the corners folded back. The ceiling vent of the cell where TW had been housed on 11 October 2023 had identical damage to the ceiling vent in Cleveland's cell. Cloth-like material was still hanging from this ceiling vent. This incident involving TW is dealt with later in my finding.[245]

ADVERSE FINDINGS

How I have assessed the evidence from witnesses

328 As I stated at the commencement of this finding, I acknowledge that the impact of Cleveland's death has extended beyond his family and has included many of the Department's employees. I also recognise that testifying in a courtroom regarding a high-profile matter with many people

[244] Ts p.3015
[245] See: **ADVERSE FINDINGS**, ***The Department***, *6. The failure to place Cleveland on ARMS during the evening of 11 October 2023*

in the public gallery can be an overwhelming and daunting experience for witnesses, and that what a witness says may be affected by those factors. Other considerations bearing on the reliability of the answers given by a witness is the length of time the witness had been questioned, and whether the answers are in response to leading questions.

329 Where necessary, I have assessed the oral evidence of a witness with those matters in mind. By doing so, I have particularly taken into account the written closing submissions from counsel for Mr Coyne and Ms Ginbey.

330 By being able to see each witness as they gave their oral evidence at the inquest, I was able to assess their reliability by not only what they said but how they said it. I also acknowledge that for those witnesses who were excused from testifying, most notably Mr Mead-Hunter, I have not had the benefit of hearing them give oral evidence. I have taken that into account when accessing the evidence they have provided by other means. Similarly, with respect to those witnesses who were not able to complete their oral evidence (e.g. Ms Ginbey and Mr Coyne), I have taken that into consideration.

331 I have also considered the evidence I heard from a number of witnesses employed by the Department regarding the hierarchy within a government organisation and how information is generally relayed. This means that in the ordinary course of events, an employee "on the floor" will relay a concern to their immediate supervisor and if that person is unable to resolve the issue, they will pass it onto their supervisor. And, if required and deemed necessary, this procedure continues up the chain of command. This means that Unit 18 would be expected to operate on the following basis at the relevant time:[246]

YCO ►

Unit Manager/Senior Officer ►

SMT at Unit 18 ►

Superintendent of Unit 18 ►

Assistant Commissioner/Deputy Commissioner, Women and Young People ►

Commissioner ►

Director General ►

[246] Ts p.2051

Minister

Potential adverse findings

332 In his written closing submissions, counsel assisting outlined the potential adverse findings and comments that he submitted were open on the evidence against the Department and 10 of its employees.[247]

333 As I outlined in my oral findings on 1 July 2025:[248]

> After careful consideration of the submissions made by counsel assisting and counsel for the interested parties, I have determined that any adverse findings or comments I make against the Department or an individual employee of the Department will be confined to (1) actions taken or not taken during the last time Cleveland was detained in Unit 18 that are connected to his death, and (2) actions taken or not taken that are directly related to matters relevant to Cleveland's death.

334 This meant that the adverse findings I have considered are not as broad as those potential adverse findings advanced by counsel assisting in his written closing submissions.

335 However, to avoid any doubt, my adverse findings can include those actions taken or not taken that relate to "*the quality of the supervision, treatment and care*"[249] of Cleveland during his last period of detention.

336 Outlined below are those adverse findings that I am satisfied have been made out on the information available to me. They include some potential adverse findings advanced by counsel for Nadene Dodd and counsel for the ALSWA in their written closing submissions. Those interested parties impacted by those potential findings were invited by the Court to file further written submissions in response.

337 With respect to each adverse finding I have made, I have carefully considered the pertinent information I have received and the written and oral closing submissions from counsel for the relevant interested parties. For each adverse finding, I have applied the ***Briginshaw*** principle and where appropriate, I have been mindful not to insert hindsight bias.

338 Each adverse finding relates to the time of Cleveland's last period of detention, and I have considered and am satisfied that each finding is sufficiently connected to Cleveland's death.

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[247] Written closing submissions from counsel assisting dated 25 March 2025, Part W, pp.224-297
[248] Ts p.4475
[249] *Coroners Act 1996* (WA) s 25(3)

339 Only those potential adverse findings I have found have been made out are referred to below. As to the balance that fall within the narrowed scope of the potential adverse findings advanced by counsel assisting, counsel for Nadene Dodd and counsel for the ALSWA in their written closing submissions, I simply state that I have not been satisfied to the required standard that they have been made out based on the information I have received.

The Department

340 In its written closing submissions, the Department accepted that there were a number of adverse findings open on the evidence with respect to its supervision, care and treatment of Cleveland during his final period of detention. The Department acknowledged that such findings were open with respect to:[250]

(a) The supervision, treatment and care provided to Cleveland during his final period of detention in Unit 18.

(b) Cleveland being subject to excessive in-cell hours during his final period of detention in Unit 18.

(c) The supervision of Cleveland on the night of 11 and 12 October 2023.

(d) Cleveland's access to a ligature anchor point by way of an unfixed broken ceiling vent.

(e) The failure by Unit 18 staff to wear radios on the night of 11 and 12 October 2023.

341 For the reasons outlined below, I am satisfied to the required standard that the above concessions were overwhelmingly supported by the evidence at the inquest. Given the generality of (a) and (c) above, there are various adverse findings that I have made which fall within these descriptions. In addition, I am also satisfied there are other adverse findings against the Department which it submitted were not open on the available information.

342 The acknowledgement that the Department made regarding the lack of adequate supervision, treatment and care provided to Cleveland had not been made in a vacuum. It was made against the background of extensive evidence before the Court of what was, or was not, available to Cleveland in terms of meeting his needs in relation to his mental health, therapeutic

[250] Written closing submissions from the Department dated 6 May 2025, p.5

treatment, education, and time out of his cell that included his access to fresh air.

343 It was not sufficient for the Court simply to note these needs were not met; it was necessary to attempt to understand why these needs were not met, in order to have the most complete understanding and the best opportunity to prevent a recurrence of such failings.

344 That involved an understanding of how it came about that Cleveland was being detained in Unit 18, which until the year before his death had been an accommodation wing for adult men in a building within a high security adult prison. In particular, it was necessary for the Court to examine whether the circumstances of the establishment of Unit 18 and its subsequent operation contributed to the occurrence of the fact acknowledged by the Department, that during Cleveland's last three months of his life, the Department failed in its supervision, treatment and care of him.

345 The adverse findings I am satisfied can be made against the Department are addressed below.

1. <u>The failure to prepare an Individual Engagement Plan for Cleveland</u>

346 An Individual Engagement Plan (IEP) was introduced by the Department for each detainee who was transferred to Unit 18. IEPs began with the first group of detainees sent to Unit 18 on 20 July 2022. The intention of an IEP was that it would set out the particular needs of each detainee about which the Unit 18 staff should be aware. As explained by Dr Cooney:[251]

> It was to provide for an individualised approach based on their needs, and to provide staff with information, including the most effective ways to interact with that young person.
>
> The idea was that the IEP would continuously be revisited, as through a process of trial and error you find out what works for that young person.

347 IEPs were supposed to be prepared by the MDT with input from psychologists from Youth Justice Psychological Services (YJPS). However, by 2023, the preparation of IEPs had dropped off. Although Mr O'Siochain did not know why this had occurred, he noted that it coincided with short staffing amongst the psychologists.[252] There is no doubt this shortage existed. Mr MacDonald's evidence was that psychology

[251] Exhibit 58, p.35
[252] Exhibit 60, p.40

services were (and still are) "*significantly short staffed*".[253] Although the Department had funding for 6.6 full-time equivalent (FTE) psychologists, from August 2023 to after Cleveland's death, only 3.5 or 3.6 FTE were filled.[254]

348 I note that the Department, "*accepts that short staffing in respect of psychologists was likely a contributing factor*."[255]

349 On the other hand, Dr Cooney had the impression that the IEPs had stopped being developed due to psychologists observing that they were not being used by Unit 18 staff. Whatever the reason, the fact remained that the Department's own policies and procedures required that an IEP be developed for all detainees transferred to Unit 18.[256]

350 It is not in dispute that Cleveland did not have an IEP prepared at the time of his final period in detention at Unit 18.[257]

351 As at October 2023, the Department accepted that IEPs were not being prepared and used in respect of all detainees at Unit 18.[258] Improvements only began in November 2023 which, of course, was after Cleveland's death.[259]

352 The concept of an IEP for a detainee being transferred to Unit 18 that would continuously evolve during the detainee's time in Unit 18 was a commendable one. However, for Cleveland, he never had an IEP when he commenced his final (and longest) period of detention in Unit 18.

353 The Department accepted that an IEP was an important component of the care that should have been provided to Cleveland, and that the lack of an IEP meant there was "*a missed opportunity for the Department to engage in a therapeutic approach to his care*".[260]

354 I am satisfied that the Department's failure to ensure Cleveland had an IEP was a significant one. As the Department conceded, "*an IEP containing information about Cleveland's triggers, warning signs, coping strategies*

[253] Exhibit 53, [25]
[254] Exhibit 53, p.6
[255] Supplementary written closing submissions from the Department dated 16 June 2025, p.30
[256] Exhibit 58, p.35
[257] A "draft IEP" for Cleveland had been developed by YJPS in October 2022, but was never finalised: Exhibit 10, [3(d)-(f)]
[258] Written closing submissions from the Department dated 6 May 2025, p.124
[259] Written closing submissions from the Department dated 6 May 2025, pp.124-125
[260] Supplementary written closing submissions from the Department dated 16 June 2025, p.30

and supports would have been beneficial to operational staff at Unit 18 in providing therapeutic care to Cleveland."[261]

355 **I am satisfied that the Department failed to prepare an IEP for Cleveland during his last period of detention in Unit 18. This was due to the lack of resources available to have IEPs prepared in 2023 and the focus of MDT meetings becoming "*primarily concerned with operational risk, security issues and general behaviour*", with the result that "*psychological information was noted but not usually discussed or incorporated into the management of the young person*".[262] Accordingly, I make that finding.**

356 Although there is now a process in place to ensure every detainee at Unit 18 has an IEP,[263] the absence of IEPs during Cleveland's last period in detention was just one example of the Department failing to provide adequate resources to ensure Unit 18 was fit for purpose and could operate safely for staff and detainees.

357 Mr O'Siochain described how the Department's failure to provide adequate resources caused the many problems facing Unit 18 to continue in a perpetual cycle by the time of Cleveland's final detention. He agreed with the following propositions put to him at the inquest:[264]

- The inability to provide what should be provided to detainees accelerated their poor behaviour.
- The acceleration of this poor behaviour created more problems for the staff in terms of stress and sometimes physical injury.
- The reduced staff numbers because people were away from work led to the detainees spending more time in their cells.
- This reduction in resources continued the escalation of the difficult behaviour of the detainees, in that when they got out they would invariably act up.

358 The lack of access to psychological services in Unit 18 was an ongoing issue for Cleveland throughout his final period of detention. As I have later outlined,[265] this lack of access was starkly illustrated as being to his detriment just days before his death.

[261] Supplementary written closing submissions from the Department dated 16 June 2025, p.31
[262] Exhibit 53, [90]
[263] Ts p.2952
[264] Ts p.2943
[265] See: **ADVERSE FINDINGS**, ***The Department***, *9. Cleveland's lack of access to mental health services*

2. Cleveland's excessive in cell hours

359 The Department's information about Cleveland's out of cell time was very informative.[266] Cleveland's final period of detention in Unit 18 was for a period of 87 days in which his out of cell time was recorded. Seventy four of those 87 days saw Cleveland locked in his cell for longer than 22 hours each day. Of these remaining 13 days in which Cleveland received two hours or more of out of cell time, the average daily time out of cell was three hours and 35 minutes. Of those 13 days, there were only four occasions when Cleveland received more than this daily average. The Department conceded that for the majority of occasions, Cleveland only received a daily time out of his cell closer to one hour and that this "*should not have occurred.*"[267]

360 The time Cleveland spent locked in his cell during his final period of detention was commensurate with those periods of time VYZ was confined in his cell at Banksia Hill which led to his successful application for declaratory relief before Tottle J in the Supreme Court in 2022.[268] Cleveland's lengths of confinement in his cell were also very similar to the successful applicants in the second Supreme Court action before Tottle J heard in 2023.[269]

361 For Cleveland's last 11 days in Unit 18 (1 – 11 October 2023), he averaged only one hour and 20 minutes out of his cell each day over that period.

362 The recognised international definition of solitary confinement is less than two hours out of a cell per day.[270]

363 Senior Counsel for the ALSWA took Dr Tomison to this data from the Department recording the very little out of cell time Cleveland experienced, particularly during his final period of detention in Unit 18.

364 Dr Tomison accepted the data indicated for more than 80% of the entire time Cleveland was in Unit 18, he was in solitary confinement.[271] As the Department's data shows, Cleveland was in solitary confinement for more than 85% of the time during his last period of detention.[272]

[266] Exhibit 1, Volume 8.1, Tab 1.3
[267] Written closing submissions from the Department dated 6 May 2025, p.51
[268] ***VYZ by Next Friend XYZ v Chief Executive Officer of the Department of Justice*** [2022] WASC 274
[269] ***CRU by Next Friend CRU2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257
[270] Ts p.1370
[271] Ts p.1370
[272] Exhibit 1, Volume 8.1, Tab 1.3

365 Dr Tomison said that he was aware one of the most significant issues to come out of the *1991 Royal Commission into Aboriginal Deaths in Custody* was how undesirable it was that Aboriginal people were put into solitary confinement. Dr Tomison acknowledged that such a confinement regime as was in place in Unit 18 was, "*making things a lot worse for these young people*".[273]

366 This is the Department's own data. This is information known to the Department on a daily basis as to what was happening in Unit 18. As Dr Tomison acknowledged when questioned by Senior Counsel for the ALSWA:[274]

> So, one of the great failings that we are dealing with this in this inquest is the failure to do what is fairly obvious, which present an analysis of the relevant data for the relevant boy in a way which is meaningful? --- Yes.
>
> If you were presented with data on either a weekly basis or a monthly basis or a quarterly basis looking at the amount of days that a particular boy or group of boys were in confinement, solitary confinement, the kinds of crises that you thought you had on your hand would have immediately been a much greater crisis in your mind? --- Yes.
>
> And the urgency to solve a problem would have been much more than it was? --- Yes, I guess.
>
> Than it was perceived? --- Yes. Yes. I will say yes.
>
> **So again, looking at those three last periods of imprisonment, and I stand to be corrected, but the precision doesn't matter too much, but it looks like he has got about 143 or days out of 166 in solitary, which is over 85%? --- Yes.**
>
> **For a boy with his disabilities in solitary for that period of time, breaching numerous international laws and obligations, it's outrageous, isn't it? --- Yes …**
>
> **Can I suggest to you that there is no way at all that this community, this government, any government in Australia, any department would sanction keeping a boy of Cleveland's problems and issues and life story in solitary confinement for months? --- That way I agree. No. I agree. You're right that way you framed it.**
>
> **And whatever the difficulties in not doing that might turn out to be upon analysis in this inquest, whatever those difficulties are, it must not have happened and yet it did? --- Yes**.
> (emphasis added)

[273] Ts p.1372
[274] Ts pp.1373-1374

367 Dr Tomison said he had not previously heard of such an analysis of this data.[275] Yet the data speaks for itself. I am satisfied that the Department should have taken the time and care to examine it and reflect upon what it meant.

368 Dr Tomison agreed there had been a lot of media interest in the issue of youth detention and "*a lot of tough political talk about these boys*" and "*that it's necessary to be tough on these kids*."[276] However, Dr Tomison also agreed that in all the media releases by the Department, there had never been any information setting out how many days, weeks or months detainees in Unit 18 were being held in solitary confinement.[277] This meant the general community were never told what was truly happening.

369 Dr Tomison agreed it was a fair statement that if the Department, "*had the welfare of these Aboriginal boys at the centre of their thinking, then there is no possible way that so many Aboriginal boys with neurological issues and mental health issues would be kept in solitary confinement for so long*."[278]

370 However, Dr Tomison also said, "*there isn't another place for these young men. … [places like a mental health unit] don't exist and we can't get those young people in there. So, the youth detention system essentially functions in that role, and I don't think that's appropriate but that's what has happened*."[279]

371 I am satisfied this is a clear acknowledgement that what had been provided by the Department during Cleveland's last period of detention was not adequate for the proper care and treatment of young people in Unit 18 with significant disabilities, one of whom was Cleveland. Unit 18 had not been adequately resourced.

372 Dr Tomison agreed that it was more than likely that if the data in respect of solitary confinement to which he had been taken, had been looked at by the Department, thought through and understood, then the huge changes that had not been considered but needed to be considered and undertaken, would have occurred during the time covered by that data.[280]

373 Dr Tomison also accepted that the culture in respect of time out of cells was to the effect that so long as the detainees are out for at least one hour a day,

[275] Ts p.1375
[276] Ts pp.1375-1376
[277] Ts p.1376
[278] Ts p.1376
[279] Ts p.1376
[280] Ts p.1376

that is, receiving 61 minutes of time out of their cell, the Department was complying with its obligations.[281]

374 Dr Tomison agreed that if this information about the extent of the use of solitary confinement in Unit 18 was in the public arena, there is no way the "*horror*" of Unit 18 would have been allowed to have continued.[282]

375 Senior Counsel for Nadene Dodd also took Dr Tomison to the Department records of Cleveland's out of cell time for each of his four periods of detention in Unit 18.[283] In his evidence at the inquest, Dr Tomison was asked:[284]

> [D]o you accept that by September and October 2023, detainees in Unit 18 were being subjected to cruel, inhumane or degrading treatments? --- Yes.
>
> And you would accept that's a very, very serious conclusion to reach isn't it? --- Yes.

376 The Department made a qualified concession that, "*the cumulative effect of the making of confinement orders during Cleveland's last period of detention <u>might</u> be described as unreasonable*"[285](underlining added). It was disappointing that the Department made the qualification that it did. I am satisfied that for a State that is part of a First World nation to solitarily confine a 16-year-old child in a cell for the length of time that Cleveland was held over a period of nearly three months, was not only clearly unreasonable but entirely inappropriate.

377 The Department also accepted, "*that Cleveland was subject to confinement orders for each day of his period of [final] detention. The Department accepts that this was a regrettable outcome.*"[286]

378 I am satisfied the Department inappropriately used confinement orders as a routine measure whenever a lockdown was required because of staff shortages. This occurred with monotonous regularity before and during Cleveland's last period in detention at Unit 18. That is not the purpose of confinement orders; they were not intended to be a stop gap measure to assist the Department in this fashion. It was incumbent upon the Department to ensure there was sufficient staff to discharge its

[281] Ts p.1408
[282] Ts p.1377
[283] Exhibit 1, Volume 8.1, Tab 1.3
[284] Ts p.1330
[285] Supplementary written closing submissions from the Department dated 16 June 2025, p.34
[286] Written closing submissions from the Department dated 6 May 2025, p.51

responsibilities to safely look after detainees in Unit 18 without subjecting them to solitary confinement.

379 **I am satisfied that the Department failed in its obligations to provide Cleveland with sufficient out of cell time during his last period of detention. I am also satisfied it was inhumane for Cleveland to be subjected to the extraordinary length of time he was confined in his cell by himself during that time. Accordingly, I make those findings.**

380 The Department contended that findings by the Court that Cleveland was subjected to "*institutional abuse*", "*cruel and unusual punishment*" or "*cruel, inhumane and degrading treatment*" were not permitted, as such terms would contravene section 25(5) of the Act.[287] That may be a matter of conjecture, but in any event, I have determined it is not necessary to use any of these phrases when making the findings I am required to make under sections 25(1) and (3) of the Act.

381 However, I am satisfied the Court is permitted to make a finding that the deceased person whose death is the subject of an inquest, was treated in an inhumane manner. Such findings have been made in previous inquests by the Court. For example, findings that three police officers' treatment of a person in their care who subsequently died was "*inhumane*" were made by the State Coroner in the ***Inquest into the death of Ms Dhu*** dated 15 December 2016.[288]

382 The level of damage to Cleveland's mental health from his solitary confinement in his cell cannot be accurately measured. Nevertheless, I accept this evidence from Mr Collins that it would have been, "*highly traumatic and distressing*" to be "*on your own, in a cell for hours on end, with very limited out of cell time, often confined to making a telephone call, with little or no interaction with other young people*".[289]

383 Should it be said that Mr Collins' opinion is not that of a suitably qualified person, then I refer to this answer from Dr Wojnarowska to the question whether Cleveland's long periods of confinement in his cell had an impact on his mental health:[290]

> … Aboriginal people are more susceptible to adverse reactions to the effects of prolonged isolation. They have come from a home environment

[287] Written closing submissions from the Department dated 6 May 2025, p.94
[288] ***Inquest into the death of Ms Dhu***, Ref No. 47/15, [496], [546], [597]
[289] Ts p.707
[290] Exhibit 24, pp.18-19

> where less restrictions are placed on their whereabouts and generally have more freedom to move on their land.
>
> The research in this area clearly highlights the detrimental effect of isolation on a person's mental state, specifically on young people and more specifically if they are of Aboriginal heritage. The high prevalence of neurodevelopmental impairment and pre-existing trauma present in the majority of Aboriginal detainees is another factor compounding their mental health problems.

384 In addition, the Department itself was very aware of this issue. In its ARMS Youth Manual that applied at the time of Cleveland's last detention in Unit 18, the following is stated under the heading "Cell Confinement":[291]

> When young people are exposed to certain factors within the detention environment this should also be considered as risk factors for suicide. When a young person is confined to a cell (as a behavioural consequence or otherwise) they are effectively isolated from their peers and other potential supports. Developmentally, adolescents are at a point where they are still largely dependent on adults, but are increasingly susceptible and reliant on peer influence and support. Limiting the access a young person has to their peers can therefore have devastating effects. Due to their developmental stage, young people are also more vulnerable to the impact of isolation. The result of which is that isolation or extended periods of cell confinement can worsen their mental state and increase their desire for suicide. International studies have shown that the majority of young people who die by suicide in detention did so when they were on cell confinement for any reason.
> (underlining added)

385 Cleveland's extended periods in his cell also meant his access to programs and supports offered by the Department was limited due to its operational issues impacting OOCH.[292]

3. The failure to adequately address the covering of cell CCTV cameras prior to 11 October 2023

386 I am satisfied to the required standard that detainees adopted the widespread practice of either covering or defacing their cell CCTV cameras so that they were ineffective. This practice had been very prevalent and longstanding by the time of Cleveland's final period of detention in Unit 18. Yet it was not successfully resolved by the Department until shortly after Cleveland's

[291] Exhibit 29, Tab 13, p.21
[292] Written closing submissions from the Department dated 6 May 2025, p.14

incident. Regrettably, it was only the incident that led to Cleveland's death that provided the impetus for that resolution.

387 The following account from Ms Bain at the inquest was consistent with other information the inquest had received:[293]

> Before October [2023] when you were in the control room, looking at the bank of screens, would the majority of the screens when you happened to look at them be in the position of being either entirely blank because they're obscured or impossible to discern because the quality is so poor? --- Yes.
>
> Did you ever raise with any of the custodial people about the lack of vision either because it's covered or poor quality? --- Yes.
>
> Who did you raise that with? --- Just in general conversation.
>
> Amongst the YCOs? --- That's correct.
>
> And the unit manager during the day? --- Yes.
>
> And the SOs[294] at night? --- Yes.
>
> And during the day? --- Yes.
>
> And what was the response from unit managers and SOs when you expressed those concerns? --- That they just - they cover them all the time.
>
> And damage them? --- That's right.
>
> So was the response, "Well, that's just the way it is. That's what we've got to work with"? --- Yes.

388 COPP 14.3 at clause 5.2 dealt with the covering of cell CCTV cameras. It provided that where a detainee has covered their cell CCTV camera, they would be asked by the YCO monitoring the CCTV cameras to uncover the camera. This request is made via the cell call intercom. If the cell CCTV camera remained uncovered, a further request using the cell call intercom shall be made and a visual check of the detainee undertaken by a YCO, who would request the detainee to uncover the cell CCTV camera. If the cell CCTV camera remained covered, YCOs shall enter the cell and ensure the cell CCTV camera is uncovered before leaving the cell.[295]

389 Although YCOs would generally uncover CCTV cameras during morning cell integrity checks or whenever staff were next in a cell, once cameras were uncovered, "*detainees would often immediately cover their camera again*".[296] As already outlined above, this is what Cleveland did on the

[293] Ts pp.408-409
[294] Senior Officers
[295] Exhibit 22, p.24
[296] Exhibit 1, Volume 2.1, Tab 8.1, [50]

afternoon of 11 October 2023 when the covering he had placed over his cell's CCTV camera was removed by custodial staff during his Children's Court video link appearance. TW, another detainee in Unit 18 during Cleveland's final period of detention, said his cell CCTV camera would remain uncovered for up to three days.[297]

390 I accept the submission from the Department that it utilised a variety of methods to ensure cell CCTV cameras were uncovered prior to Cleveland's incident.[298] However, these methods had not resolved the problem over a significant length of time. I also accept that cell breaches could be used to uncover cameras; however, YCOs felt they were not able to safely enter cells at night for the purpose of uncovering CCTV cameras because of the risk to their safety if they did so. This unchallenged evidence came from Mr Torrijos, Ms Hayden, Ms Priestley and Mr Mead-Hunter.[299]

391 The information before me established there were outside resources that could be called upon by Unit 18 custodial staff to enable tasks such as breaching a cell of a disruptive or uncooperative detainee at night to be safely undertaken. Those resources included the Casuarina Recovery Team, and the Special Operations Group (SOG) which was located at Hakea Prison. However, those resources were not regularly sought by night shift staff at Unit 18 to breach cells to remove coverings from CCTV cameras. The explanation for that is obvious; given that detainees would invariably cover the camera up again, these outside resources would be recalled on a constant and never-ending basis. This was also the view of the CCC investigation:[300]

> While theoretically possible, where most cameras were covered and then re-covered once officers had left the cell, repeatedly calling the emergency response group throughout each night to assist the uncovering of cameras was not a realistic solution. In the Commission's opinion the failure of the YCOs working the night shift of 11 to 12 October 2023 to enter young peoples' cells to remove camera coverings was a reasonable omission in the circumstances.

392 Another possible reason for the reluctance of Unit 18 custodial staff on night shift to engage these outside resources was the procedure to be undertaken which entailed the very real prospect of waking up a person holding a senior managerial position. Mr Coyne outlined the procedure at

[297] Exhibit 1, Volume 2.1, Tab 2, p.12
[298] Written closing submissions from the Department dated 6 May 2025, p.35
[299] Ts p.94; Exhibit 1, Volume 2.1, Tab 6.5; Exhibit 1, Volume 2, Tab 8.4; Exhibit 1, Volume 2.1, Tab 9.4; Exhibit 82
[300] Exhibit 22, p.27

the inquest: the Senior Officer on duty would be advised of the need for the cell breach and they would contact the on-call member of the SMT. If that person deemed it was necessary, they would contact Casuarina to have its Recovery Team attend or, alternatively, contact the SOG.[301]

393 I also accept there was another resolution by the SMT that was attempted for detainees on level 1 ARMS who refused to uncover their cell CCTV cameras. This involved placing a portable camera on a tripod outside the cell. This camera was at the same height as the viewing window of the cell door with a power cord that would be run down to the control room where a monitor would provide a livestream.[302] However, as Mr Mead-Hunter explained in his evidence at the CCC, the window of the cell door "*would also be covered with toilet paper. So maintaining constant supervision was – was just not possible.*"[303]

394 There was an obvious and simple solution to the longstanding practice of detainees covering their CCTV cell cameras. Sadly, that solution was not introduced until after Cleveland's death. Shortly after Cleveland's incident, the Department provided four SOG officers at Unit 18 during the day (subsequently reduced to two) and two SOG officers overnight.[304] As the Department advised Mr Ryan on his first inspection of Unit 18 after Cleveland's incident: "*This was to assist staff implement a no-tolerance approach to the young people covering their in-cell CCTV cameras and viewing hatch*."[305]

395 Mr Coyne and other members of the SMT told the inquest that the introduction of SOG officers permanently based at Unit 18 made a significant difference. Within six to eight weeks, the former practice of detainees covering their cell CCTV cameras and refusing to remove it had been greatly reduced and the need for custodial staff to enter a cell to remove a covering had become an "*infrequent occurrence*",[306] with covering now only occurring "*rarely*".[307]

396 Mr Idowu said that based on the experience of what happened after Cleveland's incident, if that approach had been taken at the beginning of 2023, he would have expected that after an initial four- or six-week period

[301] Ts pp.1907-1908
[302] Exhibit 1, Volume 2.1, Tab 9.4, p.39
[303] Exhibit 1, Volume 2.1, Tab 9.4, p.39
[304] Exhibit 60, p.30
[305] Ts p.812
[306] Exhibit 57, [99]
[307] Exhibit 54, [87]

the same result would have been achieved as was achieved after Cleveland's incident, namely the practice would almost stop.[308]

397 Mr Coyne regretted not issuing his Superintendent's Notices to Staff until after Cleveland's death[309] that reinforced the measures to be taken to the uncovering of cell CCTV cameras.[310]

398 I am therefore satisfied that the risk of cell CCTV cameras remaining covered for any period of time was virtually eliminated shortly after Cleveland's incident.

399 And so, a widespread problem was greatly reduced after additional resources were deployed. Which begs the question why those resources were not deployed well before Cleveland's incident; particularly when regard is had to the following.

400 Although Department policy did not require cell CCTV coverage of all detainees, it was intended that the CCTV cameras in cells at Unit 18 would be used as a form of observing detainees when they were in their cells.[311] That was acknowledged by the Department.[312] Given the excessive amount of time detainees in Unit 18 spent in their cells alone because of confinement orders, it was absolutely imperative they could be monitored via cell CCTV cameras; whether or not they were on ARMS.

401 However, the issue with cell CCTV cameras being constantly covered had become well and truly entrenched by the time of Cleveland's last period of detention.

402 Being mindful not to insert hindsight bias, I am satisfied that the introduction of permanent SOG officers at Unit 18 was a change that should not have been a reactive measure to Cleveland's incident. It ought to have been a measure introduced well before 11 October 2023 to address the chronic failure of the Department's other methods to successfully resolve the longstanding and widespread practice of detainees covering their cell CCTV cameras.

403 The Department has accepted that had Cleveland's CCTV camera been uncovered, "*his actions in the lead up to hanging himself would have been seen, and his self-harm may have been averted.*"[313] I do not accept that

[308] Ts pp.3321-3322
[309] These Notices were dated 21 and 27 October 2023: Exhibit 1, Volume 7, Tabs 2.1.6 and 2.1.7
[310] Ts p.1909
[311] Exhibit 145.2, [14.2]
[312] Written closing submissions from the Department dated 6 May 2025, p.33
[313] Written closing submissions from the Department dated 6 May 2025, p.32

Cleveland's self-harm "*may*" have been averted. I am satisfied that (i) had the cell CCTV camera been uncovered (thereby allowing constant supervision to take place by the YCO viewing the monitors in the control room), (ii) given the length of time it would take for Cleveland to prepare what he subsequently did and (iii) barring some independent unforeseen event, it is almost inevitable custodial staff would have had time to intervene and prevent the catastrophic outcome that eventuated. That level of certainty reinforces the gravity of the Department's acknowledgement that it "*failed to intervene to prevent Cleveland's self-harm attempt resulting in his death.*"[314]

404 **I am satisfied that the Department's failure prior to Cleveland's incident to successfully resolve the widespread practice of detainees in Unit 18 covering their cell CCTV cameras for extended periods of time had contributed to his death. Accordingly, I make that finding.**

4. The failure to remove Cleveland from a cell with an obvious ligature anchor point

405 As I have already noted, the Department has conceded it is open on the evidence before me to make an adverse finding with respect to Cleveland's access to a ligature anchor point in his call, namely the damaged ceiling vent. As set out below, I will make that finding.

406 The evidence regarding the extent of damaged ceiling vents in C-Wing of Unit 18 as at 11 October 2023 has caused me considerable unease.

407 The following evidence is not in dispute regarding the damaged ceiling vent in Cleveland's cell:

(a) When Cleveland was moved into the cell on 7 September 2023, there were no identified faults with the ceiling vent;[315]

(b) The damage to the ceiling vent was the subject of a repair order which was allocated to the contractor responsible for repairs at Unit 18 on 19 September 2023 (22 days before Cleveland's incident);[316]

(c) A new ceiling vent had to be custom made and then fitted by the contractor's maintenance staff when Cleveland was not in his cell;[317]

[314] Written closing submissions from the Department dated 6 May 2025, p.29
[315] Exhibit 1, Volume 7, Tab 3.1, [1]-[2]
[316] Exhibit 1, Volume 1, Tab 41.2
[317] Exhibit 1, Volume 1, Tab 41.3; Exhibit 9

(d) On 6 October 2023, attending maintenance staff could not install the replacement vent as Cleveland was in his cell and was unable to be moved at the time;[318]

(e) On the morning of 11 October 2023, attending maintenance staff could not install the new vent in Cleveland's cell as they were unable to access the cells in C-Wing and the unit manager, Ms Mitchell, advised them to return later in the day when Cleveland was due to be out of his cell;[319]

(f) Maintenance staff did not return later that day, but in any event a critical incident unrelated to Cleveland would have prevented him from being out of his cell at the time.[320]

408 In its written closing submissions, the Department noted that prior to Cleveland's death, (i) there had been no known deaths in custody using a ceiling vent as a ligature anchor point, (ii) that there were other ligature points within a cell, and (iii) that detainees had self-harmed with ligatures without using an anchor point.[321] The Department then submitted:[322]

> Given the availability of other ligature anchor points in detainees' cells, and the ability to use ligatures without any anchor point, the fact of Cleveland's use of the broken ceiling vent is better understood as a shortfall in supervision of Cleveland on the night of his death, rather than justifying an adverse comment against the Department about the condition of his cell.

409 I do not accept that submission because the inquest heard evidence that TW, another detainee in cell 11 in C-Wing,[323] used his damaged ceiling vent in an identical manner less than 12 hours before Cleveland's incident. Yet Cleveland and three other detainees in C-Wing[324] remained in their cells even though their cells had the same damage to the ceiling vents with at least one of the corners folded back.

410 On the afternoon of 11 October 2023, TW was involved in a self-harming incident. The Department's records received by the Court describe what occurred in respect of TW. There has been no challenge to the accuracy of

[318] Exhibit 1, Volume 1, Tab 41.2
[319] Exhibit 1, Volume 1, Tab 41.2; Ts pp.579-580, 633
[320] Ts pp.579-580
[321] Written closing submissions from the Department dated 6 May 2025, p.58
[322] Written closing submissions from the Department dated 6 May 2025, p.58
[323] Exhibit 1, Volume 1, Tab 28
[324] These detainees were in cells 8, 9 and 14: Exhibit 1, Volume 1, Tab 28; Exhibit 1, Volume 1, Tab 48.1, p.7

what is described in those records, and I base my conclusions on what is revealed in those records.

411 Ms Mitchell explained the circumstances of the incident involving TW.

412 Mid-afternoon on 11 October 2023, TW was found with a ligature around his neck. It was attached to a damaged ceiling vent by using two corners that had been folded back and placing the ligature through the two gaps. This was the identical method used by Cleveland in his incident.

413 Ms Mitchell agreed that in "*an ideal world*", after TW's self-harm incident, all cells would have been inspected to determine whether they too had damaged ceiling vents which could be used as ligature points.[325] However, she said it was not practical to undertake such a prompt check of other cells and it "*was not a viable option*" to move those detainees whose cells had damaged ceiling vents to cells that were functional and did not have such damage.[326] She said there was also a difficulty moving TW to another appropriate cell. Ms Mitchell said, "*every cell had potential ligature points*" and that "*there were very limited options*".[327]

414 Notwithstanding the damaged ceiling vent, TW subsequently remained in his cell. What made matters worse with respect to this detainee was that although he was elevated from level 4 to level 1 ARMS, he not only remained in his cell with access to a viable ligature anchor point he had recently used, but his cell CCTV camera remained covered and his cell call intercom was not working. This matter is explored later in my finding.[328]

415 Mr Mortley was asked about his knowledge of cells in Unit 18 in October 2023, which had damaged ceiling vents to create a hanging point. He said he was aware of such damaged cells.[329] He agreed that on the night of Cleveland's incident, Cleveland was in a cell that he (Mr Mortley) knew had a damaged ceiling vent, which he acknowledged (using hindsight bias) was a potential anchor point.[330] His reason why Cleveland remained in this cell, "*was there was nowhere else for the Department to put him. It was the best of bad options*".[331] Mr Mortley accepted that as the cells in B-Wing

[325] Ts p.619
[326] Ts p.620
[327] Ts p.620
[328] See: **ADVERSE FINDINGS**, ***The Department***, *6. The failure to place Cleveland on ARMS during the evening of 11 October 2023*
[329] Ts pp.3008-3009
[330] Ts p.3009
[331] Ts p.3010

were unavailable due to their taps being replaced, there were too many detainees in Unit 18 for them all to be housed in safe places.[332]

416 **I am satisfied that Cleveland should not have remained in his cell after the Department's custodial staff had become aware of TW's use of a damaged ceiling vent as a ligature anchor point. I am also satisfied that the failure to remove Cleveland from his cell contributed to his death. The responsibility for that lies with the Department as custodial staff did not have the resources to move Cleveland into a safer cell that did not have a damaged ceiling vent. Accordingly, I make these findings.**

417 I am also satisfied that the damaged ceiling vent in Cleveland's cell should have been repaired before his incident; and certainly, by 6 October 2023 when its replacement was ready to be installed by maintenance staff who were in attendance at Unit 18 on that day. As already noted above, the reason for the work not taking place was because Cleveland, "*was unable to be moved at the time.*"[333] Although the reason for this is not stated, I strongly suspect it was because of "operational issues/constraints/reasons"; which I have learnt from the documents tendered at the inquest invariably meant "not enough custodial staff".

5. <u>The failure to provide water to Cleveland on the night of 11 October 2023</u>

418 As I have already outlined above, Cleveland repeatedly requested cups of water via cell calls on the evening of 11 October 2023. He was not provided with water at any time.

419 The Department accepted that Cleveland did not have access to running water in his cell since 20 September 2023. This was because he had broken the taps and they could not be replaced as stock was not available due to widespread tap damage in cells at Unit 18 at the time.[334]

420 Dr Tomison gave evidence at the inquest that there was no good reason not to provide Cleveland with additional water when he requested it. Mr Coyne gave evidence that Cleveland's cell should have been unlocked and water provided.[335] Mr Coyne also gave evidence that if a detainee wanted water during the night and Unit 18 staff had formed the view that could not be done safely, then staff from Casuarina or the SOG would be required to breach the cell.[336] I am not satisfied that was a practical measure as it would

[332] Ts pp. 3008-3009
[333] Exhibit 1, Volume 1, Tab 41.2
[334] Written closing submissions from the Department dated 6 May 2025, p.38
[335] Ts pp.1910-1911
[336] Ts p.1911

require the regular attendance of such outside resources every night, with all the inconvenience that would entail.

421 The Department has conceded that additional water should have been provided to Cleveland on the night of 11 October 2023.[337] That concession was entirely appropriate.

422 **I am satisfied that the failure by the Department to have an adequate number of custodial staff on duty in Unit 18 during a night shift at the time of Cleveland's final detention was the primary reason why his requests for water on the night of 11 October 2023 were not addressed. Accordingly, I make that finding.**

423 Whether or not he was responsible for the outcome, the fact that Cleveland had no access to running water in his cell for the final 22 days of his detention in Unit 18, of which 20 of those days he was in solitary confinement,[338] is a very poor reflection of the level of care the Department was providing to him during this period.

424 The Department has, very appropriately, conceded there were other issues regarding Cleveland's cell that were unacceptable. These included its cleanliness, the cell door hatch being welded closed and the shower taps being inoperable (in addition to the basin taps).[339] One further unacceptable issue was the inability to flush the toilet from within the cell. A YCO had to flush the toilet via an external means.[340]

6. The failure to place Cleveland on ARMS during the evening of 11 October 2023

425 The ARMS Youth Manual in operation during Cleveland's last period of detention was a detailed 126-page document stressing the importance of identifying and then responding to, risks of self-harm or suicide by detainees. There is no doubt that the objectives and comprehensive information regarding these risks are commendable. What is not commendable is if a youth detention centre is not able to fulfil those objectives or implement the procedures that are set out as it renders the contents of such a manual redundant. I am satisfied that Unit 18 was such an environment during Cleveland's last period of detention.

[337] Written closing submissions from the Department dated 6 May 2025, p.38
[338] Exhibit 1, Volume 8.1, Tab 1.3, p.5
[339] Written closing submissions from the Department dated 6 May 2025, p.53
[340] Ts p.88

426 I have already outlined above the four levels of ARMS observations for detainees. In one of only three sentences in the ARMS Youth Manual that is entirely in uppercase and with some words in bold type is the following direction:[341]

> *IT IS THE RESPONSIBILITY OF **ALL** STAFF IN **ALL** AREAS OF THE DETENTION CENTRE TO GENERATE AN **ARMS** REFERRAL IF THEY HAVE CONCERNS REGARDING THE RISK OF A YOUNG PERSON.*

427 The ARMS Youth Manual provides that if a staff member obtains information about a young person's potential risk-to-self then they are required to ensure the safety of the detainee and commence the ARMS process by placing that detainee on ARMS.[342]

428 The nine criteria for a detainee being placed on level 1 ARMS includes threatening suicide or non-suicidal self-injury, voicing a plan or method to suicide and with access to a means to suicide.[343] What Cleveland said in his cell calls and the existence of the damaged ceiling vent in his cell satisfied each of these three criteria on the night of 11 and 12 October 2023.

429 The identification and referral process set out in the ARMS Youth Manual makes it mandatory for a detainee to be placed on level 1 ARMS if one or more of the above criteria are met. It also addresses the behaviour of detainees who may be regarded as "*manipulators*" with respect to threats or suicidal behaviour. The ARMS Youth Manual makes it clear as to what approach should be taken in those circumstances:[344]

> There is no way to tell with absolute accuracy if a young person is "manipulating" or if they truly wish to harm themselves. The intent of the behaviour is therefore irrelevant in regards to staff response. Every incident or threat of NSSI[345] or suicide should be treated with equal care, monitoring and support, regardless of the perceived motivation or intent.

430 I also have information before me that despite what the ARMS Youth Manual says regarding the approach to be taken towards "manipulators", YCOs considered that self-harm or threats to self-harm by detainees were attempts to manipulate staff. For example, Mr Torrijos' evidence at the inquest was that, "*[TW] does do a lot of, you know, self-harm acts that are*

[341] Exhibit 29, Tab 13, p.49
[342] Exhibit 29, Tab 13, p.68
[343] Exhibit 29, Tab 13, p.52
[344] Exhibit 29, Tab 13, p.38
[345] Non suicidal self-injury

superficial. And he does play the game."[346] Ms Hayden also said that some custodial staff saw self-harm threats as manipulative behaviour.[347]

431 There was a documented record of Cleveland supposedly engaging in such manipulative behaviour:[348]

> Appears he has settled but today called through to say he has cut himself, staff have conducted a welfare check and Dodd was fine. Appears to be trying using self-harm threats to manipulate staff attention.

432 As already outlined above, Cleveland threatened to self-harm on no less than eight occasions during the night of 11 and 12 October 2023. Compliance with the ARMS Youth Manual required him to be placed on level 1 ARMS after each occasion, whether or not custodial staff believed he would carry out those threats.

433 Cleveland was not placed on any level of ARMS at any stage on the night of 11 and 12 October 2023. Appropriately, the Department has accepted that Cleveland, "*was not managed in accordance with the Youth ARMS Manual on the night of 11 and 12 October 2023.*"[349]

434 This failure to place Cleveland on level 1 ARMS was not an aberration at the relevant time. There were at least 17 threats of self-harm or self-harm attempts made by detainees in Unit 18 in the 24 hours before Cleveland's incident.[350] Yet only one, the incident involving TW referred to above, resulted in an engagement with the ARMS process.

435 I can understand the reasoning why Cleveland and the other detainees involved in self-harm threats or attempts were not placed on ARMS by custodial staff. As Mr Coyne said in his evidence at the CCC investigation, if you were to place a detainee on ARMS every time a threat of self-harm was made, "*you would effectively have every young person [on] ARMS.*"[351]

436 The other issue facing the handful of custodial officers allocated night shift duty during Cleveland's final period of detention was the extreme difficulty to comply with the monitoring conditions of a detainee on level 1 ARMS if their cell CCTV camera was covered. This difficulty would be magnified if

[346] Ts p.111
[347] Ts p.364
[348] Exhibit 1, Volume 3, Tab 10.1, ARMS Detainee Risk Assessment Group Minutes dated 19 September 2023, p.1
[349] Written closing submissions from the Department dated 6 May 2025, p.56
[350] Exhibit 22, pp.20-21
[351] Exhibit 22, p.20

more than one detainee was on level 1 ARMS with no means of observing them on their cell CCTV cameras.

437 The ARMS Youth Manual also sets out other strategies to assist a detainee on ARMS apart from the monitoring process. That included the provision of psychological services, and access to Aboriginal Welfare Officers, education and sport.[352] When questioned at the inquest about the availability of such supports, Ms Mitchell agreed that the conditions in Unit 18 prevented the use of these additional supports.[353]

438 At the inquest, Mr Coyne was asked the following questions by counsel assisting:[354]

> Mr Coyne, do you accept that during the time you were the Superintendent in Unit 18, it was your view that Banksia was generally better equipped to house detainee on ARMS level 1 than Unit 18?--- Yes.
>
> And, from your understanding of what you learnt once you became the super, that had also been the case from when Unit 18 first opened until you arrived?--- Yes.
>
> The reason you held that view, I suggest, was twofold: the first, that there was an onsite health service at Banksia; and the second was the four Perspex-wall cells in the ISU at Banksia. Do you agree they were the two reasons?--- Yes.
>
> And, in your view, there was not, therefore, an appropriate cell in Unit 18 to look after someone on ARMS level 1. Do you agree?--- Yes.

439 Following Cleveland's death, Superintendent Coyne decided that a detainee who was on level 1 ARMS at Banksia Hill would not be transferred to Unit 18.[355]

440 However, that decision was not made by Mr Coyne until after the first tranche of the inquest, which finished on 12 April 2024 (nearly six months after Cleveland's death). Mr Coyne was asked by counsel assisting:[356]

> Well, I suggest that you making a decision that you weren't going to take anyone on ARMS [level] 1 from Banksia, is another example of you responding to the concerns you now know are front and centre of this inquest. Do you accept that proposition?--- Yes.
> …

[352] Exhibit 29, Tab 13, pp.58-59
[353] Ts p.650
[354] Ts pp.2037-2038
[355] Ts p.2040
[356] Ts p.2041

> My question was, I put to you the proposition that this is yet another example that if Cleveland's death had not occurred and this inquest was not opening the door of Unit 18, ARMS [level 1] young people would still be coming into Unit 18 and, if there was no inquest, that practice would go on and on and on. Do you accept that proposition?--- It appears that way, yes.

441 Mr Coyne was unable to explain why it had taken him so long after Cleveland's death to introduce that policy.[357]

442 **I am satisfied there was a failure to place Cleveland on level 1 ARMS once he began making cell calls threatening to self-harm on the evening of 11 October 2023. The ARMS Youth Manual required that to take place. I am satisfied that the responsibility for this failure rests with the Department as custodial staff did not have the resources to effectively monitor Cleveland in accordance with the ARMS Youth Manual. Accordingly, I make that finding.**

443 It was not possible to place Cleveland on level 1 ARMS with continuous observations as required, as there was no cell available to enable him to be continuously monitored. Even if there had been, it is almost inevitable that Cleveland would have covered the CCTV camera in that cell thereby negating the only effective means by which he could be monitored in accordance with the ARMS Youth Manual.

444 I am also satisfied custodial staff at Unit 18 were regularly placed in this invidious position regarding the monitoring of detainees on level 1 ARMS during Cleveland's final period of detention. It was a case of making do with what limited resources they had. They should never have been burdened with that predicament.

7. <u>Other failures to comply with the ARMS Youth Manual regarding Cleveland</u>

445 In her letter to the Court, Dr Cooney outlined a number of other incidents where there were elements of the Department's management of Cleveland that were, "*not in accordance with the Youth ARMS Manual*".[358] During Cleveland's final period of detention, there were three such incidents.

446 The first was on 25 July 2023, when Cleveland was not placed on any level on ARMS following a self-harm threat. The second incident occurred on 26 July 2023 when, at a time when he was on ARMS, Cleveland's threat of self-harm did not result in his level of supervision increasing. Finally, on

[357] Ts p.2042
[358] Exhibit 1, Volume 7.1, Tab 1, p.8

15 September 2023, there was a delay in an ARMS referral being made, notwithstanding an actual self-harm incident involving Cleveland.[359]

447 Unfortunately, the Department is not able to say what was the exact reason(s) for the non-compliance on these occasions. However, Dr Cooney identified a number of general factors which contributed to non-compliance with the ARMS Youth Manual. The factors she cited included a high volume and frequency of incidents, and operational demands.[360]

448 I highlight these occurrences to demonstrate (a) the non-compliance of the ARMS Youth Manual on 11 and 12 October 2023 regarding Cleveland was not an isolated incident and (b) the lack of resources, including insufficient staff numbers, were factors adversely impacting the supervision of Unit 18 detainees in accordance with the ARMS Youth Manual.

8. The failure by staff to wear radios on the night of 11 and 12 October 2023

449 It was not disputed that staff members (custodial and non-custodial) were each required to wear radios while on day and night shift. None of the staff on duty during the night shift on 11 and 12 October 2023 wore a radio for the entire shift. Mr Mead-Hunter said he was not wearing a radio.[361] Mr Torrijos admitted he was not wearing a radio and that it was rare for him to wear a radio on night shift. It was his experience that the common practice of night shift custodial staff was not to wear a radio. Nevertheless, he accepted he should have been wearing one.[362] Ms Hayden was not wearing a radio. She said it was not common practice to wear a radio when working night shifts and did not collect her radio that night.[363] Ms Priestley would ordinarily wear a radio on night shift and commenced her shift wearing a radio. However, she took it off when she noticed other staff were not wearing one, noting that it was pointless if only one custodial officer was wearing a radio.[364] Mr McClennan admitted to the CCC he was not wearing a radio.[365] Ms Bain did not wear a radio during night shift as she was told when she commenced working at Unit 18 she did not need to wear one because the staff were all in close proximity of each other.[366]

[359] Exhibit 1, Volume 7.1, Tab 1, pp.8-9
[360] Exhibit 1, Volume 7.1, Tab 1, p.9
[361] Exhibit 1, Volume 2.1, Tab 9.4, p.23
[362] Ts pp.77-78
[363] Ts p.302
[364] Exhibit 1, Volume 2.1, Tab 8.1, [52]
[365] Exhibit 1, Volume 2.1, Tab 7.3, p.17
[366] Exhibit 1, Volume 2.1, Tab 10.1, [27]-[31]

450 When I asked Mr Torrijos at the inquest whether it had ever crossed his mind that no custodial officer having a radio was going to make it difficult for people to respond to an emergency, he answered:[367]

> I am not sure. I have worn a radio there when there has been an emergency. But there has been a lot of nights there where we haven't had the radio when we are doing checks.

451 **I am satisfied that on the night of 11 and 12 October 2023, the Department failed to ensure its staff wore radios at Unit 18. Accordingly, I make that finding.**

452 From the information before me, I am satisfied this failure on the night of 11 and 12 October 2023 was not an aberration.

453 I am also satisfied that had radios been used to alert staff of Cleveland's incident, his cell door would have been unlocked earlier than it actually was. However, I accept the Department's submission that:[368]

> There is no evidence to support a finding that there would have been any difference to the ultimate outcome had assistance arrived to Cleveland's cell earlier upon his self-harm being detected.

9. Cleveland's lack of access to mental health services

454 On 9 October 2023, Cleveland asked for a referral to see a psychologist and made two further requests on 10 October 2023. None of these requests was facilitated.[369] The psychologist was unable to see Cleveland on 9 October 2023 as they were tasked with another detainee, and a visit could not take place on the next day due to, "*staff being required to facilitate psychiatrist and official visits.*"[370] It is not recorded whether this reference to "*staff*" is to custodial staff. However, I am satisfied that it was as it refers to the staff being required for "*official visits*".

455 The Department has conceded that Cleveland's mental health was, "*likely to have [been] adversely impacted*" due to his inability to see a psychologist despite his requests.[371]

456 I am satisfied that Cleveland's mental health was not just "*likely*" to have been adversely impacted. From the information before me, Cleveland was not a detainee who actively sought the assistance of psychological services

[367] Ts p.144
[368] Written closing submissions from the Department dated 6 May 2025, p.37
[369] Exhibit 24, p.8
[370] Exhibit 1, Volume 8.2, Tab 1.14, p.265; Exhibit 45, p.62
[371] Written closing submissions from the Department dated 6 May 2025, p.21

during his final period of detention. On those rare occasions that he was required to see a psychologist (rather than making a request to see one), he did not always engage. That occurred on 2 August 2023 when he was seen by a clinical psychologist for the purpose of an ARMS risk assessment. The psychologist noted that Cleveland refused to answer basic questions and was not responsive in efforts to engage him.[372]

457 I am therefore satisfied that Cleveland was experiencing issues with his mental health when he made the requests to see a psychologist on 9 and 10 October 2023. When that did not occur and in light of what happened on the night of 11 and 12 October 2023, it is obvious his mental health was adversely impacted.

458 Unfortunately, the failure to provide Cleveland with access to a psychologist in the days prior to his death was not an aberration. Dr Wojnarowska detailed the following occasions when planned contact for Cleveland with mental health services during his last period of detention did not take place:[373]

- 26 July 2023: Cleveland was referred to psychological counselling, but could not be seen due to no coverage.
- 15 August 2023: Cleveland was not seen due to operational delays caused by the Children's Court affecting psychological services ability to see detainees.[374]
- 17 August 2023: Cleveland was unable to be seen due to a lack of operational staff to facilitate contact and due to a lack of confidential space to see detainees on ARMS.
- 22 August 2023: Cleveland was not seen for an ARMS assessment due to a lack of YJPS capacity at Unit 18.
- 24 August 2023: Cleveland was not able to be seen for an ARMS assessment due to TPL[375] status.
- 25 August 2023: Cleveland was not seen due to there being no YJPS coverage at Unit 18.

[372] Exhibit 24, p.7
[373] Exhibit 24, pp.7-8
[374] I am satisfied this would have been due to the same room being allocated to the psychologist and for video links to the Children's Court: Exhibit 53, p.13
[375] Temporary Placement Leave

- 28 August 2023: Cleveland could not be seen for an ARMS assessment due to operational delays in seeing detainees resulting in a lack of psychological services capacity.
- 29 August 2023: Cleveland was not able to be seen for an ARMS review due to limited YJPS capacity, limited operational capacity and prioritisation of higher-level ARMS detainees.
- 30 August 2023: Although Cleveland was seen on this occasion, an ARMS assessment was not completed due to "*prioritisation of higher level ARMS referrals and limited YJPS capacity*".
- 1 September 2023: A risk assessment could not be completed for Cleveland due to a lack of confidentiality and isolation requirements due to detainees' current illnesses.
- 11 September 2023: Cleveland was not seen due to limited operational staff availability.

459 According to Dr Wojnarowska, Cleveland ended up only being seen on three occasions by mental health services during his last period of detention in Unit 18 (which was 87 days).[376]

460 As can be seen from above, the reasons for Cleveland's inability to see a mental health service provider primarily came down to lack of adequate resourcing for Unit 18 with respect to infrastructure, custodial staff and health service providers.

461 Mr MacDonald's recollection was that he recommended two confidential rooms and the allocation of two FTE psychologists for Unit 18. However, when Unit 18 became operational, it was readily apparent that infrastructure and operational constraints meant it was not possible for two psychologists to see detainees at any one time.[377] This meant:[378]

> As a consequence of operational constraints, infrastructure limitations and staffing constraints, the role of treating psychologists at Unit 18 was practically limited to ARMS assessments and, sometimes, where possible, general supportive counselling. It was difficult to find opportunities for offence-specific counselling. On some days, the number of ARMS assessments exceeded the psychologist's capacity to provide them (noting that only one psychologist was operationally feasible at Unit 18). Likewise, operational and infrastructure constraints also prevented these assessments from occurring.

[376] On 2 August 2023, 4 and 11 September 2023: Exhibit 24
[377] Exhibit 53, p.12
[378] Exhibit 53, [66]

462 As Mr O'Siochain agreed at the inquest, by October 2023, there were many things that ought to have been happening, but they were not happening and the reason why they were not happening was due to a chronic lack of resources to make them happen.[379]

463 Or, as Ms Mitchell succinctly put it in her evidence before the CCC: "*If we do not have anything to work with, we can't work with anything.*"[380]

464 Of all the detainees in the youth custodial estate, the uncontroverted fact is that those in Unit 18 required the provision of well-resourced mental health services the most. However, as Cleveland's plight regarding access to those services shows, it was sadly lacking and made a mockery of Ms Ginbey's public pronouncement at the time of Unit 18's opening that detainees housed there would receive, "*really intensive support*".[381]

465 In her report to the Court, Dr Wojnarowska was of the view that if her diagnosis of complex post-traumatic stress disorder for Cleveland was accepted (which I have done), it was her opinion that:[382]

> … the quality of the mental health care provided to Cleveland during his period of detention in Unit 18 would not be adequate. Cleveland required trauma-informed treatment and management which would be very difficult to deliver in places like Unit 18 where even standard ARMS risk assessments have not been conducted on numerous occasions due to operational issues.

466 In relation to Cleveland's last period of detention, I accept this opinion from Ms Wojnarowska.

467 The Department accepted there were failures in the provision of psychological care to Cleveland during his last period of detention and that they were "*due to the competing demands on staff (both psychologists and operational staff) and infrastructure limitations.*"[383]

468 **I am satisfied that the Department failed to provide appropriate resources to enable detainees to have adequate mental health services provided to them during Cleveland's last period of detention. I am satisfied this failure had a significant impact on Cleveland. Accordingly, I make those findings. The Department's incapacity to arrange a psychologist's appointment for Cleveland in the days before**

[379] Ts p.2942
[380] Exhibit 1, Volume 2.1, Tab 11.1, p.49
[381] Exhibit 68.1
[382] Exhibit 24, p.13
[383] Written closing submissions from the Department dated 6 May 2025, p.45

his death (despite his three requests) is a sad example of the Department's inability to provide sufficient resources for the care and treatment of those detainees in its care who were the most vulnerable.

469 Although I agree with the Department's submission that there is insufficient evidence for me to find that Cleveland's failure to see a psychologist "*caused*" his incident,[384] I am satisfied that given the close proximity to Cleveland's incident, it most likely had contributed to it occurring.

10. Cleveland's lack of access to education

470 There was no dedicated area for education when Unit 18 opened. By October 2023 that had not changed. The first time there was a dedicated space for education at Unit 18 was on 25 March 2024,[385] which was the week before the inquest commenced.

471 During Cleveland's last period of detention, he attended education for a total of 7 hours 40 minutes over 66 school or educational days. Of that time, one hour and 25 minutes occurred with the teacher communicating with Cleveland through his cell door. The most education Cleveland received on a single day was just 45 minutes.[386]

472 I am satisfied that Cleveland requested and received educational materials whilst in his cell that is not included in the 7 hours 40 minutes of education referred to in the preceding paragraph. In addition, I am satisfied there were occasions when Cleveland interacted with teachers and that this time was also not included in this total.[387] However, it is not suggested by the Department that these occasions meant that Cleveland's access to education was adequate.

473 Detainees could only attend education classes during the time out of their cells.[388] A teacher would only attend Unit 18 between 9.30 am and 12.00 pm and 1.00 pm and 3.00 pm but not when there was staff training.[389] If a detainee was not out of their cell during those hours, they could not access education.[390]

474 As already noted, Cleveland was 16 years old at the time of his death, and was therefore of compulsory school age for the entirety of his final time in

[384] Written closing submissions from the Department dated 6 May 2025, p.21
[385] Ts p.2057
[386] Exhibit 1, Volume 8.3, Tab 1.20
[387] Exhibit 1, Volume 8.3, Tab 1.20
[388] Ts p.4302
[389] Ts p.3405; Exhibit 23
[390] Ts p.3402; Exhibit 23

detention at Unit 18. Yet he received less than three hours of education in the month preceding his incident, which was delivered in blocks of 10 or 20 minutes and often through his cell door.[391] Cleveland's access to education was further limited by the absence of any additional supports such as a speech pathologist.[392]

475 The delivery of education during Cleveland's final period of detention was impacted, like so many other services to detainees, by custodial staff shortages and other matters that stemmed from that.[393]

476 Sadly, the inquest heard evidence from Dr Cooney that there were occasions when a teacher attended Unit 18 and sat in an empty room for the day, unable to access detainees, "*hoping that they would be able to provide a service*".[394]

477 Faced with a decision to use their limited time out of their cell to recreate, participate in education, engage with programs or make phone calls to family, detainees did not always choose education. That is hardly surprising. Cleveland fell into this category as it was noted in his mentoring notes that: "*Cleveland said that he doesn't get much time out and when he does, he prefers to spend the time doing other activities with mentor like colouring or playing sports.*"[395]

478 However, at other times, despite having a limited opportunity to do so, Cleveland was "*receptive to engage in education*", and on several occasions requested that education occur through his cell door.[396] With respect to that evidence, counsel for the ALSWA submitted:[397]

> It is an unacceptable state of affairs that when a young child in detention is willing to engage with education, the best the State can provide is some handouts under a cell door.

479 I accept that submission.

480 The Department conceded that Cleveland's education during his final period of detention was "*inadequate*" and expressed its regret that he was not provided with more opportunities to engage in education which was caused by his poor out of cell hours.[398] The Department also accepted that

[391] Exhibit 1, Volume 8.3, Tab 1.20
[392] Exhibit 1, Volume 1, Tab 17
[393] Supplementary written closing submissions from the Department dated 16 June 2025, p.25
[394] Ts p.3407
[395] Exhibit 1, Volume 7.1, Tab 1.2, attachment 2, p.51
[396] Exhibit 1, Volume 5, Tab 4.4, p.2
[397] Written closing submissions on behalf of the ALSWA dated 6 May 2025, p.38
[398] Supplementary written closing submissions from the Department dated 16 June 2025, p.24

Cleveland declined to engage in education on occasions as he had limited time and "*therefore understandably chose to engage in other activities such as phone calls to family*".[399] The Department also expressed its regret that he was required to make such choices.[400] I am satisfied Cleveland should never have been placed in that position.

481 A recommendation from the *1991 Royal Commission into Aboriginal Deaths in Custody* considered the provision of education. It stated:[401]

> That Corrective Services authorities ensure that all Aboriginal prisoners in all institutions have the opportunity to perform meaningful work and to undertake educational courses in self-development, skills acquisition, vocational education and training including education in Aboriginal history and culture.

482 That recommendation is of even greater relevance to indigenous young people in detention.

483 **I am satisfied that the Department fell substantially short of providing Cleveland with the opportunity to access an adequate level of education during his final period of detention in Unit 18. Accordingly, I make that finding.**

11. Cleveland's lack of access to his YJO

484 One of the tasks of a YJO is to manage the case coordination of detainees and deliver diversionary and statutory services by assisting them and their families, with an emphasis on addressing their criminogenic needs.[402]

485 YJOs are to have regular contact with detainees who are assigned to them. The relevant manual recommends metropolitan YJOs maintain weekly contact, rotating between in-person and phone contact with the detainee. Regional YJOs should use video contact through e-Visits to maintain rapport and their regional community centre should be partnered with a metropolitan centre to provide face-to-face contact with a detainee for the purpose of supplementing the e-Visits by the regional YCO.[403]

486 Although Cleveland was assigned a regional YJO throughout the period of his last detention at Unit 18, he never had any contact with his YJO.[404]

[399] Supplementary written closing submissions from the Department dated 16 June 2025, p.24
[400] Supplementary written closing submissions from the Department dated 16 June 2025, p.24
[401] *Royal Commission into Aboriginal Deaths in Custody*, National Report, Volume 5 (1991), Recommendation 184
[402] Exhibit 23, p.27
[403] Exhibit 23, p.28
[404] Exhibit 23, p.31

Cleveland had requested to see his YJO on 19 September 2023.[405] Outlined below are the attempts made for Cleveland to speak to his YJO during his last detention:[406]

- 7 September 2023: Cleveland's YJO made a request for an e-Visit on 14 September 2023 with Cleveland (this was the first attempt by the YJO to make contact with Cleveland since 17 July 2023 when he was transferred to Unit 18).
- 14 September 2023: The proposed e-Visit was rescheduled by Unit 18 staff to 22 September 2023 due to "*operational restraints*".
- 22 September 2023: The e-Visit which was booked for 2.00 pm was rescheduled to 26 September 2023.
- 26 September 2023: No contact was made between the YJO and Cleveland. There was conflicting documentation as to the reason for this non-contact. Unit 18 records stated that the YJO failed to attend the e-Visit, whereas the YJO's case note said he had attempted to make contact for the e-Visit without success.

487 Although no further attempt was made by Cleveland's YJO to arrange contact with him before his death, the YJO did have contact with others during this period such as Cleveland's grandmother, Cleveland's lawyers and a hostel regarding accommodation options if Cleveland was to be granted bail.[407]

488 Dr Cooney accepted that with respect to contact with his YJO, Cleveland was not maintained to the standard required by the Department during his last period of detention at Unit 18. She noted there was no record of regular attempts by the YJO to arrange contact with Cleveland and no attempt by the relevant regional community centre (which was Meekatharra) to partner with a metropolitan centre to co-work in respect of Cleveland and provide some face-to-face contact.[408]

489 I am satisfied on the information before me that the YJO can be excused for not making contact with Cleveland at any stage during his final period of detention in Unit 18 for the following reasons.

490 First, the YJO was unaware of the Department's recommendation of weekly contact with detainees. He understood that the Case Planning

[405] Exhibit 1, Volume 3, Tab 10.1, p.2
[406] Exhibit 23, pp.31-32
[407] Exhibit 23, p.32
[408] Exhibit 23, p.32

section based at Banksia Hill had primary responsibility for detainees. This understanding was based on his earlier work with juveniles in community justice (dating back over 20 years ago) and that he had received no specific training or induction for his role upon commencing with the Department in April 2023.[409]

491 Secondly, this YJO had been assigned 30 cases when he commenced in April 2023. The Meekatharra Regional Community Centre had a total caseload of 51 at that time and Cleveland's YJO was often required to cover the other YJO's caseload of 21 cases due to that YJO frequently being on leave.[410] The Workload Management Strategy for YJOs sets a benchmark workload of 10-14 cases for regional YJOs.[411]

492 Dr Tomison agreed that with respect to Cleveland's lack of access to his YJO, "*the bulk of the responsibility has to lie at the Department's feet.*"[412]

493 I am satisfied the Department had an obligation to ensure Cleveland's YJO was better trained. The Department also had an obligation that it did not assign cases to the YJO at a rate of more than double the benchmark workload pursuant to the Workload Management Strategy. The Department also had a responsibility to audit, check and internally review how its staff were performing.

494 The work of a YJO in circumstances where the young person is in detention, particularly in a youth detention centre which had all the difficulties of Unit 18, could not be overstated. It was a serious failing on the part of the Department that Cleveland was not seen at any time during his last period of detention, in circumstances where he should have been seen weekly by his YJO via video contact during that period.

495 The Department accepts there was a failure that Cleveland's assigned YJO did not see him during his final period of detention in Unit 18.[413] That concession was appropriately made.

496 Although I accept the Department's submission that there was no evidence to suggest Cleveland's lack of contact with his YJO had any significant impact on him,[414] it is nevertheless another example of the lack of resources existing in the youth custodial estate at the time of Cleveland's last period

[409] Exhibit 23, p.33
[410] Exhibit 23, p.33
[411] Exhibit 23, p.28
[412] Ts p.1197
[413] Written closing submissions from the Department dated 6 May 2025, p.39
[414] Written closing submissions from the Department dated 6 May 2025, p.39

of detention. This meant that services detainees were supposed to receive to assist them whilst they were in custody were not being provided.

497 **I am satisfied that the Department failed to ensure that appropriate resources were allocated to regional YJOs during Cleveland's last period of detention. I am also satisfied the outcome for Cleveland was that his YJO had an excessive caseload which prevented him from devoting the necessary time to contact Cleveland. Accordingly, I make those findings.**

12. The failure to have adequate staffing numbers and to provide staff with appropriate experience at Unit 18

498 At the inquest, YCOs who worked at Unit 18 gave evidence of being deployed there at very short notice and with no additional training or assistance specific to the operations of Unit 18. They were also given more senior roles in an acting capacity with no induction and little to no training, other than on-the-job. This evidence was not challenged by counsel for the Department at the inquest.

499 Mr Coyne told the Court that as at the date of Cleveland's incident, 27% of the full time positions within youth detention were held by probationary officers, 44% of the Senior Officer lines were empty, 42% of the Unit Manager lines were empty and 31% of the YCO lines were unfilled. [415] Dr Tomison agreed that having those vacancy rates indicated that at the time of Cleveland's incident, the staffing situation within the Department was dire, and there had been "*staffing problems since the second half of 2021 at the very least.*"[416]

500 Mr Coyne said that for all his time as Superintendent at Unit 18 (i.e. from May 2023 to July 2024) he had never been provided with enough staff for either the day or night shifts. He understood the inability to get an adequate number of staff for these shifts had been a problem at Unit 18 since it opened.[417]

501 Mr Coyne accepted that the usual rostered staff for a night shift at Unit 18 during Cleveland's final period of detention (a Senior Officer plus four YCOs) could never safely breach a cell with an uncooperative detainee at

[415] Exhibit 1, Volume 8.1, Tab 1.0
[416] Ts pp.1267-1268
[417] Ts p.1908

night because there was insufficient staff.[418] Outside resources had to be utilised for that to happen.

502 Mr Coyne sat through the first tranche of evidence and heard the various criticisms made by custodial staff from Unit 18. He accepted it was a valid criticism that during the life of Unit 18 prior to and including Cleveland's final period of detention, it had been significantly understaffed with custodial staff. He also accepted it was a valid criticism that there was a significant shortfall in the provision of non-custodial service providers.[419]

503 In addition, Mr Coyne accepted it was a valid criticism that the Department did not have enough experienced custodial staff, with the consequence it relied upon probationary and inexperienced officers.[420] The ranking for custodial staff on the floor was probationary YCO, YCO, Unit Manger and Senior Officer. A Unit Manager is only allocated for day shifts.

504 The lack of experience of the custodial staff on duty for the night of Cleveland's incident is a perfect example:

(a) Three of the four YCOs were probationary (the only YCO not on probation was Mr Torrijos). Mr McClennan had only completed his training on 25 May 2023 (less than five months before Cleveland's incident). He had worked less than 10-night shifts before 11 October 2023.[421] Ms Priestley and Ms Hayden had each been on probation for less than one year before 11 October 2023.[422]

(b) Even though Ms Hayden was on probation, she had previously worked as a Unit Manager during the day shift in Unit 18.[423]

(c) Ms Hayden had also worked in the role of Senior Officer on a night shift when she was still a probationary YCO. She had done this twice before the night of Cleveland's incident. She expressed reluctance to do the work because of her lack of experience, but was persuaded to do so. She had a couple of hours' notice. Ms Hayden had no formal training or induction for the role. The Senior Officer from the day shift stayed back for a few hours to show her how to do the job.[424] Self-evidently, this is a most

[418] Ts p.1908
[419] Ts p.1973
[420] Ts pp.1974-1975
[421] Exhibit 1, Volume 2.1, Tab 7.3, p.3 (CCC transcript)
[422] Ts p.257
[423] Ts p.271
[424] Ts pp.278-281

unsatisfactory situation. Ms Hayden did not think it was fair that she be asked, in all the circumstances, to do such work.[425]

(d) Mr Torrijos and Mr Mead-Hunter received no additional training, assistance or preparation for moving from Banksia Hill to Unit 18.[426]

(e) Mr Mead-Hunter was an acting Senior Officer. He had also been an acting Unit Manager. He had received no training in how to perform those roles.[427] Prior to his allocation to Unit 18, he had only performed the role of a YCO at Banksia Hill.[428] For his first night shift at Unit 18 he had to perform the duties of the Senior Officer, which he learnt from the custodial staff he was supposed to be supervising.[429]

505 Mr Coyne gave evidence at the inquest that to operate Unit 18 safely at night with eight detainees would require a Senior Officer, a minimum of five YCOs, a nurse and an additional two SOG officers or prison officers.[430] He also agreed that the greater the number of detainees, the more custodial staff would be required. Unit 18 had 16 detainees on the night of 11 and 12 October 2023.

506 Mr Coyne also accepted it was a valid criticism that it had been difficult to get people to fill the more senior positions of Unit Manager or Senior Officer.[431]

507 Ms Mitchell came to work in Unit 18 in September 2022. It was intended she was to work only an initial six weeks as the Unit Manager at Unit 18. At the end of that six-week period, she remained on as Unit Manager at Unit 18.

508 Ms Mitchell was working the day shift immediately before Cleveland's incident. She only worked for a short period after the incident. Her last shift at Unit 18 was on 17 October 2023.[432]

[425] Ts p.286
[426] Ts p.67; Exhibit 1, Volume 2.1, Tab 9.4, p.69
[427] Exhibit 1, Volume 2.1, Tab 9.4, p.28
[428] Exhibit 1, Volume 2.1, Tab 9.4, p.68
[429] Written closing submissions from Mr Mead-Hunter dated 6 May 2025, p.4
[430] Ts p.1865
[431] Ts p.1975
[432] Ts p.548

509 Ms Mitchell was a witness who was able to say what it was like to work in Unit 18 and was able to describe the physical and emotional circumstances in which the detainees were kept.

510 There was no effective challenge to her evidence. I accept her account given at the inquest of what it was like to work in Unit 18 and what it was like for the detainees to live in Unit 18. Ms Mitchell also gave evidence regarding these topics at the CCC.[433] It was not challenged during the inquest.

511 Ms Mitchell's own initial experience of Unit 18 was harrowing. She received only a few days' notice of her deployment to Unit 18. She asked for orientation but did not receive it. Ms Mitchell was told she was to be the Unit Manager during the day shift. When she arrived, she was told she was not going to be the Unit Manager, she was going to be the Senior Officer for the shift. It was literally a baptism of fire, because Unit 18 was on fire following an incident the previous night.

512 Even without the complications of this major incident, the circumstances of Ms Mitchell's deployment to Unit 18 were most unsatisfactory.

513 At the inquest, counsel for the Department presumed that the reason Ms Mitchell was required to work as the Senior Officer on her first shift in Unit 18 was because the allocated Senior Officer had not come to work. Ms Mitchell said that was not the case. She explained that the way the Department structured the roster meant that for the first Monday of a new three-week roster (which was her first day), there was no Senior Officer rostered.[434]

514 Mr Mead-Hunter said that working in Unit 18 as compared to working in Banksia Hill was "*horrible*".[435] The staff were not sufficiently experienced. He told the CCC that he did not consider any probationary YCOs should be working in Unit 18.[436]

515 At the inquest, Mr Royce said it was not safe to place a probationary YCO in a supervisory role.[437] He also said it was not appropriate to place a YCO in a supervisory position at Unit 18 without an induction or orientation.[438] Those concessions were entirely appropriate.

[433] Exhibit 1, Volume 2.1, Tab 11.1
[434] Ts p.662
[435] Exhibit 1, Volume 2.1, Tab 9.4, p.5
[436] Exhibit 1, Volume 2.1, Tab 9.4, p.61
[437] Ts p.2673
[438] Ts p.2674

516 Notwithstanding the evidence as outlined above with respect to inadequate staffing numbers, and the lack of experience and lack of training for staff being assigned to more senior positions (factors which were evident regarding the night shift on 11 and 12 October 2023), the Department submitted:[439]

> Despite staff shortages creating general difficulties filling the roster, on the night of Cleveland's self-harm, the roster was filled. The staffing level on night shift at Unit 18 on 11 October 2023 was four YCOs, one senior officer (SO) and one nurse which is not of itself an inadequate level of staffing. However, the question of adequacy of staffing levels and the management of resources at any given time in Unit 18 (or in youth detention generally) is complex and subject to fluctuation.
> (underlining added)

517 The above underlined portion ignores the evidence from Mr Coyne that I have already cited as to the number of night shift staff required to operate Unit 18 safely with just eight detainees.[440] I am satisfied Mr Coyne was qualified to give that evidence given his time as the Superintendent at Unit 18 before and after Cleveland's incident. I am also satisfied Mr Mead-Hunter was suitably qualified and experienced to express his opinion regarding the unsuitability of placing probationary YCOs at Unit 18 prior to and during Cleveland's last period of detention. Given the dysfunctional and dangerous state Unit 18 was operating in at these times, that opinion was entirely reasonable.

518 The folly of the Department's submission that night shift custodial staff numbers were adequate because off-site officers could be called to assist, was demonstrated by the following evidence from Mr Coyne. He told the inquest that for the simple exercise of night shift custodial staff providing water to a detainee who was upset and disruptive because they had no water, officers from Casuarina or the SOG would have to be called to Unit 18 to breach the cell.[441]

519 I also note that shortly after Cleveland's incident, those off-site resources became permanently on-site with the placement of SOG officers at Unit 18 during day and night shifts. In those circumstances, I am satisfied I can draw the inference that the Department did not come to the realisation that the use of off-site resources was either inadequate or not appropriate until after Cleveland's incident.

[439] Written closing submissions from the Department dated 6 May 2025, p.31
[440] One Senior Officer, five YCOs, one nurse and two SOG officers or prison officers.
[441] Ts p.1911

520 **I am satisfied that the Department failed to staff Unit 18 during Cleveland's last period of detention with appropriately experienced custodial staff. On the night of Cleveland's incident, three of the four YCOs were still on probation and a YCO held the position of Senior Officer in an acting role. Accordingly, I make that finding.**

521 The evidence before me has established that this lack of experience on this particular shift was not an aberration.

522 **I am also satisfied that during Cleveland's last period of detention, the Department failed to staff Unit 18 with appropriately trained and inducted persons in positions of responsibility for shifts: namely, Unit Managers and Senior Officers. Accordingly, I make that finding.**

523 **Finally, I am satisfied that during Cleveland's last period of detention, the Department failed to have an appropriate number of staff rostered for night shifts to ensure Unit 18 was operating safely. Accordingly, I make that finding.**

524 I have no doubt that prior to and at the time of Cleveland's final detention in Unit 18, the Department was facing difficulties finding and then retaining adequate numbers of custodial officers in the youth custodial estate. Whilst that is an explanation for the parlous state of affairs that existed in October 2023 (and for some considerable period of time before then), it is not an excuse. Once the Department's Director General had determined the need for a second youth detention centre, there was an obligation to ensure there would be a sufficient number of custodial staff available to have it operate safely without the lockdowns created by continuous confinement orders.

13. The failure to provide additional training and support to custodial staff to address the very high volume of threats of self-harm and suicide at Unit 18

525 It is almost trite to say that understanding the behaviour and identifying and mitigating the risks of self-harm or suicide of detainees by custodial staff relies on these staff being adequately trained and supported.[442]

526 Dr Wojnarowska questioned whether custodial staff at Unit 18 had received the necessary training and support for the environment in which they were working as at the time of Cleveland's last detention:[443]

[442] Written closing submissions from the ALSWA dated 6 May 2025, p.77
[443] Exhibit 24, [82]

> It is also evident that the staff who have been dealing with extreme behaviours of [a] very distressed and disturbed population in Unit 18, have not been provided with adequate training, support and supervision. Of a specific note is the enormous pressure placed on custodial officers who are manning the cell calls and who are expected to respond adequately to numerous threats of suicide of young people without having enough man force to attend to each and every repeated threat.

527 Dr Wojnarowska also identified another issue facing custodial staff who worked after-hours and/or in the absence of psychological services:[444]

> The other issue requiring addressing is the quality of support the self-harming/suicidal detainees receive after-hours or when psychological services were not available which was more frequently than not due to operation[al] issues. On the night Cleveland attempted suicide, the level of acuity in Unit 18 was equal to or exceeded that seen in acute psychiatric facilities. A duty officer on call was left to respond to numerous calls from suicidal detainees, counsel them and assess who required the immediate assistance. This task would be unmanageable even by a professional mental health worker.

528 Mr Mead-Hunter said that "*self-harm was so common for the kids at Unit 18*" and that "*self-harm (and threats of self-harm) were an almost daily occurrence*".[445] He said that notwithstanding the prevalence of self-harm in Unit 18, there was no guidance from the SMT for managing or responding to such incidents, and he responded to incidents as he saw fit and to the best of his ability.[446] Mr Mead-Hunter said that in circumstances where custodial staff did not determine a threat to be a "real threat", they referred it to him for evaluation.

529 Ms Hayden did not consider that YCOs had adequate training to assess whether self-harm threats were genuine.[447] When asked what tools or training YCOs were given to assess whether or not a threat of self-harm was genuine, Mr Coyne told the CCC: "*Look, life experience, to be honest.*"[448]

530 At the inquest, Dr Tomison accepted that the Department "*could've done better*" in relation to providing training around the trauma and mental health issues of the detainees in Unit 18.[449] The Department also accepted that its

[444] Exhibit 24, [74]
[445] Exhibit 82, [134]-[135]
[446] Exhibit 82, [158]
[447] Ts p.367
[448] Exhibit 22, [87]
[449] Ts p.943

training to staff around issues of trauma and dealing with mental health of young people "*can be improved*".[450]

531 I accept that at the relevant time the Department's entry level training program (ELTP) included courses relating to youth mental health, suicide prevention training and instructions regarding ARMS. In addition, beyond the ELTP, the Department provides ongoing training to YCOs and yearly refresher training for requalification. It also regularly reviews, updates and enhances its training programs

532 Given those circumstances, the Department submitted that its training for YCOs in relation to dealing with threats of self-harm and suicide was adequate.[451]

533 I am satisfied the Department's training of its YCOs with respect to threats of self-harm/suicide or actual self-harm by detainees would be adequate in the environs of Banksia Hill as the ARMS Youth Manual could be implemented more effectively. However, Unit 18 was starkly different at the time of Cleveland's last detention there.

534 It is clear from the information available to me that the sheer weight of threats of self-harm or suicide and actual self-harm in Unit 18 required additional training and support for custodial staff to deal with this constant demand. The overwhelming number of those incidents meant that the procedures outlined in the ARMS Youth Manual regarding detainees deemed to be at high risk of self-harm or suicide could not be followed. As the CCC found:[452]

> Plainly, DOJ[453] policies and procedures require threats of self-harm to trigger a reporting process. The Commission is satisfied that at Unit 18 those requirements were not always followed by the YCOs. They were certainly not followed by the YCOs working on the night of 11 October 2023. That appears to be largely due to the volume of the threats of self-harm.

535 The information available to me supports those findings by the CCC. Indeed, the Department itself has accepted its policies and procedures regarding threats of self-harm were not always followed during Cleveland's

[450] Written closing submissions from the Department dated 6 May 2025, p.39
[451] Supplementary written closing submissions from the Department dated 16 June 2025, p.12
[452] Exhibit 22, [92]
[453] Department of Justice

last period of detention and that this, "*was largely due to the volume of threats of self-harm which were received.*"[454]

536 It was therefore imperative that the Department provided additional training and support to the custodial officers on the ground at Unit 18 to enable them to deal with the large volume of these threats. The additional support ought to have included increased availability of custodial and non-custodial staff to manage the high level of detainees deemed to be at risk of self-harm and/or suicide.

537 **I am satisfied that the Department failed to provide additional training and/or support to custodial staff at Unit 18 with respect to the high number of threats of self-harm or suicide and actual self-harm by detainees. Accordingly, I make that finding**.

538 It was simply not appropriate for the Department to expect YCOs at Unit 18, many of whom were very inexperienced, "to do the best they could with what they had". Sadly, the Court frequently heard that phrase or iterations of it, from custodial staff working at Unit 18 during Cleveland's last period of detention.

14. <u>The failure to implement a model of care at Unit 18</u>

539 When I refer to a model of care in this section, I am referring to a document that provides "*high-level principles for the care and management of young people in detention*".[455]

540 The evidence at the inquest revealed that there was no model of care at Unit 18 when it opened in July 2022.[456]

541 When Ms Maj gave evidence at the inquest in August 2024, she confirmed that Unit 18 still did not have a model of care.[457]

542 Indeed, as at December 2024 (nearly 2½ years after Unit 18 was opened), Unit 18 did not have an operational philosophy or a model of care. Ms Butt told the inquest that her understanding of the documents prepared by Nous Group (Nous) outlined a model of care that was specific to Banksia Hill and did not apply to Unit 18.[458]

[454] Supplementary written closing submissions from the Department dated 16 June 2025, p.13
[455] Exhibit 27, [6]
[456] Ts pp.1188-1189
[457] Ts p.2730
[458] Ts p.4118

543 It was the Department's submission that as the plan was only to operate Unit 18 as a temporary facility for 12 months, it was not necessary to implement a model of care.[459] The Department noted that as late as October 2023, Ms Ginbey believed Unit 18 would be closed once the infrastructure works were completed following the major disturbance at Banksia Hill in May 2023.[460] The Department contended that:[461]

> The 'way' care was provided at Unit 18 during the time of Cleveland's final period of detention included the policies, procedures and training, and the staff and services available on the ground and upon request at Unit 18.

544 However, there are three problems with that submission. First, the Briefing Note stated: "*The model of care in Unit 18 will be therapeutic and trauma-informed, not punitive or as punishment.*"[462]

545 Secondly:[463]

> The evidence establishes that the operational model of Unit 18 was primarily focused on security, and that the provision of services to young people was seen as contingent on and secondary to, the security and operational imperatives.

546 Notwithstanding the Department's submission to the contrary, I agree with that submission from counsel for Nadene Dodd.

547 Thirdly, although the "Banksia Hill Detention Centre Unit 18 Operating Model dated 10 July 2022" (the Operating Model) had been prepared for Unit 18 by Christopher Rule (the Deputy Superintendent at Banksia Hill at the relevant time), the various versions of that document[464] did not have the features of an operational philosophy and/or model of care as set out in the documents prepared by Nous that emphasised a trauma-informed, culturally safe and therapeutic approach to the care of detainees. Indeed, the Department has accepted that the Operating Model was not the equivalent of a model of care.[465]

548 Even before Unit 18 had begun operating, Nous had been engaged by the Department to prepare the model of care for youth detention. Tim Marney,

[459] Written closing submissions from the Department dated 6 May 2025, p.46
[460] Exhibit 145.3, [22.4]
[461] Written closing submissions from the Department dated 6 May 2025, p.46
[462] Exhibit 1, Volume 6.1, Tab 1.6, p.7
[463] Written closing submissions on behalf of Nadene Dodd dated 7 May 2025, p.43
[464] See Exhibits 70.1-70.6
[465] Written closing submissions on behalf of Nadene Dodd dated 7 May 2025, p.116

the principal consultant at Nous, subsequently prepared the following documents:

- Banksia Hill's Operating Philosophy and Service Model – Best Practice Review dated 4 February 2022.[466]
- Banksia Hill's Operating Philosophy and Service Model – Implementation Plan dated 16 May 2022.[467]
- Banksia Hill's Operating Philosophy and Service Model dated 17 May 2022 (the OPSM).[468]

549 The OPSM sets out a model of care and it has been made operational through the Department's "Model of Care Instruction" document.[469] This streamlined version of the OPSM had been prepared by Ms Butt and was approved by the Department on 21 December 2023.[470] This model of care is described as being, "*the way care is provided to young people and their family and extended families, and the role of staff and partners in the young person's time in detention*".[471]

550 The Department has accepted, "*that dedicated implementation of the OPSM would have been of benefit to the operation of Unit 18.*"[472] That concession was appropriately made.

551 I am satisfied it was not appropriate for Unit 18 to be operating without an operational philosophy or model of care that emphasised a trauma-informed, culturally safe and therapeutic approach to the management and care of detainees. Accordingly, I make that finding.

15. <u>The failure to be able to adequately monitor detainees on level 1 ARMS</u>

552 The dangers of covered CCTV cameras in cells for detainees on high level ARMS were strikingly illustrated less than 12 hours before Cleveland's incident.

553 TW had been on level 4 ARMS at the time of his self-harm incident using the damaged ceiling vent in his cell. After this incident, Ms Mitchell, as the Unit Manager, directed that TW's ARMS status be raised to level 1. This, of course, meant TW required constant observations.

[466] Exhibit 27.1
[467] Exhibit 27.2
[468] Exhibit 27.3
[469] Exhibit 27.4
[470] Exhibit 27, p.2
[471] Exhibit 27.4
[472] Written closing submissions from the Department dated 6 May 2025, p.46

554 However, TW remained in the cell in which he had attempted self-harm. Ms Mitchell explained she left TW in the same cell because it had a fully functioning CCTV camera, he had access to running water and the cell had a flushing toilet. She said the cell was quite clean and had no uneaten food or other rubbish in it.[473]

555 By the time of the inquest, Ms Mitchell knew that the CCTV camera in TW's cell remained covered for the entire period he was on level 1 ARMS. She did not recall if any staff brought that to her attention at the time. Ms Mitchell said that she would expect the staff to have tried to gain TW's compliance to remove the toilet paper when they became aware of it being covered.[474]

556 The inquest was also aware that TW's intercom was not working either at the time he self-harmed or after the self-harm incident when he remained in his cell, and that it had not been working for about a week.[475]

557 The information available to me is that the CCTV camera in TW's cell was covered throughout the night shift of 11 and 12 October 2023, until just before the start of the day shift on 12 October 2023. Mr Torrijos said that during the night he spoke to TW frequently.[476]

558 By the time of Cleveland's last period of detention, it was readily apparent to custodial officers such as Ms Mitchell that cells with their CCTV cameras covered were not fit for detainees on level 1 ARMS.[477] She said that she had raised that repeatedly with four Senior Officers at Unit 18 prior to Cleveland's incident.[478]

559 I am satisfied that Mr Torrijos from the commencement of the night shift on 11 and 12 October 2023 and Mr Mead-Hunter from sometime during the shift, became aware TW was supposed to be on continuous observations. Both these custodial officers described the inability to undertake such observations in Unit 18.

560 Mr Torrijos said there was "*no sense at all*" in placing a detainee in Unit 18 on level 1 ARMS because of this inability.[479]

[473] Ts p.569-570
[474] Ts pp.573-575
[475] Exhibit 1, Volume 2.1, Tab 2, p.13
[476] Ts p.109
[477] Ts p.592
[478] Ts p.592
[479] Ts p.111

561 After Cleveland's incident and before his death, the Department undertook an audit of compliance with clause 5.2 of COPP 14.3 which required cell CCTV cameras to be uncovered. The SMT were advised of the results of that audit on 19 October 2022. The audit revealed:[480]

> Direct observations at Unit 18 confirmed that between 10 and 11 October 2023 – 13 out of 16 detainees had their CCTV cameras covered, and staff were not actively asking the detainees to uncover the cameras. In addition, staff were not observed to enter the cell to ensure the CCTV was uncovered and no TOMS incident reports were submitted.

562 I am satisfied on the information available that the outcomes of the audit conducted for 10 and 11 October 2023 were typical of what was occurring during Cleveland's last period of detention. I also accept the evidence from the custodial officers at Unit 18 of the impracticalities complying with the policies and procedures for a detainee who was (or should have been) on level 1 ARMS.

563 The Department made the following submission (footnotes omitted):[481]

> The evidence shows that the Department considered, as reflected in its official policies, that:
>
> a. Every incident or threat of NSSI or suicide should be treated with equal care, monitoring and support, regardless of the perceived motivation or intent;
>
> b. Any young person who threatened or attempted suicide or threatened or engaged in NSSI was to be placed on ARMS level 1, which required uninterrupted, constant observation of the young person; and
>
> c. The welfare of [a] young person following a threat to, or an actual incident of NSSI is paramount and that regardless what view might be taken of their motives for the threat or incident, a young person who threatens to or has harmed themselves in any way is not to be left unattended under any circumstances.

564 If "*the evidence*" that the Department relies on for this submission is a reference to the provisions of the ARMS Youth Manual, then the above is an accurate summary which I have no hesitation in accepting.

565 However, the information before the Court about how detainees at a high risk of self-harm or suicide were supervised and cared for in Unit 18 during Cleveland's final period of detention paints a completely different picture.

[480] Exhibit 1, Volume 7, Tab 2.1.5, attachment 5A
[481] Written closing submissions from the Department dated 6 May 2025, p.33

That is not a criticism of the custodial staff who worked "on the floor" or the SMT. The conditions they worked in made it extremely difficult, and at times impossible, to adhere to the requirements of the ARMS Youth Manual. The responsibility for that lies squarely with the Department.

566 In the ARMS Youth Manual's Executive Summary section, it is stated: [482]

> The Department of Justice is committed to maintaining a safe environment for young people and providing a clear and transparent risk management approach in the centre.[483]

567 These commitments were merely aspirational in Unit 18 by the time of Cleveland's last detention. I am satisfied there was an abject failure by the Department to achieve the objectives cited above with respect to its care, treatment and supervision of Cleveland and the other detainees during that time who had been classified (or should have been classified) under the ARMS Youth Manual as being at high risk of self-harm and/or suicide.

568 The circumstances that TW was in following his self-harm incident on 11 October 2023 was definitely not "*a safe environment*". Although he was correctly elevated to level 1 ARMS, TW remained in a cell (i) with an effective ligature anchor point he had recently used, (ii) that had its CCTV camera covered, making monitoring by that means impossible, and (iii) with a broken intercom which meant he and custodial staff in the control room were unable to communicate.

569 The risk management approach that involved intermittent checks of TW by YCOs from his cell door during the night of 11 and 12 October 2023 fell substantially short of what was required to monitor a detainee on level 1 ARMS under the ARMS Youth Manual.

570 I am satisfied that during Cleveland's last period of detention, Unit 18 was unfit to adequately care, treat and supervise detainees at high risk of self-harm or suicide. Accordingly, I make that finding.

571 This unfit state was primarily because of the inability to adhere to the policies and procedures set out in the ARMS Youth Manual. That was largely due to not only a lack of custodial staff, but also to an insufficient number of non-custodial support staff who had duties to perform under the ARMS Youth Manual.

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[482] Exhibit 29, Tab 13, p.8

[483] Although this reference to "*the centre*" concerns Banksia, it is not disputed that the ARMS Youth Manual also applied to Unit 18.

572 And when the limitations that existed regarding the infrastructure at Unit 18 are added (such as there being no discrete medical section, no dedicated room for mental health service providers, and limited recreational space), the extent of the unfit nature of Unit 18 for detainees at high risk of self-harm or suicide during Cleveland's last period of detention is simply magnified.

573 Finally, I am satisfied that this finding is sufficiently connected to the circumstances of Cleveland's death as he was not dealt with in accordance with the ARMS Youth Manual on the night of 11 and 12 October 2023. From the information before me, I am satisfied this was not an aberration but rather a reflection of how Unit 18 was often operating during Cleveland's last period of detention.

574 The adverse finding I am satisfied can be made against Dr Tominson is addressed below.

Dr Tomison

1. <u>The failure to have adequate staffing numbers at Unit 18 by the time of Cleveland's last period of detention</u>

575 I acknowledge the potential reputational damage that Dr Tomison may sustain as a result of an adverse finding against him.[484] It is therefore important that I state the following at this point.

576 Dr Tomison gave his evidence at the inquest in a most commendable manner. I found him to be a truthful and credible witness who accepted responsibility for the Department's and his own actions; even when doing so was potentially against his interests. This can only reflect favourably on Dr Tomison and the finding I have made against him should in no way overshadow the invaluable assistance he provided to the Court with his evidence.

577 I was also impressed with Dr Tomison's heartfelt and sincere apology to Cleveland's family, which he gave unprompted very early in his evidence at the inquest:[485]

> So, Nadene and family, I'm truly sorry about what happened with Cleveland. It's ultimately just a total tragedy. I wish it didn't happen. I wish I could take it back, but I can't, and I'm extremely sorry for what

[484] Written closing submissions from Dr Tomison dated 6 May 2025, [28]
[485] Ts p.948

> you've gone through. All I can say is you've got my deepest condolences and the Department and I failed you. And I'm sorry about that.[486]

578 Before Cleveland's last period of detention, the two significant Supreme Court decisions regarding the Department's conduct in ***VYZ*** and ***CRU*** had been handed down. Dr Tomison was named as the First Respondent in both proceedings.[487] There were a number of clear messages for Dr Tomison from these two decisions; one of those was that the presiding judge in both proceedings had taken a very dim view of the Department's practice of regularly confining all detainees in their cells for extended periods of time.

579 Yet despite that clear message, this practice continued until Dr Tomison's resignation in late January 2024. It finally stopped in August 2024 (and only after the practice had been carefully scrutinised at the inquest).

580 The detainee identified as VYZ was detained on remand in Banksia Hill between 20 January 2022 and 19 July 2022. During that period there were days where he was locked in his cell for periods of more than 20 hours and, on some days, for between 23 and 24 hours.

581 VYZ applied for a declaration in the Supreme Court that locking him in his cell on the days specified in his application were not authorised under the *Young Offenders Act 1994* (WA) and were therefore unlawful. He had not been locked in his cell for any breach of discipline and had been confined to his cell through what was described in the proceedings as "*rolling lockdowns*".[488]

582 On 25 August 2022, Tottle J handed down the Supreme Court's decision which included the finding that the respondents did not have the authority to lock the applicant in his cell on the days specified in the application. A declaration was made to that effect.

583 I accept the submissions from the Department at the inquest that ***VYZ*** primarily involved a determination that section 11D of the *Young Offenders Act 1994* (WA) was not a source of power to make confinement orders. I also acknowledge that this section was not used to make any confinement orders that impacted Cleveland during his last period of detention.[489]

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[486] Mr Tomison then explained that what he meant when he said the Department and he failed: "*Well, Cleveland self-harmed. And obviously the result is that we have an inquest. That's a failure in itself, but the fact that it got so far that this young man has taken his life is a failure.*": Ts p.948

[487] The other respondent in ***VYZ*** was the Superintendent of Banksia Hill. The other respondents in ***CRU*** were the respective Superintendents of Banksia Hill and Unit18 and included Mr Coyne.

[488] ***VYZ by next friend XYZ v Chief Executor Officer of the Department of Justice*** [2022] WASC 274, [5]

[489] Supplementary written closing submissions from the Department dated 16 June 2025, p.43

584 However, what Tottle J said in his judgment ought to have set the alarm bells ringing for the Department and Dr Tomison regarding the prolonged use of confinement orders that were imposed on every detainee in a youth detention centre. His Honour stated:[490]

> *First*, confining detainees or prisoners to their sleeping quarters or cells for long hours is a distinct form of confinement which involves a significant reduction in liberty and amenity. It is a severe measure. Confining children to their sleeping quarters in a detention centre for long hours, thus effectively confining them in isolation, can only be characterised as an extraordinary measure - one that should only be implemented in rare or exceptional circumstances. Among the many reasons why it should be so characterised is because of the very significant harm such confinement can do to children in detention, many of whom are already psychologically vulnerable. Further, the Act[491] recognises that young people have a different sense of time, and it is a significantly more difficult and challenging experience for a young person to spend 24 hours in isolation that it is for an adult.
>
> … framing the practice of locking detainees, who are children, in the sleeping quarters for between 20 and 24 hours a day on a regular basis, by reference to an inability to provide "optimal services", grossly distorts the perspective from which the practice should be assessed. …
>
> *Secondly*, it may be accepted that it is not the role of the court to become involved in the management of detention centres and prisons. It is important to state, however, that there is no general principle that decisions made in good faith by those responsible for the administration and management of prisons are not susceptible to judicial review. Indeed, the respondents accepted that the courts may intervene when the actions of prison authorities are unlawful and beyond power.
> (underlining added)

585 In the judgment, Tottle J summarised the respondents' 13 principal contentions. Included in those contentions were the following:[492]

> (i) In the event that the court concludes that the applicant has been confined to his sleeping quarters in circumstances which make this action unlawful, no declaration should be made in the exercise of the Court's discretion.
>
> (j) The courts have no legitimate involvement in the review of the bona fide acts performed by persons involved in the administration of detention centres in the course of steps taken to avoid injuries to a detainee or detainees generally as opposed to steps taken to punish a detainee which

[490] ***VYZ by next friend XYZ v Chief Executor Officer of the Department of Justice*** [2022] WASC 274, [71]-[73]
[491] *Young Offenders Act 1994* (WA)
[492] ***VYZ by next friend XYZ v Chief Executor Officer of the Department of Justice*** [2022] WASC 274, [69]

> would attract review. … In the absence of any evidence of bad faith the court should not grant declaratory relief.
> …
>
> (l) The consequences of the relief, if granted, would be disproportionate to the consequences of the unlawful decision, and therefore against the public interest. Accordingly, the relief sought should not be granted. (citations omitted)

586 At the inquest, Dr Tomison accepted he gave the instructions to make the above submissions on behalf of the Department.[493]

587 Tottle J categorically dismissed these three contentions. Under the heading "Declaratory relief should be granted", his Honour said in the judgment:[494]

> I do not accept the respondents' contention that even if the court concluded that confinement of the applicant to the sleeping quarters in the manner described in these reasons was not authorised by the Act the court should decline to grant declaratory relief because "locking detainees in their sleeping quarters is a regular occurrence" and the practical problems that granting a declaration would create would be "disproportionate to the consequences of the unlawful decision". Read in one way the submission might be understood to suggest that even if the practice of locking detainees in their sleeping quarters was beyond the respondents' statutory power, it is a practice that would continue unless a declaration was made. If that is the way in which the submission was intended to be understood it is to be deprecated in the strongest terms.
>
> I accept that granting declaratory relief may cause practical problems especially in the light of the chronic staff shortages referred to in the evidence and that is a matter that cannot do otherwise than weigh heavily. So too, however, does the harm that may be caused to detainees by confining them to their sleeping quarters on a regular basis for long hours in the manner in which the applicant was confined. That harm may affect the lives of detainees for years to come. Ultimately, the answer to the concern about practical problems is that the Detention Centre must be administered in accordance with the Act and the Regulations. The chief executive officer[495] is under a statutory duty to administer the Act in accordance with its terms and is empowered to appoint such officers as is necessary for that purpose. It is simply not open for those who are responsible for the care and welfare of detainees to adopt practices which are not authorised by the Act.

[493] Ts p.972
[494] ***VYZ by next friend XYZ v Chief Executor Officer of the Department of Justice*** [2022] WASC 274, [87]-[89]
[495] i.e. Dr Tomison

> It follows that I do not accept that it is not in the public interest to grant declaratory relief. To the contrary, the public interest in granting relief is compelling. The potential for considerable harm to be suffered by detainees who are confined to their sleeping quarters for periods of almost 24 hours a day on a regular basis is ample justification for granting declaratory relief.
> (underlining added)

588 Following this decision, the Department continued to make daily confinement orders which applied to every detainee in Banksia Hill and Unit 18. However, it did so by using Regulation 74(2) of the *Young Offenders Regulations 1995* (WA) (Regulation 74(2)) which stated:

> A superintendent may order that a detainee be confined to that detainee's sleeping quarters or to a designated room in order to maintain good government, good order or security in a detention centre.

589 Regulation 79 of the *Young Offenders Regulations 1995* (WA) set out the confinement procedures to be followed in respect of "*good government, good order or security confinement*". Regulation 79(4) of the *Young Offenders Regulations 1995* (WA) (Regulation 79(4)) provides: "*a detainee whose confinement is for 12 hours or longer is entitled to at least one hour of exercise each six hours during unlocked hours*."

590 This meant detainees were confined in their cells by themselves for up to 23 hours per day. That was because the period defined by the Department for "unlocked hours" per day was about 11 hours 15 minutes.[496] This meant the Department was able to comply with Regulation 79(4) if a detainee received at least one hour of exercise for each day that a confinement order was imposed.

591 ***CRU*** was also heard by Tottle J and the judgment was delivered on 11 July 2023. This was six days before Cleveland's final period of detention and 11 months after the decision in ***VYZ*** was handed down. From the available information before me, there was no reduction in the number of confinement orders that were imposed on every detainee in Unit 18 during this period.

592 As in ***VYZ***, Dr Tomison was named as the First Respondent by the three applicants in ***CRU***. One of these applicants had been detained in

[496] Supplementary written closing submissions from the Department dated 16 June 2025, p.36

Banksia Hill and the other two were detained at times in both Banksia Hill and Unit 18. As Tottle J summarised in the judgment:[497]

> The periods of confinement in question were not periods of confinement imposed as punishment for the commission of detention offences. The applications concerned periods of confinement resulting from "rolling lockdowns". This term describes the practice of confining detainees in their cells during those hours when they would otherwise be allowed to leave their cells and engage in educational or recreational activities. Detainees are released on a unit by unit or cell by cell basis for brief periods only before being confined again. The source of the authority relied on to confine detainees during a rolling lockdown is reg.74(2) that authorises the superintendent of a detention centre to make an order confining a detainee to his or her sleeping quarters as a way of maintaining good government, good order or security of a detention centre. Regulation 79 sets out the procedures to be followed if an order for confinement under reg.74(2) is made. Among other matters the procedures provide that a detainee whose confinement is for 12 hours or longer is entitled to at least one hour of exercise each six hours during "unlock hours".

593 Tottle J granted the applications and made declarations, together with injunctions. The declarations were based on whether a confinement order had been made for the day in question or, if it had been made, whether Regulation 79(4) had been complied with regarding the required time for exercise on each of those days. His Honour concluded:[498]

> I find that HBS was confined in her cell unlawfully on 12 days, that OPS was confined to his cell unlawfully on 133 days and that CRU was confined to his cell unlawfully on 22 days. The periods of confinement were unlawful either because no order for confinement had been made or, in the case of OPS and CRU, they were deprived of their entitlement to exercise. I will make declarations in accordance with these findings.
>
> In addition, I will grant the injunctive relief in terms substantially as sought by HBS and OPS.

594 As was done in ***VYZ***, Tottle J again reminded the Department and, as he was a respondent, Dr Tomison, of the dangers of rolling lockdowns:[499]

> The Act[500] includes a statement of its objectives and a statement of the general principles that must be observed in the performance of the

[497] ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [4]
[498] ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [11]-[12]
[499] ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [5]-[10]
[500] *Young Offenders Act 1994* (WA)

> functions for which it provides including the detention of young persons. These emphasise the importance of rehabilitating young offenders, providing them with an opportunity to develop a sense of social responsibility, and otherwise develop in beneficial and socially acceptable ways. The objectives and general principles contain clear statements that young offenders are not to be treated more severely than adult offenders, that they are to be dealt with in a cultural appropriate manner which recognises and enhances their cultural identity and that the legal rights of young persons are to be observed.
>
> Assessed against the objectives and governing principles enshrined in the Act, the imposition of frequent periods of solitary confinement on young people evidences a systemic failure. The seriousness of the systemic failure is made manifest by the recognition that solitary confinement is an exceptional form of detention rarely sanctioned even in adult prisons and is reinforced by the frequency of the occasions on which the applicants were subjected to such confinement. ...
>
> Subjecting young people - children - to solitary confinement on a frequent basis is not only inconsistent with the objectives and principles of the Act but also with basic notions of the humane treatment of young people. It has the capacity to cause immeasurable and lasting damage to an already psychologically vulnerable group. Depriving children of the opportunity to socialise by confining them in their cells for long hours is calculated to undermine the development of a sense of social responsibility and frustrate the Act's objective of rehabilitation.
>
> …
>
> The causes of the systemic failure are an endemic shortage of suitably qualified staff, inadequate infrastructure and a consequent inability to manage detainees with difficult behavioural problems. It is beyond the court's power to grant remedial orders addressing these causes. No order this court can make within the proper exercise of its powers has the capacity to prevent rolling lockdowns from occurring in the future. … I am compelled to add, however, that I very much doubt that Parliament envisaged that a superintendent's power to order a young person to be confined in his or her cell would be exercised as frequently or in the circumstances in which it has, and is likely to continue to be, exercised.
>
> …
>
> Remedying the system to ensure that rolling lockdowns do not occur is a matter for the executive government which, of course, is obliged to administer all aspects of juvenile justice in this State as Parliament intended, that is, in accordance with the Act, its objectives and governing principles.
>
> (underlining added)

595 Tottle J made it clear that the applications in ***CRU*** were decided on the basis that if a confinement order had been made and a detainee was given the

opportunity to exercise as required by Regulation 79(4), then the confinement was lawful.[501] Although his Honour observed:[502]

> It is, however, at least questionable whether pt 9 of the Regulations confers power to confine groups of detainees or all detainees in a detention centre to their cells at the same time under the power conferred by reg 74(2).
>
> Notwithstanding that s 10(c) of the *Interpretation Act 1984* (WA) provides that a reference to "a detainee" includes "detainees" there are indications in the Regulations that the power conferred by reg 74(2) is to be exercised in respect of an individual detainee as opposed to groups of detainees or an entire detention centre.[503]

596 As this matter was not argued before the Supreme Court, Tottle J did not have regard to it in the disposition of the applications.[504]

597 In the judgment's concluding remarks, Tottle J could not have made it any clearer as to the position the Supreme Court was taking with respect to the plight of detainees solitarily confined to their cells for extended periods:[505]

> … the evidence adduced by the applicants leaves no room for doubt that prolonged confinement due to rolling lockdowns causes serious harm to the physical and psychological health of detainees. …
>
> Relatedly, the grant of injunctive relief serves to emphasise that regular periods of prolonged confinement are not to be regarded as the norm and that allowing detainees out of their cells to exercise is not to be regarded as an aspiration rather than a statutory requirement.
>
> … I stress again the entitlement to exercise conferred by reg 79(4) is an absolute entitlement and not subject to any implied limitations. As I said earlier this may appear harsh, but it is not sufficient for the superintendents and their staff to do their best in difficult circumstances - the requirements of the Regulations must be observed.
>
> I appreciate that as recently appointed superintendents Ms Lancaster and Mr Coyne have inherited very difficult situations that are not of their making but they are the persons who are in charge of the detention centres. Further the first respondent, under the direction of the Minister, is subject to the duty to carry into operation the provisions of the Act so far as that

[501] ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [47]
[502] ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [47]-[48]
[503] Tottle J then cited five indications: ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [48]
[504] ***CRU by Next Friend CRU2 v Chief Executive Officer of the Department of Justice*** **[2023] WASC 257** [49]
[505] ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [188]-[191]

> duty is not committed to any other person. In short, the respondents have statutory responsibilities and must administer the detention centres in accordance with the Act and the Regulations and in that endeavour they are supported by the resources of the State.

598 The unchallenged evidence at the inquest from those custodial officers working at Unit 18 was that there was a particular emphasis on one or two detainees having two hours of exercise every day when a confinement order was imposed.[506] I am satisfied that these detainees were very likely the applicants in the Supreme Court proceedings. As to the balance of detainees, the direction to the YCOs was that they must have the opportunity to exercise for at least one hour every day. However, as can be seen from Cleveland's prolonged periods of detention in his cell, that did not always eventuate for him.[507]

599 I am satisfied that the detainees who had been successful applicants in the Supreme Court proceeding were afforded the "luxury" of two hours of daily exercise as that was the minimum requirement for out of cell hours to ensure compliance with the Beijing Rules. However, the Department does not consider it is required to follow the Beijing Rules (or the Mandela Rules), even though Australia is a signatory to both. Consequently, the vast majority of detainees could only hope to have at least one hour of exercise each day outside of their cell whenever a confinement order was imposed (as required by Regulation 79(4)).

600 At the inquest, Dr Tomison was questioned about the Supreme Court proceedings of ***VYZ*** and ***CRU***. As to the submissions by the respondents already referred to that were made on his instructions in ***VYZ*** and emphatically rejected by Tottle J, Dr Tomison was asked:[508]

> Do you accept it is a valid criticism to say, it is quite extraordinary for a government department to go to the Supreme Court and say, "even if you find that we are doing the wrong thing, don't make a declaration to that effect because we are not going to be able to comply with it"?--- I accept it is a valid criticism.

601 That concession by Dr Tomison was entirely appropriate. I find it most disquieting that the three contentions in ***VYZ*** that I have already cited above were made. It is of considerable concern that a government department entrusted with the care of the State's most vulnerable children would effectively say there is no option other than to maintain the longstanding

[506] For example, the evidence of Ms Mitchell: Ts p.566-567
[507] Exhibit 1, Volume 8.1, Tab 1.3, pp.3-5
[508] Ts p.973

practice of keeping these children confined in their cells for prolonged periods day after day.

602 What was also concerning was Dr Tomison's response to the decisions by Tottle J. His evidence at the inquest was not that his most significant concern was addressing the excessive use of confinement orders that the Supreme Court had described as a "*systemic failure*". Rather, Dr Tomison said, "*my biggest concern with **VYZ** was, how do we make these confinement orders operate? Because we have to keep using them for a while.*"[509] And:[510]

> The bigger issues I had was, how are we going to comply? If we are using these lockdowns - and I agree it was excessive - how are we going to comply with the legislation? I don't want to be unlawful. What can we do? And it was essentially a message of, try to find a solution. Because if we get the decision we got, we had to comply. I accept it.
> (underlining added)

603 Unfortunately, the "*solution*" that was found did not address the "*excessive*" use of lockdowns through confinement orders which continued to be used relentlessly. Instead, the provisions of Regulation 74(2) were invoked and used with monotonous regularity in Unit 18 during Cleveland's last period of detention.

604 As identified by Tottle J, a major reason for the use of lockdowns was staffing issues. Not surprisingly, at the inquest, Dr Tomison agreed:[511]

> Do you accept that the principal reason you couldn't comply with the law, you didn't have enough staff to get these people out for the bare minimum of time? That was the principal reason? --- Certainly, one of the main reasons. Yes.

605 Counsel assisting explored the issue of staff shortages further:[512]

> But isn't the problem that the Department, and you as its head, were asleep at the wheel? Because the staffing problem didn't eventuate overnight. The staffing problem just kept building and building and building. And the starkness of the problem manifests itself in 2022, in 2023. That is the kernel of this problem, isn't it? --- I think it is certainly one of the main areas. Certainly.
>
> And the people who could do something about the staffing problem were people within the Department? --- Yes. And we did do things as well, but

[509] Ts p.973
[510] Ts p.973
[511] Ts p.974
[512] Ts pp.974-975

> we didn't start early enough. We let it build, as you said, and it took time to actually replace the staff and the attrition we had.
>
> Yes. Too little too late? --- I don't think it was too little, but certainly it started too late.

606 That was an appropriate concession from Dr Tomison.

607 Dr Tomison acknowledged that even before Unit 18 was established, lockdown regimes at Banksia Hill were being overused, "*precisely because there was a staff shortage.*"[513] He also recognised there were different types of lockdowns involving a rolling lockdown through a site, a lockdown of a whole wing, or a lockdown of the whole facility; and that he understood each of these types of lockdowns were used at Banksia Hill before Unit 18 was established. Dr Tomison accepted, "*that each of those types of lockdowns, upon reflection, were excessively used and that the criticism they were excessively used is valid*."[514]

608 Dr Tomison accepted that whilst some of the reasons for confinement orders were justified (e.g. disruptive incidents or so that visits could occur), "*the actual total number of those orders I think is unreasonable.*"[515]

609 I refer to this evidence to place the prolonged use of confinement orders at Unit 18 during Cleveland's last period of detention in its proper context. It was a hardly a new phenomenon, nor was it peculiar to Unit 18 only. It had been a longstanding issue at both youth detention centres. In fact, Tottle J in ***CRU*** noted:[516]

> There is a final matter that it is important to record in this overview. It is that symptoms of systemic failure to which I have referred were identified and reported on by the Inspector of Custodial Services in 2017.

610 Something else that the OCIS had reported on was the cycle created by extended confinement orders. In its report dated May 2023, the OCIS noted:[517]

> It is well understood that stress factors, such as extended lockdowns, often precede serious incidents in custodial places (Shuard PSM, 2018, OCIS, 2013). It is a vicious cycle. Lockdowns increase the "temperature" of a facility which in turn increases the number of critical incidents. This often means more staff are injured or assaulted, which drives up the number who

[513] Ts p.954
[514] Ts p.955
[515] Ts p.966
[516] ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [13]
[517] Exhibit 20, p.17

> are on workers' compensation or subject to return-to-work conditions. It also leads to more people booking off shift because they are psychologically unable to face the day or from exhaustion having to take on additional work. Increased resignations/separations often follow so there are fewer staff to perform standard duties resulting in further and often lengthier lockdowns. The cycle repeats over again.

611 Or put another way: the more rolling lockdowns that occur, the greater the unrest, the greater the unrest the greater the number of incidents, the greater the number of incidents the greater the number of staff away, the greater the number of staff away the greater the number of rolling lockdowns.

612 During Cleveland's final period of detention in Unit 18 lasting 87 days, a confinement order for all detainees was made under Regulation 74(2) every day.[518] On every occasion the reasons for the confinement order either explicitly cited low staffing numbers or cited particular tasks that required the use of custodial staff. Many of these tasks would be routinely expected e.g. "*facilitating visits*", "*multiple detainees on ARMS*", "*the risks associated with unlocking large groups of detainees*", and "*contact restrictions and risks to and from alerts between most detainees*".[519]

613 For the first 37 days of his final period of detention, Cleveland (and every other detainee in Unit 18) had a confinement order imposed on them every day (18 July 2023 to 23 August 2023). From 6 September 2023 to 11 October 2023 (the final 36 days before his incident), Cleveland and every other detainee were subjected each day to a confinement order.

614 For his last 13 days at Unit 18, Cleveland had a daily time out of his cell that ranged from five minutes to 1 hour 50 minutes, with an average time of 1 hour 13 minutes. Disturbingly, Cleveland only had 13 days during his final period of detention where he received two or more hours out of his cell. Or put another way, for 74 of the 87 days (or 85%) he was in Unit 18 for the final time, Cleveland spent more than 22 hours in his cell every day.[520] This was in clear breach of the Beijing Rules and the Mandela Rules; and amounted to solitary confinement as defined in these Rules.

615 Percentage wise, Cleveland's penultimate period in Unit 18 from 19 April to 16 June 2023 was actually worse. For the 58 days until he was transferred to Banksia Hill early on 16 June 2023, he was confined to his cell for more than 22 hours on 53 of those days (or 91%).[521]

[518] Exhibit 1, Volume 8.1, Tab 1.0, [56]
[519] Exhibit 1, Volume 8.1, Tab 1.7 (spreadsheet)
[520] Exhibit 1, Volume 8.1, Tab 1.3
[521] Exhibit 1, Volume 8.1, Tab 1.3, pp.2-3

616 I have cited these figures to illustrate that Cleveland's confinement in his cell was arguably worse than the example used by Tottle J in ***CRU***. After referring to the "*seriousness of the systemic failure*" of keeping detainees in their cells for prolonged periods, his Honour said:[522]

> To give but one example - OPS was confined to his cell for 23 out of the 31 days in July 2022 for more than 20 hours each day and in most instances for more than 22 hours each day. Nineteen of those days were successive days between 1 and 19 July 2022.

617 As I have already noted, ***VYZ*** and ***CRU*** had been handed down before Cleveland's last period of detention. As the First Respondent in both proceedings, Dr Tomison had read the decisions and would have been very aware of the concerns Tottle J had raised regarding the deleterious effect of confining young people by themselves for extended periods of time in very small cells, and also his Honour's view that confinement orders to enable lockdowns to occur should only be used sparingly. It is worth repeating that Tottle J had also clearly stated in ***CRU*** that:[523]

> I very much doubt that Parliament envisaged that a superintendent's power to order a young person to be confined in his or her cell would be exercised as frequently or in the circumstances in which it has, and is likely to continue to be, exercised.

618 It is clear that the "*circumstances*" Tottle J was referring to was subjecting every detainee within a youth detention centre to one confinement order.

619 In his capacity as Director General, it is expected that Dr Tomison would have also read the reports from the OICS that highlighted the vicious cycle that extended confinement orders create.

620 Yet the regular practice of issuing confinement orders for all detainees in Unit 18 continued to be made; with an emphasis that detainees be granted at least one hour of exercise per day so that the confinement order was lawful. Given the Supreme Court's and the OCIS's criticism of this practice, the emphasis should have been to immediately address ways to prevent continuous lockdowns through confinement orders. However, that was not possible due to severe custodial staff shortages, which I am satisfied was the Department's and its Director General's own making.

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[522] ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [6]

[523] ***CRU by Next Friend CRU 2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [9]

621 In his examination of Dr Tomison at the inquest, Senior Counsel for Nadene Dodd cited various findings from the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (the Disability Royal Commission). Dr Tomison accepted that, at different points, "*Staff shortages have been a consistent feature of Banksia Hill and a known cause of cell lockdowns over many years*".[524] He also accepted the finding from the Disability Royal Commission that "*the Department has also known for a long time that staff shortages have been a cause of excessive lockdowns for detainees*".[525] In addition, Dr Tomison agreed that "*the Western Australian Government did not contest the finding that staff shortages have been a consistent feature at Banksia Hill Detention Centre, and a known cause of cell lockdowns since 2013*" and that it did not contest "*the finding that the Department of Justice failed to adequately staff Banksia Hill and that this has been a critical factor in the solitary confinement imposed on detainees during 2021 and 2022* ".[526]

622 The Department and Dr Tomison have both accepted there was an "*excessive*" use of confinement orders. That goes without saying. This excessive use had commenced long before Cleveland's final period of detention. For a majority of the 87 days Cleveland was in Unit 18 for the final time, he was subjected to time by himself in his small cell of such a magnitude that I am satisfied was inhumane.

623 Although not the only reason,[527] the lack of custodial staff, "*was a significant contributing factor in the confinement of detainees at Unit 18 during Cleveland's final period of detention*".[528] On Dr Tomison's own admission, this was an issue that was addressed "*too late*".

624 The evidence from other witnesses supported Dr Tomison's concession.

625 During the time he was Commissioner (from November 2020 to October 2023), Mr M Reynolds agreed that the staffing issues in the youth custodial estate "*never got better, it in fact got worse*".[529] He also said that he was informed of a critical staffing problem in the youth estate "*probably*

[524] Ts p.1276
[525] Ts p.1276
[526] Ts p.1276
[527] I accept infrastructure damage and poor behaviour from detainees were also cited as additional reasons for confinement orders. However, as Tottle J noted in ***CRU***: "*The causes of the systemic failure are an endemic shortage of suitably qualified staff, inadequate infrastructure and a consequent inability to manage detainees with difficult behavioural problems.*" (underlining added): ***CRU by Next Friend CRU2 v Chief Executive Officer of the Department of Justice*** [2023] WASC 257, [9]
[528] Supplementary written closing submissions from the Department dated 16 June 2025, p.38
[529] Ts p.1518

within the first six months"[530] after his appointment. Mr M Reynolds agreed the problem "*doesn't happen overnight*" and is "*the results of a slow build up.*"[531] He accepted the proposition that the reason for the critical staff shortages was there had "*been a systemic failure by the Department beforehand to manage its recruiting to meet the need created by attrition*".[532]

626 There were significant efforts to increase custodial staff numbers from 2021. These included running recruitment efforts for YCOs, using prison officers in support roles, and introducing special incentives to retain custodial staff.[533]

627 Notwithstanding those measures, Ms Ginbey said: "*Despite these efforts, it takes a long time to see demonstrable change by way of boots on the ground.*"[534] Dr Tomison was of a similar view, stating at the inquest, "*it took time for the numbers to get to the point where they were helpful*."[535]

628 As Ms Ginbey put it at the inquest:[536]

> There - there had absolutely been a lack of planning and investment in youth custody for a significant period of time. The situation that we found ourselves in in late 2021 and early 2022 was a product of that, absolutely.

629 Ms Ginbey had earlier told the CCC this meant that by late 2021, Banksia Hill:[537]

> … was significantly understaffed every day. So, I think, you know, we need about 50 staff to run it every [day] – you know, we'd have sometimes 20, sometimes less than 20. Sometimes we'd have less than night shift staff trying to run the facility during the day.

630 At the inquest, Mr Beck agreed that in the second half of 2021, Banksia Hill was "*in a spiral; it was deteriorating*".[538] He prepared an action plan that identified the concerns as infrastructure, the capacity and capability of senior management and insufficient staff.[539] When asked what was the

[530] Ts p.1517
[531] Ts p.1516
[532] Ts p.1516
[533] Ts p.974 (Dr Tomison); see also: Ts p.2189-2193 (Mr Beck); Ts p.2346 (Ms Ginbey); Exhibit 61, [84(a)-(f)], [282]-[286] (Ms Ginbey's statement); Exhibit 50 [117]-[127] (Mr M Reynolds' statement)
[534] Exhibit 61, [287]
[535] Ts p.974
[536] Ts p.2346
[537] Exhibit 1, Volume 2.1, Tab 13, p.39
[538] Ts p.2188
[539] Ts p.2189

response he was getting from the Director General and the Commissioner, Mr Beck answered:[540]

> The response was, "That's not good enough, it needs to be done quicker" and my response to that was, "There are systematic logical changes that need to take place in Banksia Hill", and despite the desire for instant success, it was never going to be possible without staff on the ground, improving the infrastructure and actually building the capacity of the [senior management] team.

631 The repetitive use of confinement orders in Unit 18 also questioned the accuracy of the Department's intention cited in the Briefing Note (which Dr Tomison had co-signed) that: "*The planned out of cell hours for the detainees in Unit 18 will be 9 hours 55 minutes*".[541] It is difficult to understand how Dr Tomison and the Department thought this could be achieved when there were not even enough custodial staff to safely run Banksia Hill at the time. As it transpired, the initial group of detainees transferred to Unit 18 on 20 July 2022 only received an average of six hours 23 minutes out of their cells each day until 30 July 2022. On that day there was a major incident which led to "*minimal*" OOCH.[542] As for the outcome for Cleveland, I also note the evidence from Dr Tomison at the inquest that is outlined at [364] – [375] above.

632 In his written closing submissions, counsel assisting submitted that a potential adverse finding against Dr Tomison was: "*A failure to provide adequate leadership and oversight to prevent the failings of the Department as identified above.*"[543] The potential adverse findings that counsel assisting had previously identified against the Department included:[544]

- The Department failed to ensure it had adequate staff.
- Dr Tomison said that one of the main reasons the Department could not comply with the law as explained by Tottle J was that it did not have enough staff to ensure detainees could be released from their cells for the bare minimum of time as legally required.
- At Unit 18, both before and after Cleveland's death, there had been an excessive use of confinement orders and "*the actual number of those orders I think is unreasonable*".[545]

[540] Ts pp.2189-2190
[541] Exhibit 1, Volume 6.1, Tab 1.6, p.7
[542] Exhibit 1, Volume 6.2, Tab 1.14, p.4
[543] Written closing submissions from counsel assisting dated 25 March 2025, p.242
[544] Written closing submissions from counsel assisting dated 25 March 2025, pp.224-225
[545] Citing Dr Tomison's evidence at the inquest: Ts p.966

- Dr Tomison acknowledged that even before Unit 18 was established, lockdown regimes at Banksia Hill were being overused, "*precisely because there was a staff shortage*".[546]

633 After the filing of written closing submissions and the oral submissions from counsel for the interested parties I reached a view that in order to ensure procedural fairness and that section 44(2) of the Act had been complied with fully, any proposed adverse finding against Dr Tomison should be particularised in greater detail and that his counsel be given the opportunity to provide further written submissions if required.

634 Consequently, by email dated 3 October 2025 to Dr Tomison's counsel, the Court advised there was one potential finding it was considering making against Dr Tomison. The email drafted that finding in these terms:

> Dr Tomison failed to adequately address the repetitive nature of confinement orders in Unit 18 by the time of Cleveland's last period of detention. This meant that Cleveland spent more than 85% of his final period in detention locked in his cell for more than 22 hours or more each day. A primary reason for this failure was the lack of available custodial staff to ensure Unit 18 could be safely operated without the need for confinement orders to be continuously imposed on all its detainees.

635 In this email, the Court noted that the closing submissions from Dr Tomison's counsel dated 6 May 2025 and 16 June 2025 had already addressed this particular area; however, the Court was prepared to receive further written submissions now that the finding had been defined more precisely.

636 As to this potential finding, the Court's email drew counsel's attention to the following:

> In this regard, the Court has noted Dr Tomison was a respondent in the Supreme Court proceedings of ***VYZ*** and ***CRU***, both of which were handed down prior to Cleveland's last period of detention. These decisions were particularly critical of the repetitive use of confinement orders that created rolling lockdowns and also drew attention to the deleterious effect such orders had on children. At the inquest, Dr Tomison accepted the use of lockdowns was "*excessive*" (Ts 973) and that what was done to address staffing problems was "*started too late*" (Ts 975).
>
> (underlining added)

637 On 22 October 2025, counsel for Dr Tomison provided detailed further supplementary written submissions opposing the potential adverse finding.

[546] Ts p.955

I have carefully considered these submissions in reaching my decision and will address some of the points raised (and one that was not raised) in them.

638 First, it was contended that Dr Tomison's alleged shortcoming was "*too remote to be a cause or contribution to [Cleveland's] death to warrant an adverse finding.*"[547]

639 I am not satisfied a finding that Dr Tomison failed to ensure there was sufficient custodial staff to operate Unit 18 safely without the imposition of confinement orders was too remote to Cleveland's death. The insufficient number of custodial staff at Unit 18, which I am satisfied was systemic, was an underlying cause of the lack of appropriate supervision, treatment and care provided to Cleveland during his last period of detention.[548]

640 In addition, I am satisfied there was an appropriate connection between Cleveland's long periods in solitary confinement and his decision to end his life. Although it was just one of a number of circumstances that were highly likely to have contributed to that decision; it was a significant one. An example of the specific impact the nature of Cleveland's confinement had on his mental state can be seen from his requests to Mr McClennan in his cell calls shortly before his incident to calculate the time he had spent "*locked up*".[549]

641 More generally, I will again cite what Tottle J said in ***VYZ*** regarding the impact of locking a child in a cell for prolonged periods:[550]

> It is a severe measure. Confining children to their sleeping quarters in a detention centre for long hours, thus effectively confining them in isolation, can only be characterised as an extraordinary measure - one that should only be implemented in rare or exceptional circumstances. Among the many reasons why it should be so characterised is because of the very significant harm such confinement can do to children in detention, many of whom are already psychologically vulnerable. Further, the Act[551] recognises that young people have a different sense of time, and it is a significantly more difficult and challenging experience for a young person to spend 24 hours in isolation than it is for an adult.

[547] Further supplementary submissions from Dr Tomison dated 22 October 2025, [22]
[548] See: **THE QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF CLEVELAND**
[549] Exhibit 1, Volume 1, Tab 40
[550] ***VYZ by Next Friend XYZ v Chief Executor Officer of the Department of Justice*** [2022] WASC 274, [71]
[551] *Young Offenders Act 1994* (WA)

642 These observations are not controversial. They mirror the observations made by Dr Wojnarowska in her report to the Court.[552]

643 Although commencing prior to Cleveland's last period of detention, I am satisfied that Dr Tomison's failure to adequately address the longstanding chronic custodial staffing levels in the youth estate was connected to the death. That is because these staff shortages remained during Cleveland's last period of detention. The measures that could have been undertaken included those that did not occur until 2021.[553] As the outcome of these measures taken in 2021 take some time, they did not improve staffing levels before Cleveland's death.

644 Secondly, counsel for Dr Tomison contended that the operational management of business areas within the Department had been lawfully delegated by Dr Tomison[554] and that he was not directly involved in staff recruitment at the operational level.[555] That may be so.

645 However, it was Dr Tomison's decision to create a second detention centre at a time when custodial staffing levels at Banksia Hill were woefully inadequate; a fact that he knew. In addition, Dr Tomison said at the inquest he was receiving "*weekly reports of out of cell hours at both sites when Unit 18 was going.*"[556] This is consistent with Ms Ginbey's evidence:[557]

> A weekly report is provided to the Minister on Banksia Hill and Unit 18 which includes information about out of cell times, staffing numbers and other matters. This report goes through the Commissioner to the Director General for his approval before going to the Minister's Office.

646 Dr Tomison also agreed that he was aware there were instances when detainees were not even getting their minimum OOCH.[558]

647 Finally, I note what was not in counsel's supplementary written submissions (nor in the two written submissions filed earlier). Despite the Court's email dated 3 October 2025 referring counsel to Dr Tomison's concession that what was done to address staffing problems in the youth custodial estate "*started too late*", that was not addressed. From the information before me regarding his knowledge at the relevant time, I am

[552] Exhibit 24, pp.18-19
[553] See: Ts p.974 (Dr Tomison); Ts p.2189-2193 (Mr Beck); Ts p.2346 (Ms Ginbey); Exhibit 61, [84(a)-(f)], [282]-[286] (Ms Ginbey's statement); Exhibit 50 [117]-[127] (Mr M Reynolds' statement)
[554] Further supplementary submissions from Dr Tomison dated 22 October 2025, p.7
[555] Further supplementary submissions from Dr Tomison dated 22 October 2025, p.10
[556] Ts p.967
[557] Exhibit 93, [10]
[558] Ts p.967

satisfied Dr Tomison is not able to contend that concession was made with the benefit of hindsight.

648 The crisis that the Department had in 2021 regarding the shortage of custodial staff in the youth estate was of its own making. As the Department's Director General, I am satisfied Dr Tomison is to be held responsible for not addressing this shortage before he made the decision to operate the second youth detention which became Unit 18. From very shortly after it opened until Cleveland's incident 15 months later, Unit 18 did not have sufficient custodial staff for it to continuously operate safely without resorting to regular confinement orders.

649 **After a careful consideration of the available information, I am satisfied that at the time of Cleveland's final period in detention at Unit 18, Dr Tomison had failed to ensure there were sufficient custodial staff to operate Unit 18 safely without the need for imposing continuous confinement orders on all of the detainees. This meant that Cleveland spent 85% of his final period in detention locked in his cell for 22 hours or more each day. Accordingly, I make that finding.**

650 The wording of the finding I have made is not the same as the potential adverse finding specified in the Court's email dated 3 October 2025 to counsel for Dr Tomison. However, I am satisfied that counsel's supplementary written submissions dated 22 October 2025 and the relevant parts of counsel's written submissions dated 5 May and 16 June 2025 have addressed the reworded finding.

651 In making this finding, I have taken into consideration the impact of the COVID-19 pandemic on the availability of current and potential custodial officers at the relevant times.[559] I remain satisfied that notwithstanding the constraints created by the COVID-19 pandemic, the finding is established.

652 During the course of the inquest, the Court ensured that it was kept apprised of the number of confinement orders being made at Unit 18. It became evident that there was a noticeable shift in the number of confinement orders that applied to every detainee. This is considered in more detail later in this finding.[560] I will simply note at this point it is regrettable this shift did not occur until almost two years after the handing down of the decision in ***VYZ***, more than a year after ***CRU*** was handed down, and 10 months after the death of Cleveland.

[559] Exhibit 20, p.12

[560] See: **RECOMMENDATIONS REGARDING THE FUTURE OF UNIT 18, *Issues that remain in Unit 18 since Cleveland's death,*** *Use of confinement orders*

653 This time lag is most likely attributable to the fact that concerted planning to increase custodial staffing in the youth estate did not begin until 2021.

654 The adverse findings I am satisfied can be made against Mr Coyne are addressed below.

Mr Coyne

1. The failure to adequately address the covering of cell CCTV cameras prior to 11 October 2023

655 As I have already outlined above, there was a widespread and common practice for detainees in Unit 18 to cover their cell CCTV cameras and/or damage them so they were ineffective to monitor the detainees in their cells. I have already made a finding that the Department failed to adequately address the covering of cell CCTV cameras prior to Cleveland's incident.[561]

656 Although I have made that finding against the Department, it does not necessarily follow that such a finding is to be made against Mr Coyne in his capacity as the Superintendent of Unit 18 for the five months before Cleveland's death. That finding can only be made if I am satisfied Mr Coyne had knowledge, prior to Cleveland's incident, of (i) the widespread practice of detainees covering or damaging cell CCTV cameras and (ii) the failure by custodial staff to resolve that issue.

657 I have found that Mr Coyne's evidence regarding his knowledge of these matters was noticeably inconsistent in key areas. It was also inconsistent with other information the Court had. Although Mr Coyne is to be commended for the rapid action he took which successfully addressed this issue following Cleveland's death, I am satisfied that he had the requisite knowledge that should have had him bring the matter to the attention of his superiors and implement that or a similar resolution well before 11 October 2023.

658 I will now outline how I came to this conclusion. It is detailed and I have extensively quoted the relevant parts of Mr Coyne's evidence at the CCC, and his written and oral evidence at the inquest. This is necessary as counsel for Mr Coyne provided comprehensive and detailed submissions to rebut counsel assisting's proposed adverse finding against Mr Coyne regarding this matter.[562]

[561] See: **ADVERSE FINDINGS, *The Department,*** *3. The failure to adequately address the covering of cell CCTV cameras prior to 11 October 2023*

[562] Written closing submissions from Mr Coyne dated 6 May 2025, pp.6-22

659 Mr Coyne first gave evidence regarding his knowledge of cell CCTV cameras being covered or damaged at the CCC. That took place on 7 February 2024, and the Court had the transcript from that hearing.[563]

660 The counsel assisting the Corruption and Crime Commissioner questioned Mr Coyne regarding the evidence the CCC had heard regarding the very common practice of detainees covering their cell CCTV cameras. Mr Coyne maintained he was not aware of that until the day of Cleveland's incident (i.e. 12 October 2023).[564] He was then asked:[565]

> In one YCO's estimate to the Commission on any particular night that he worked - just focusing on night shifts - there would be at least 90% of the cameras covered. Did you have any awareness of that practice before the night of Cleveland's self-harm? --- No.
>
> No. And in another YCO's estimate to the Commission, the cell cameras were covered every day for the majority of the day? --- Mm.
>
> Were you aware of that practice happening during the day shifts? --- No, that - that never got raised with me.
>
> At any time prior to Cleveland's self-harm, so from 11 to 12 October? --- Um, not - not that I recall.

661 After giving that evidence, Mr Coyne was shown an email exchange on 27 September 2023 between Mr O'Siochain and the Department's Principal Project Officer for Infrastructure Maintenance (the Principal Project Officer). These emails were copied to Mr Coyne. The emails concerned damage to cell windows by detainees at Unit 18 and the Principal Project Officer asked why there was no operational intervention regarding the window damage, noting "*reports are the kids covering cameras for hours while attaching [sic - attacking] window*".[566] Mr O'Siochain responded that the window damage:[567]

> … should be witnessed on CCTV, however <u>every single detainee has their cameras either covered, or damaged so badly there is no visual</u>.
>
> We do clear their cameras every time we leave their cell, but they use toilet paper, part of their t-shirt, faeces or even their dinner to cover it as soon as we are out.
> (underlining added)

[563] Exhibit 1, Volume 2.1, Tab 12.3
[564] Exhibit 1, Volume 2.1, Tab 12.3, p.31
[565] Exhibit 1, Volume 2.1, Tab 12.3, p.31
[566] Exhibit 1, Volume 1, Tab 41.4, p.2
[567] Exhibit 1, Volume 1, Tab 41.4, p.1

662 At the CCC, Mr Coyne said he did not recall if Mr O'Siochain had ever raised with him prior to 27 September 2023 that every single detainee had their camera either covered or badly damaged.[568] With respect to Mr O'Siochain's reference to the covering of cell CCTV cameras in the above email, Mr Coyne explained that his focus was probably more on the window damage.[569]

663 Mr Coyne's evidence at the CCC was that when he was in the control room, he did not notice cell CCTV cameras were covered, explaining he "*didn't pay any real particular attention to that*".[570] He also denied that any of the senior officers of operations (i.e. the SMT at Unit 18) had raised with him the damage to cell CCTV cameras or the covering of them.[571]

664 Counsel assisting the Corruption and Crime Commissioner then showed Mr Coyne clause 5.2 of COPP 14.3 that detailed the procedures to be followed if a cell CCTV camera remained covered by a detainee, with the final procedure requiring custodial officers to enter the cell and ensure the camera is uncovered before leaving the cell. Mr Coyne was then asked:[572]

> So did you know about that particular procedure on page 9 relating to the covering on the cameras? --- Um, as - as I said earlier, I would expect that if cell cameras are covered that they would be uncovered and staff would take action to uncover them. So to say that I've actually read that specifically, I would be saying no because I - I consider it standard procedure that if there's a cell camera there, it's not to be covered. Otherwise why have the cell camera?
>
> And focusing on the period of time from when you started at Unit 18 up until 11 October [2023] do you know whether that procedure was being followed? Were staff going in to uncover the cell cameras? --- I would - I would say that staff are probably somewhat, <u>but not - but not to the extent that that requires.</u>
>
> The Commission's heard evidence that that procedure wasn't being followed on night shift at that time, focusing particularly on September, October of 2023 because of the risk of it ending in a cell extraction, and the view that there was insufficient YCO staffing on a night shift to safely perform those. Did anyone ever raise those concerns with you about being able to comply with this particular procedure at night? --- No, no. I can understand their concerns, but it wasn't - certainly wasn't raised with me. (underlining added)

[568] Exhibit 1, Volume 2.1, Tab 12.3, p.33
[569] Exhibit 1, Volume 2.1, Tab 12.3, p.33
[570] Exhibit 1, Volume 2.1, Tab 12.3, p.33
[571] Exhibit 1, Volume 2.1, Tab 12.3, p.33
[572] Exhibit 1, Volume 2.1, Tab 12.3, p.34

665 The CCC report, under the heading "*The practice of covering cell cameras*", considered Mr Coyne's evidence regarding his knowledge of this practice as follows:[573]

> Given the prevalence of the practice of the young people covering their cell cameras, the email exchange to that effect copying in Superintendent Coyne and his fortnightly visits to Unit 18, it is difficult to accept Superintendent Coyne's evidence that he was unaware that cell camera covering was an issue.

666 Although it is not referred to in the CCC report, Mr Coyne's evidence that I have underlined above is open to be read as a concession from Mr Coyne that he knew, before 11 October 2023, that the provisions of COPP 14.3 relating to custodial staff entering cells to uncover the CCTV cameras were not being complied "*to the extent that that [i.e. clause 5.2 of COPP 14.3] requires*." This reading would mean that Mr Coyne had admitted having knowledge that staff were not always entering cells to uncover CCTV cameras before 11 October 2023. However, his answer may have also been given in the context of what he said he knew following Cleveland's incident. Not without some hesitancy, I will accept this alternative explanation which is more favourable to Mr Coyne.

667 Nevertheless, there were significant inconsistencies with Mr Coyne's evidence before the CCC when it is compared to his written and oral evidence at the inquest.

668 The CCC report was published on 11 June 2024. On 22 July 2024, Mr Coyne signed his witness statement for the inquest.[574] In that statement, he said he told the CCC:

- "*I did not have any awareness of the practice of detainees covering their cell cameras before the night of Cleveland's self-harm.*"[575]
- "*No senior officers of operations raised damage to cell cameras or covering of cell cameras with me.*"[576]

669 Nowhere in his statement for the inquest did Mr Coyne seek to amend or change those propositions.

[573] Exhibit 22, [116]
[574] Exhibit 57
[575] Exhibit 57 [53(a)]
[576] Exhibit 57 [53(b)]

670 Mr Coyne also said: "*I do not have any recollection of being told about CCTV cameras being covered for long periods of time, prior to the incident involving Cleveland*."[577]

671 The inconsistent evidence that Mr Coyne gave regarding his knowledge of cell CCTV cameras being covered began from the very first question asked of him at the inquest by counsel assisting that addressed this matter:[578]

> Now, when you were the Superintendent at Unit 18, before Cleveland's death, you knew that there was an issue with the cameras being covered, didn't you? --- Young people would cover cameras for - for a period, and I expected them to be removed.
>
> Right. So we will just break that down. Do you now accept that when you were the Super, before Cleveland's death, you knew there was a practice of young people wetting paper and covering their cell cameras?--- Not for extended periods.
>
> Right. So the --- ? --- Short periods, yes.
>
> Right? --- Extended periods, no.
>
> Right. And you had known that was a practice from 1 May or the beginning of May 2023, when you went to work at Unit 18?--- I knew - I - I knew of it, that - that kids would wet toilet paper and cover some of the cameras.

672 Mr Coyne then said he learnt of this practice, "*probably in May, some point in May [2023]*."[579]

673 Despite his evidence at the CCC that when he was in the control room he did not notice cell CCTV cameras were being covered as he did not pay any particular attention to that, Mr Coyne gave this evidence at the inquest:[580]

> And in the control room when you visited, you would see the control room people, amongst other things, watching the banks of screens? --- Yes.
>
> And when you looked at those banks of screens there would be inevitably, I suggest, some screens on which there was no vision. Do you agree? --- Yes.
>
> …
>
> Yes. So, when you saw that one of the screens was not showing vision from a cell, you would raise that with one of the officers? --- Generally, yes. Yes.

[577] Exhibit 57 [62]
[578] Ts p.1897
[579] Ts p.1897
[580] Ts pp.1899-1900

> And what sort of answers would you get? --- That camera is not working. The lens is scratched. You can't see. It has been like that. It has been reported, those type of responses.
>
> Did you get told the camera is covered? They have put wet paper over it? --- No.

674 As Mr Coyne had said only minutes earlier that he knew, "*that kids would wet toilet paper and cover some of the cameras*",[581] I asked:[582]

> Mr Coyne, are you absolutely certain about that? --- I don't recall it. No.
> …
> **COUNSEL ASSISTING***:* Well, when you say to his Honour, I don't recall, are you saying to his Honour, that might have happened, but I now don't remember it, or I can positively tell you, your Honour, that did not happen? --- It may have happened. And I don't recall it.
> …
> So, when you were in the control room, and you can see that a camera in a particular cell is not working because it has been covered, do you do anything else other than say that needs to be uncovered? --- I would instruct it to be uncovered.

675 The internal inconsistencies with Mr Coyne's evidence continued:[583]

> So you've told his Honour that sometime in May 2023, you learn that there is a practice of cameras being covered? --- Yes.
>
> Did you learn that that was a practice that happened both during the day and at night? --- No.
>
> But you thought it was only a daytime problem? --- Yes.
>
> Who told you about the practice? --- I don't recall. I - I really don't recall at all.
>
> Did the Senior Management Team tell you that that was a problem, that people were covering their cameras? --- No. I - it wasn't something that we spoke a lot about at all.
>
> Who's we? --- The Senior Management Team. I would talk with my deputy, Marc O'Siochain. We would talk a lot about the operations of the unit, the damage that was going on in the unit, the safety of staff, the - all sorts of ---
>
> Yes. Just focus on the question of camera covering? --- Yes.

[581] Ts p.1897
[582] Ts pp.1900-1901
[583] Ts pp.1903-1905

> Was that something that the Senior Management Team told you was a problem? --- No, I don't believe they would have.

676 Mr Coyne, when pressed on that last answer by counsel assisting, said his answer was "*in error*" and that he would have expected the SMT to tell him.[584] He then recalled having one specific conversation as follows:[585]

> And did the Senior Management Team tell you that covering the cameras was a problem? --- I had one discussion that I can recall with Marc [O'Siochain], and it was about the covering of cameras, and our discussion as - Marc said that if it was an issue, that if he received a phone call about it, especially after-hours, that he would - he would just tell them to get it down. That was - that was my discussion with Marc in relation to that.
>
> So, did the Senior Management Team - this is just a simple yes or no - is your evidence they never raised it with me, or they did raise it with me? --- I don't believe that they raised it with me as a major issue, no, as an issue.
>
> Well, there are two different answers there, a major issue or an issue. Are you qualifying that they did raise it as an issue but not as a major issue, or they didn't raise it at all? --- I recall having the conversation with Marc about cameras being covered. And our conversation was that if - if he received calls after-hours about cameras being covered, and they couldn't do their checks, that he would instruct them to remove the coverings.
>
> Your usual source of information came from your Senior Management Team? --- Yes.
>
> So, if you are having a discussion with Marc O'Siochain about covering cameras, that suggests you have learned from someone that there is a problem with covering cameras. Do you agree? --- Yes.
>
> And the most likely source of information that there was a problem is the Senior Management Team. Do you agree? --- Likely, yes.
>
> Doesn't that suggest that the Senior Management Team did tell you it was a problem, and the conversation with Marc is an example of a discussion about how we are going to deal with it? Do you agree? --- Yes.
> (underlining added)

677 The above evidence from Mr Coyne was inconsistent with his evidence at the CCC. It was also inconsistent with his earlier evidence at the inquest that he thought the practice of cameras being covered was only a daytime

[584] Ts pp.1903-1904
[585] Ts p.1904

problem. With respect to that, this exchange occurred between counsel assisting and Mr Coyne:[586]

> So, a moment ago, I asked, did you understand it was a problem at night? And you said no. Remember that evidence? --- Yes.
>
> What is the basis of you telling his Honour that your belief was that it was not happening at night? --- Based on the discussion that I had with Marc, that if - if it was happening at night, and you receive the phone call after-hours, that he would have instructed them to remove it.
>
> Why would --- ? --- and we never went further with that conversation.
>
> Why would you be having a discussion with Marc about something at night if it was your belief it was not a problem at night? --- Because during the day, they would just - they would whoever it is would just let us know because - we are there. If we are there, they would just tell us.
>
> Mr Coyne, I will ask the question again and ask you to pay attention to it and answer it. Why would you be having a conversation with Marc about what to do at night if you had a belief the problem didn't occur at night? --- Well, in that circumstance, you are correct. It could have been anytime.

678 Mr Coyne was then asked the following:[587]

> Ok. So, do you now agree that in May 2023, you received information from the members of the SMT that cameras being covered was a problem?
>
> **CORONER:** I am going to remind you what your evidence has already been about exactly --- ? --- Yes.
>
> --- that question, Mr Coyne? --- I take it that - yes.
>
> **COUNSEL ASSISTING:** You accept that proposition I put to you? --- Yes.
>
> And do you accept that when you were told that, there was no distinction on whether it was a day problem or a night problem?--- Yes.
>
> Do you accept, therefore, that the information you had in May 2023 was to the effect that this was a problem in Unit 18? --- I didn't think it was a widespread problem.
>
> I will ask it again. Your information was that this was a problem? --- Yes.
>
> Alright. And the way you dealt with the problem was, you told Marc, or rather Marc told you, that if he got a phone call at night, he would do what? --- He would instruct them to have it removed.
>
> In other words, breach the cell? --- Yes.

[586] Ts p.1905
[587] Ts pp.1905-1906

> Obviously, the first port of call is you ask the young person to uncover it? --- Yes.
>
> And if they don't, the next step is someone has to breach the cell? --- Yes.

679 Later in his evidence, when answering questions from counsel for the Department, Mr Coyne gave a different version of the conversation he had with Mr O'Siochain regarding the covering of cameras after-hours:[588]

> And you explained that you have had conversations or a conversation with Michael [sic – Marc] O'Siochain about cameras being covered; do you remember that? --- Yes.
>
> And that you explained that he had given instructions to other officers that camera coverings be taken down; do you remember that? --- Yes.
>
> For my friends, it's transcript 1904. In the course of going through this evidence, you said it was not raised with you as [a] "major issue", and you didn't think it was a widespread problem. Do you recall giving that evidence?--- Yes.
>
> Can you explain why you had that view? --- When I spoke to Mr O'Siochain about the camera coverage, his comment back to me at the time was that, "Doug, it's - it's not an issue because I'm not receiving any after-hours phone calls or phone calls in relation to coverage. And if - if I did receive a phone call, I would instruct them to take the coverings down", and there was [sic] avenues they could use to assist in removing those coverings.

680 On this version, Mr O'Siochain was informing Mr Coyne that there were actually no issues with cell CCTV cameras being covered at night.

681 I reject this version, and I am satisfied it was an attempt by Mr Coyne to water down the significance of his previous answers to questions from counsel assisting. It would make no sense for Mr O'Siochain to tell Mr Coyne that cell coverage at nighttime was "*not an issue*". The overwhelming evidence I heard at the inquest was that it was a longstanding and significant issue day and night.

682 That was not only verified by Mr O'Siochain's email from 27 September 2023 cited above, but also his evidence at the inquest:[589]

> Now, during 2023, in the lead up to Cleveland's incident, you were aware that there was constant problem with the cameras being covered? --- In the lead up to?
>
> During 2023? --- Yes.

[588] Ts p.2116
[589] Ts pp.2935-2936

> Before Cleveland's death, you knew there was a constant problem with the cameras being covered? --- Yes.
>
> Staff on the floor had made that clear to you and other members of the SMT? --- About kids covering the cameras?
>
> Yes. And not uncovering them? --- When asked, yes.
>
> What do you mean when asked? --- Like, when instructed to remove the coverings?
>
> Yes? --- There was a level of non-compliance, yes.
>
> …
>
> Right. Did you tell anyone there was a problem? --- In regards to Doug[590] and that, I think everybody knew that there were problems with kids covering the camera.
>
> **CORONER:** Listen to the question, Mr O'Siochain: did you tell anyone?
>
> **COUNSEL ASSISTING:** Everyone knew. Everyone on the SMT knew that it was a problem, as far as you understood? --- Yes.
>
> And you understood Doug knew? --- Yes.

683 Similarly, Mr Mortley, another member of the SMT, said that the covering of cell CCTV cameras in 2023 was "*common knowledge*".[591]

684 Unsurprisingly, counsel assisting in his re-examination of Mr Coyne explored the different version he had provided to questions from counsel for the Department regarding his conversation with Mr O'Siochain:[592]

> You understand that you told his Honour last week that you had received information from the members of your SMT that cameras being covered was a problem? --- Yes.
>
> And you understood that you told his Honour that when you were told that by the SMT, there was no distinction as to whether it was a day problem or night problem? --- Yes.
>
> And you told his Honour that you accepted, therefore, that the information you had in May 2023 was to the effect that this was a problem in Unit 18? --- Yes.
>
> So the situation as of last Friday was that if someone said, "Did you have any awareness of the practice of detainees covering their cell cameras before the night of Cleveland's self-harm?" in light of last Friday's evidence, you would have said, "Yes, I did have awareness of that practice"? --- Yes.

[590] Mr Coyne
[591] Ts p.3032
[592] Ts pp.2130-2131

> And if someone had said to you last Friday evening, "Did senior officers of operations"- you understand that to mean the SMT? --- Yes.
>
> If someone had said to you, "Did senior officers of operations raise damage to cell cameras or the covering cell cameras with me?", you would have said, "Yes, they did." If you had been asked that last Friday night, that would have been your position. Do you agree? --- Yes.
>
> Now, from those two positions, do you wish to modify either position? That's a yes or no question at this stage? --- What you've just asked me, no.
>
> Right. So let me remind you of the two things I've put to you. The first is you'd say "I did have an awareness of the practice of detainees covering their cell cameras before the night of Cleveland's incident"? --- Yes.
>
> And you still maintain that? --- Yes.
>
> The second proposition is, "Yes, senior officers of operations, namely, my SMT did raise with me damage to cell cameras or the covering of cell cameras"? --- Yes.
>
> **CORONER: A**nd the third one is that the information you received from SMT is that this was a problem? --- The covering of cell cameras is a problem, yes.

685 I should also add that I am satisfied Mr Coyne did actually want to "modify" the evidence he gave the previous Friday (2 August 2024); namely, that he was aware detainees would cover cameras, "*but not for long term*".[593]

686 After the above questions from counsel assisting, Mr Coyne was taken to that portion of his written statement to the inquest that summarised the effect of his evidence that he gave to the CCC. And, in particular, that part which read:[594]

> I told the Corruption and Crime Commission (CCC) that:
>
> (a) I did not have any awareness of the practice of detainees covering their cell cameras before the night of Cleveland's self-harm;
>
> (b) No senior officers of operations raised damage to cell cameras or covering of cell cameras with me.

687 Mr Coyne then agreed that those two statements were "*completely inconsistent*" with the propositions he had accepted in re-examination a moment earlier.[595]

[593] Ts p.2128
[594] Exhibit 57, [53 (a) (b)]
[595] Ts p.2131

688 Mr Coyne went on to explain that he thought what he had said at the CCC was correct at the time, and it was only afterwards that he realised it was not.[596]

689 Mr Coyne then told the inquest he had this realisation after he had seen the CCC report and read that his evidence had not been entirely accepted by the CCC regarding his knowledge of the covering of cameras. He also said: "*… and I think also, I've then recalled that at times I would go into the Unit in the morning and I would see cameras that were placed outside cells as well*".[597]

690 The questioning of Mr Coyne by counsel assisting continued:[598]

> When you came and sat throughout the first tranche of the evidence [at the inquest] where you heard almost every word of evidence, didn't you? --- Yes.
>
> You heard the various staff members describe, in great detail, the practice - the widespread practice and their inability to stop the practice of the young people covering their cells cameras with wet paper? --- Yes.
>
> And the CCC report was published on 11 June this year. I ask you to accept that date. It's about two months after the end of the first tranche of the evidence? --- Yes.
>
> When you heard that first tranche of evidence, you realised I suggest, that the story that you had told the CCC would be exposed as not true, given the extent of the evidence that the YCOs had given in the first tranche. That was a part of your thinking as you sat through the first tranche, wasn't it? --- I - I don't recall all the YCOs raising it to me.
>
> No, that's not my question, Mr Coyne? --- Yes. Okay.
>
> My question is, as you sat in this Court in the two weeks after Easter, you heard for the first time the YCOs give evidence. You hadn't heard them give evidence at the CCC, had you?[599] --- No.
>
> And I'm suggesting that when you heard them give evidence, you realised that the story you had told the CCC about not knowing would not withstand scrutiny in the inquest? --- Yes.
>
> And that's why you changed your story. That's why you decided to tell the truth, isn't it? --- Yes.
>
> Which means that last Friday, you - you must have known, coming to court, you were going to be asked about this? --- Yes.

[596] Ts p.3121
[597] Ts p.2132
[598] Ts pp.2132-2133
[599] The Department's staff all gave evidence at the CCC via private hearings.

> You knew when the CCC report came out, and you read it, that the Commission had not accepted you - when you said you did not know? --- Yes.
>
> You knew that in the face of the type of evidence that his Honour had heard after Easter, it was going to be an impossible sell to maintain that same story, wasn't it? --- Yes.
>
> And you knew that at some stage, I was going to ask you about this topic? --- Yes.
>
> And that came Friday afternoon? --- Yes.
>
> And when I began asking the questions, you decided to tell the truth? --- Yes.

691 There is other evidence (which is circumstantial) that points to Mr Coyne being aware there was an issue with cell CCTV cameras being covered for extended periods of time. That is because the issue had come to the attention of Mr M Reynolds, the Commissioner at the time.

692 Mr M Reynolds told the inquest that he became aware of a problem with detainees covering their cell CCTV cameras not long after Unit 18 opened.[600] Mr M Reynolds said that he was aware detainees were regularly covering cameras and that he had conversations with the Women and Young People leadership about that issue.[601] At the inquest, Mr M Reynolds was asked:[602]

> And were the discussions – are we talking about one or two discussions, or 10 or 20 over a period of months? And just to focus you, we're talking about between the creation of Unit 18 and the death of Cleveland, that period of time?---Yes. Look, yes, it would be 10 or 20, because [it] was an ongoing concern, and, you know, there was conversations about restraints and other things, and of course, you know, I was clear that we had to keep the detainees safe, and camera observation was definitely part of that.

693 After I raised with Mr M Reynolds the difficulties of a cell breach during a night shift with the number of custodial staff present at Unit 18, I asked this question:[603]

> So can you remember whether this issue was ever discussed, that during a night shift it's going to be extremely difficult to have a cell camera uncovered if a detainee was not going to do it voluntarily?---It was discussed, and I met with the leadership team from Women and Young

[600] Ts p.1834
[601] Ts p.1835
[602] Ts pp.1835-1836
[603] Ts p.1838

> People, and the superintendent and his team, and I tasked them with building me a better staffing model, which they did, so we could actually be able to do those things. We never achieved it because we didn't have the staffing. It's I think ---
>
> Yes? --- There might have been some discussions about the A, B, and C Wing model. That was that model.
>
> Can you recall who the individuals were in those discussions?---It would have been DC Ginbey, Superintendent Coyne, and some of his – some of the other staff. I'm not sure who else. The reason I've got such a strong recollection is Superintendent Coyne, I think, actually had COVID, so he was (indistinct) very similar to one today for those discussions.[604] So my mission from them was to come up with a plan and present it, which they then later did.
>
> I see. So you have a clear recollection that Superintendent Coyne was involved in those discussions?---Yes, your Honour.

694 Mr M Reynolds then confirmed that this meeting took place before 11 October 2023.[605]

695 At the inquest, Mr Coyne was shown the relevant paragraphs from Mr M Reynolds' written statement to the inquest that dealt with the above matter. Mr Coyne was then asked these questions from counsel for the ALSWA:[606]

> So, obviously enough, that is quite informed and precise information on the issues arising around cameras being covered and entry of cells and so on? --- Yes.
>
> Is that information that you gave to Commissioner Reynolds? --- No.
>
> Did you give that information to Ms Ginbey? --- No.
>
> Did you give that information to any of your superiors? --- No.
>
> Did you receive that information from any of the people who worked for you when you were the - - -? --- I discussed the matter with Mr O'Siochain.

696 Mr Coyne then denied having a meeting with Mr M Reynolds about the issue of cameras being covered which he attended remotely because he had COVID. Mr Coyne was emphatic he did not have such a meeting and said that Mr M Reynolds may be mistaken he attended remotely because he has never had COVID, adding that Mr M Reynolds might have been talking about a meeting before he commenced as Superintendent at Unit 18.[607] In

[604] That passage of the transcript that read "*(indistinct) very similar to one today*" was Mr M Reynolds referring to the manner in which he was giving evidence at the inquest i.e. remotely via a monitor.
[605] Ts pp.1838-1839
[606] Ts p.2102
[607] Ts p.2104

light of this conflicting evidence, I cannot be satisfied to the required standard that Mr Coyne did participate in this meeting.

697 However, what this evidence does show is that the issue regarding the practice of detainees covering their cell CCTV cameras for extended periods of time was a lengthy and unresolved problem that had been escalated up the chain of command to the Commissioner himself. It was also an issue that Mr M Reynolds had to consider on a number of occasions prior to Cleveland's death.

698 If the meeting that Mr M Reynolds recalled had taken place before Mr Coyne commenced as the Superintendent of Unit 18 on 1 May 2023, that simply reflects the longstanding nature of the problem which was still widespread during the time Mr Coyne was the Superintendent of Unit 18 before 11 October 2023. In those circumstances, is it plausible that Mr Coyne was completely ignorant of the scale of the problem?

699 Counsel for Mr Coyne has submitted that the following summary of Mr Coyne's evidence should be accepted:[608]

(a) he was not aware prior to Cleveland's incident that there was a widespread practice of detainees commonly covering cell cameras for long periods of time;

(b) he was aware from around May 2023 of some cameras being covered for short periods of time;

(c) he understood and expected that in such instances, the coverings would be removed;

(d) he recalled a conversation with Mr O'Siochain in which Mr O'Siochain said that if instances arose where cameras were covered at night, those coverings would be removed and that it was not a major issue; and

(e) he did not recall any conversation with Mr O'Siochain or other member of the Senior Management Team that identified a widespread practice of common coverings of cameras, or identified a major issue with actioning the removal of such coverings.

700 Although extracts from Mr Coyne's evidence are consistent with this summary and notwithstanding his counsel's valiant (and at times, very nuanced) submissions, I am unable to accept this account of Mr Coyne's evidence.

[608] Written closing submissions from Mr Coyne dated 6 May 2025, [63]

701 There is an overwhelming amount of evidence from YCOs on the floor to Unit Managers to Senior Officers to the SMT at Unit 18, and even as high up as the Commissioner to show that they were all aware of the widespread and longstanding practice of detainees covering their cell CCTV cameras. It is inconceivable that the Superintendent of Unit 18 for more than five months before Cleveland's incident was unaware of that practice; a practice that prevented the only effective means for every detainee to be simultaneously monitored in their cells (a space that they were very often kept in for 22 hours or more per day).

702 I am satisfied that at various times when giving evidence Mr Coyne downplayed his knowledge of this issue. It was in his interests to do so as it would not reflect well on him that he did not resolve the issue in the time he was Superintendent at Unit 18 before Cleveland's death.

703 Although I have commended Mr Coyne for being able to resolve the issue within a short period of time by the 24-hour placement of SOG officers at Unit 18, I am satisfied he expected to face scrutiny at the inquest as to why he did not implement such a change before Cleveland's death. By asserting he was not aware of the magnitude of the problem until after Cleveland's incident, Mr Coyne was able to provide an explanation. Unfortunately for him it was not a plausible one.

704 In light of the many internal inconsistencies I have found in Mr Coyne's evidence, and the inconsistencies with the version of his account that his counsel has invited me to accept when it is compared to all the other available information, I am not satisfied Mr Coyne gave credible or reliable evidence whenever he attempted to minimise his knowledge of cell CCTV cameras being covered.

705 **After a careful consideration of the available information, I am satisfied Mr Coyne was aware of the widespread and significant practice of detainees covering their cell CCTV cameras during the time he was Superintendent at Unit 18. I am satisfied that in or about May 2023, he became aware of this practice and that it had not been resolved. I am also satisfied he was aware it had remained unresolved by the time of Cleveland's incident. Accordingly, I make those findings.**

706 **In addition, I am satisfied Mr Coyne failed to raise the matter with any of his superiors (including Ms Ginbey and Mr M Reynolds) and failed to implement a "no-tolerance" resolution to the problem; something which only occurred after Cleveland's incident with the placement of**

SOG officers at Unit 18 on a full-time basis. **Accordingly, I also make those findings.**

707 In making these findings, I have taken into consideration that Mr Coyne was on personal leave from 26 July to 17 September 2023 and that he had the additional role as Superintendent of Banksia Hill from 25 June to 25 July 2023, and then from 18 September 2023 to after Cleveland's death. Despite that extended period of leave and the increased workload from being the Superintendent of both youth detention centres, I remain satisfied that Mr Coyne was (a) aware of the extent and magnitude of the issues regarding the covering of cell CCTV cameras at Unit 18 and (b) had sufficient time to implement a long-term resolution of the problem.

708 I have also taken into consideration the length of time that Mr Coyne gave evidence at the inquest when assessing his answers to questions. Although Mr Coyne's counsel submitted he was "*in the witness box for three full days of evidence*",[609] Mr Coyne gave evidence during the following periods:

- Friday, 2 August 2024: 2.16 pm - 4.51 pm (2 hrs 35 mins)
- Monday, 5 August 2024: 11.46 am - 12.56 am (1 hr 10 mins) and 2.15 pm - 4.30 pm (2 hrs 10 mins[610])
- Tuesday, 6 August 2024: 9.49 am – 11.04 am (1 hr 15 mins), 11.34 am to 1.04 pm (1 hr 30 mins) and 2.22 pm – 4.27 pm (1 hr 50 mins[611])

709 The only full day Mr Coyne testified was 6 August 2024. The entire length of his oral evidence was closer to two full days, not three, and was interspersed with a weekend.

710 The adverse finding I am satisfied can be made against Mr O'Siochain is addressed below.

Mr O'Siochain

1. The lack of IEPs being prepared for Unit 18 detainees

711 As I have already noted above, by 2023 the requirement that detainees transferred to Unit 18 were to have an IEP was no longer being followed.

712 At the inquest, Mr O'Siochain said he was not surprised Cleveland had no IEP and he agreed that a detainee in Unit 18 without an IEP was "*an entirely*

[609] Written closing submissions from Mr Coyne dated 6 May 2025, [80]
[610] There was a break of 5 mins during this part of Mr Coyne's evidence.
[611] There was a break of about 15 mins during this part of Mr Coyne's evidence.

unacceptable position" as it was deemed an essential requirement for a detainee who was going to be placed in Unit 18.[612]

713 Not surprisingly, Mr O'Siochain accepted that an IEP was very important for the following reasons:[613]

(a) "*The structure around moving people to Unit 18 expressly required the preparation of an IEP*";

(b) "*Part of that purpose was to ensure that those who are caring for the individuals had as much information about their background, their disabilities, their triggers and how to manage that as possible*";

(c) In the absence of IEPs, YCOs on the floor would be missing out on a whole lot of information about the detainees;

(d) Although there was a profile on TOMS to obtain information about a detainee's disabilities, there was no profile on TOMS to obtain information about triggers or how to manage a detainee and that is why an IEP, "*was deemed essential if [the Department was] going to put anyone in Unit 18*"; and

(e) Although staff who knew Cleveland would know something about him, the new YCOs entering Unit 18 and who did not know Cleveland would not "*know anything about his disabilities, his triggers and the professional advice how best to manage that*".

714 When Mr O'Siochain became aware of the failure to prepare IEPs for detainees being transferred to Unit 18, he did not do anything about it because there was nothing he thought he could do.[614] This was despite the fact that he was responsible for custodial staff having access to IEPs to assist them in their care of detainees at Unit 18.

715 Counsel assisting asked Mr O'Siochain the following questions at the inquest:[615]

> I will ask you again: having realised the problem, having identified what caused the problem, why, as a member of the Senior Management Team did you not do anything about it? --- Because I raised it with the principal

[612] Ts pp.2937, 2941
[613] Ts pp.2940-2941
[614] Ts p.2942
[615] Ts pp.2941-2942

> psychologist. I listened to their concerns and, obviously, the issues they were having with staffing, and I accepted - I accepted that.
>
> Well, that's just - - -? --- And I know that's not good enough, but I understood the difficulties. I understood the importance of why they had been doing their risk assessments, and they were quite stretched, and - - -
>
> Mr O'Siochain, can I suggest that is simply an exercise in confirming what the problem is. I have no doubt that you worked out what the problem was?---Mm.
>
> My question is, why did you not try and do something to solve the problem if you realised how important an IEP was? --- I'm not sure why. I'm not sure why I didn't.
>
> Well, are you comfortable with the fact that you did nothing about it? --- No.
>
> Why aren't you comfortable with the fact? --- The reasons you've just highlighted, the importance, identifying the – not only the problems, but giving staff the additional tools to deal with them, knowing the triggers and knowing what to do.
>
> …
>
> Well, that's just an appalling state of affairs, isn't it? --- Agreed.
>
> And that happened on your watch as a senior manager? --- Correct.
>
> So can I invite you to say to his Honour the completion of this sentence, "Your Honour, I accept this was an appalling failure on my behalf, and the reason I failed to do anything was." Can you finish that sentence? --- Because the concerns I raised and the reasons as to why they weren't being done, I accepted it. I accepted that, and I didn't want to put additional pressure, I suppose, on people who were already under pressure.
>
> Mr O'Siochain - - -? --- And - - -
>
> Go on? --- And it's – and I'm aware that that's obviously my responsibility, so I accept responsibility for the IEPs not being developed.

716 That was an appropriate concession from Mr O'Siochain. I am satisfied it was his responsibility to do something about the lack of IEPs; namely, escalate it up the management line to see what could be done about it. Although the Department had failed to provide adequate resources, that merely identified the cause of the problem. Mr O'Siochain had an obligation as the senior manager responsible for IEPs to respond, and not simply accept the situation.

717 **I am satisfied that Mr O'Siochain failed in his responsibility to address the issue of IEPs not being prepared for detainees, including Cleveland, who were transferred to Unit 18 during the period of Cleveland's last detention. Accordingly, I make that finding.**

718 The adverse findings I am satisfied can be made against Mr Mead-Hunter are addressed below.

Mr Mead-Hunter

1. The failure to wear a radio on the night of 11 and 12 October 2023

719 As already outlined above,[616] contrary to the Department's policies and procedures, Mr Mead-Hunter and the YCOs on night shift duty for 11 and 12 October 2023 were not wearing their radios for the duration of their shift. This fact was never in dispute and Mr Mead-Hunter, "*unreservedly concedes that this adverse finding must be made against him*".[617]

720 Mr Mead-Hunter not only accepted responsibility for his own failing, he has also accepted "*full responsibility*" for the failure that no custodial staff member was wearing a radio that night, adding: "*I'm sorry for it*"[618]

721 I commend Mr Mead-Hunter for accepting responsibility for this failing.

722 I find that Mr Mead-Hunter failed to wear a radio for the night shift of 11 and 12 October 2023. I also find that in his capacity as the acting Senior Officer for that night shift, he failed to ensure other custodial staff were each wearing a radio. Accordingly, I make those findings.

2. Response to Cleveland's incident

723 As I have stated earlier in this finding, Mr Mead-Hunter did not give oral evidence at the inquest. However, he had given oral evidence at the CCC,[619] and provided a signed written statement and two affidavits to the inquest.[620]

724 With respect to his response to Cleveland's incident, Mr Mead-Hunter's account of what he thought was happening and to what he was responding can be ascertained from these materials.

725 I am satisfied that Mr Mead-Hunter did not respond appropriately to Cleveland's incident. My reasoning is detailed and I have extensively quoted the relevant parts of Mr Mead-Hunter's evidence at the CCC, his written evidence at the inquest, and other evidence I have taken into account. This is necessary as counsel for Mr Mead-Hunter also provided

[616] See: **ADVERSE FINDINGS, *The Department,*** *8. The failure by staff to wear radios on the night of 11 and 12 October 2023*
[617] Written submissions of Mr Mead-Hunter dated 6 May 2025, p.3
[618] Exhibit 82, [16]
[619] Exhibit 1, Volume 2.1, Tab 9.4.
[620] Exhibit 1, Volume 2.1, Tab 9.1; Exhibits 82 and 82.1

detailed submissions to rebut counsel assisting's proposed adverse finding against Mr Mead-Hunter regarding this matter.[621]

726 There is no doubt about the following facts. Mr Mead-Hunter went into his office at about 12.55 am on 12 October 2023 and did not leave again until after Mr Torrijos had attended at about 1.50 am. During this time, he was having his break and had his feet up on the desk with the office lights turned off. I am satisfied Mr Mead-Hunter was not asleep when Mr Torrijos attended his office and that he was entitled to combine his two 30-minute breaks into the one break.

727 Mr Mead-Hunter told the CCC that when Mr Torrijos spoke to him, he said: "*I need your keys*" and that he then mumbled. Mr Mead-Hunter did not know exactly what Mr Torrijos had said when he mumbled.[622]

728 At the CCC, Mr Mead-Hunter said:[623]

> So, it became quite a regular occurrence for staff to come and borrow my key to prep things for the next day. So, it wasn't an abnormal thing for [Mr Torrijos] to ask for my key. But because he mumbled and I wasn't sure what he said, I do remember getting up and following him out to sort of see if he needed a hand. But I certainly wasn't alert to anything severe.
> …
> [Mr Torrijos] seemed a little tense which is what led to me getting up and going out there to see if he needed a hand or anything because it seemed – like, it was a normal thing to ask for my keys, but he said it in a way that made me a bit uncomfortable, so I – I went out there after him.

729 Mr Mead-Hunter told the CCC that he did not recall Mr Torrijos saying "*Cleveland's hanging, give us the keys*" when he attended his office.[624]

730 In his written statement to the Court, Mr Mead-Hunter said that Mr Torrijos, "*was speaking very quickly and panicky.*"[625] In his first affidavit to the Court, Mr Mead-Hunter said he did not disagree with Mr Torrijos' characterisation that he spoke in an "*urgent voice*"[626] and that his assessment was: "*Something seemed odd*", and that is why he followed Mr Torrijos.[627]

[621] Written submissions of Mr Mead-Hunter dated 6 May 2025, pp.4-20
[622] Exhibit 1, Volume 2.1, Tab 9.4, p.50
[623] Exhibit 1, Volume 2.1, Tab 9.4, p.50
[624] Exhibit 1, Volume 2.1, Tab 9.4, p.57
[625] Exhibit 1, Volume 2.1, Tab 9.1, [22]
[626] Exhibit 82, [65]
[627] Exhibit 82, [67]

731 At the CCC, Mr Mead-Hunter was informed that Ms Bain had earlier told the CCC that she heard Mr Torrijos say, in a panicked voice, "*Kyle, I need your keys. I think Cleveland's hung himself.*" Mr Mead-Hunter responded:[628]

> That's not what I heard. If I heard someone was hanging, my reaction would have been to run to the cell with all staff, with the H kit, which is for hanging, with the nurse - the - the - the usual procedures you'd follow. Those weren't done because that's not what I heard.

732 At the inquest, Ms Bain repeated that Mr Torrijos' voice sounded "*a bit panicky*",[629]meaning it "*was nervous, like anxious*".[630] In addition, she said that the words she heard Mr Torrijos say were not said as he went past her door, but after he went past.[631] This would be consistent with Mr Torrijos speaking to Mr Mead-Hunter upon entering his room.

733 Before Mr Mead-Hunter concluded his shift, he completed an Incident Description Report. In that document he wrote: "*I was alerted by YCO TORRIJOS, Daniel [Mr Torrijos' ID details cited] that detainee DODD [Cleveland's ID details cited] had self-harmed in cell*"[632] (underlining added).

734 When that document was put to him at the CCC and it was suggested it accurately recorded that Mr Torrijos had told him Cleveland had self-harmed, Mr Mead-Hunter rejected the suggestion saying, "*Danny did not tell me anyone was hanging in the cell*".[633] His explanation for what he had written was:[634]

> I'd posit that that would be a mishap on my time because of the state I was in when writing the report. I'd just had a young boy die in my arms.[635] I wanted to write my report and go home.

735 In his first affidavit to the inquest, Mr Mead-Hunter again repeated his denial that he had heard the word "*hanging*" when Mr Torrijos spoke to him.[636] He said that if Mr Torrijos had conveyed that he wanted the keys

[628] Exhibit 1, Volume 2.1, Tab 9.4, p.58
[629] Exhibit 1, Volume 2.1, Tab 10.1, [93]
[630] Ts p.442
[631] Ts p.442
[632] Exhibit 1, Volume 2.1, Tab 9.3.
[633] Exhibit 1, Volume 2.1, Tab 9.4, p.61
[634] Exhibit 1, Volume 2.1, Tab 9.4, p.61
[635] I note that Cleveland had not died at this stage and that the resuscitation efforts by staff had actually achieved a ROSC.
[636] Exhibit 82, pp.16-17

because Cleveland had been found hanging in his cell, then he did not hear it.[637]

736 In his written closing submissions, counsel for Mr Mead-Hunter advised that Mr Mead-Hunter accepted that it was open for the Court to find that Mr Torrijos used the word "hanging" in or near to Mr Mead-Hunter's office.[638] Given the evidence from Mr Torrijos and Ms Bain, I am satisfied I am able to make this finding and that it was said when Mr Torrijos was in Mr Mead-Hunter's office. It was most likely said just after Mr Torrijos had turned on the office's lights.

737 However, what is contested by Mr Mead-Hunter is a finding by the Court that he heard Mr Torrijos use the word "hanging".[639] After reviewing the relevant information before the Court, I am satisfied to the required standard that Mr Mead-Hunter not only heard Mr Torrijos ask for the keys but also heard Mr Torrijos say that Cleveland was hanging. My reasons are as follows.

738 First, Mr Torrijos asked Mr Mead-Hunter for the keys and said that Cleveland was hanging in a loud enough voice for Ms Bain, who was seated in the office next door to Mr Mead-Hunter's, to hear what Mr Torrijos had said. That is not consistent with Mr Mead-Hunter's account that Mr Torrijos began to mumble after he said he wanted the keys.

739 On this point, counsel for Mr Mead-Hunter noted that Mr Torrijos was frequently reminded during the course of his oral evidence at the inquest to keep his voice up. However, I am satisfied not much weight can be placed on that given the context of the two completely different environments. A person giving evidence as the very first witness in a large and full courtroom regarding a matter that had generated considerable publicity is not the same as how that same person would speak when he is urgently wanting something in a work environment that he is very familiar with. As Mr Torrijos explained at the inquest:[640]

> Exactly what I just told you is what I thought I said, "Cleveland is fucking hanging and I need the keys".
>
> Alright?--- Like, I - I - that's how I speak. I know I would have - that I was urgent, I wanted the keys. I wasn't there saying "Can I please have the keys?" sort of thing.

[637] Exhibit 82, [76]
[638] Written closing submissions from Mr Mead-Hunter dated 6 May 2025, p.4
[639] Written closing submissions from Mr Mead-Hunter dated 6 May 2025, pp.5-20
[640] Ts pp.137-138

> **CORONER**: And what about your level of voice, because we know you've got a soft voice?--- My voice is only soft when I don't know what I'm talking about, which is a lot of the time here.
>
> Ok. So in this instance here you would have said it in a loud voice?--- Yes.

740 I have a firm recollection that I asked: "*So in this instance here you would have said it in a louder voice?*", and not "*a loud voice*". Nevertheless, the submission from Mr Mead-Hunter's counsel that this final question from me was leading in nature would still apply.[641] However, I am satisfied Mr Torrijos would have spoken to Mr Mead-Hunter in a louder voice than the one he had used in the inquest where he was clearly very nervous. Mr Torrijos himself made that point in a non-leading fashion in his two responses immediately before I asked this final question.

741 Secondly, if Mr Mead-Hunter had not heard Mr Torrijos say why he wanted the keys, then it would be expected he would seek clarification. This is particularly so when regard is had to the following. Mr Mead-Hunter: (i) accepted Mr Torrijos was speaking in a panicked way, (ii) did not dispute the description that Mr Torrijos' voice was "*urgent*", and (iii) thought that something was odd which had made him a bit uncomfortable. All these observations would have indicated that Mr Torrijos was not needing the keys to do a mundane task such as unlocking a cell being used as an office or a storeroom.[642]

742 Had Mr Mead-Hunter not known why the keys were needed, had he been unaware of why Mr Torrijos was speaking urgently in a panicked manner, and had he felt that something was odd, it is reasonable to expect he would have asked Mr Torrijos something like:

- "What do you need the keys for?"
- "You mumbled something, can you repeat what you just said?"
- "Is everything alright?"

743 Yet Mr Mead-Hunter did not say he spoke to Mr Torrijos. This was consistent with Mr Torrijos' evidence at the inquest. He said that when Mr Mead-Hunter gave him the keys, "*he didn't actually say anything*".[643]

744 Thirdly, Mr Mead-Hunter following Mr Torrijos without questioning him is more consistent with him knowing why Mr Torrijos required the keys. Mr Mead-Hunter's explanation that he followed Mr Torrijos to an unknown

[641] Written closing submissions from Mr Mead-Hunter dated 6 May 2025, p.11
[642] Exhibit 82, p.18
[643] Ts p.136

destination because he thought Mr Torrijos might need some help about a task unidentified to Mr Mead-Hunter lacks veracity. I also note that Mr Mead-Hunter was still on his break and needed to put his shoes back on and rearrange his clothing. To do all that whilst still on his break on the off-chance that Mr Torrijos might have required his assistance for some unspecified task is difficult to accept; particularly when Mr Mead-Hunter did not even ask Mr Torrijos as he left the office with the keys: "Do you need my help?"

745 Fourthly, Mr Mead-Hunter's written account in his Incident Description Report supports a conclusion that he did actually hear Mr Torrijos say Cleveland was "*hanging*".[644]

746 Notwithstanding it was undoubtedly a distressing time for Mr Mead-Hunter to record the incident a matter of hours after the traumatic scene he came upon in Cleveland's cell, it is entirely consistent with Mr Torrijos' Incident Description Report which relevantly stated:[645]

> … I witnessed detainee DODD in Cell 15 was hanging from the air vent above the toilet, I yelled out to detainee DODD who did not respond.
>
> I immediately went downstairs and informed S/O MEAD-HUNTER, Kyle [Mr Mead-Hunter's ID details cited] and took his keys …

747 I also note "COPP 8.1: Incident Reporting" states: "*Incident Descriptions must be concise, objective and factually accurate*." (underlining added)[646]

748 I confirm that I have carefully considered the reasons that counsel for Mr Mead-Hunter has made in support of his detailed written submissions that no adverse finding should be made with respect to Mr Mead-Hunter's response. After considering those reasons in their entirety, I am not persuaded the adverse finding has not been established on all the information available to me. I will, however, specifically refer to two of counsel's reasons.

749 The first is the citing of a portion of Mr Torrijos' evidence at the CCC.[647] The three questions and answers (that are quoted in part) need to be put in context. I will therefore set out the entirety of the transcript that I regard as relevant to this aspect of Mr Torrijos' evidence at the CCC. Those parts of

[644] Exhibit 1, Volume 2, Tab 9.3
[645] Exhibit 1, Volume 2.1, Tab 5.2
[646] Exhibit 1, Volume 7, Tab 1.2, p.4
[647] Written closing submissions from Mr Mead-Hunter dated 6 May 2025, [51]

the transcript cited by Mr Mead-Hunter's counsel are in italics and in blue:[648]

> Mr Torrijos, the Commission has evidence that Mr Mead-Hunter's recollection is that when you went into his office, he was on a break, and he was resting with his eyes closed. Do you remember that?--- I can't remember him being asleep, because - I've just approached him and went "Keys, Cleveland's hanging", you know, like - and straightaway he gave me the keys, so I can't ---
>
> And your recollection was that he was at the computer with his eyes open? --- At the computer, yeah.
>
> …
>
> *The Commission also has evidence that Mr Mead-Hunter's recollection is that when you entered his office, you did not say anything about someone hanging. You just asked for his keys. What would you say to that?--- No. I'm pretty sure I said, "Cleveland's hanging, give us the keys".*
>
> *So if Mr Mead-Hunter gives evidence to the Commission all you said, "Can I have your keys?", and then possibly mumbled something else, what would you say to that evidence?--- The mumbling could have been "Cleveland's hanging". I'm pretty sure I said it*. That's why he threw me the keys.
>
> *How loudly did you say it?--- I can't say how loudly.* He gave me the - he understood straightaway, because he gave me the keys very quickly.
>
> Yes, how quickly did he give you the keys? --- Well, straight ---
>
> **THE COMMISSIONER:** Well, loudly enough for Mr Mead-Hunter to respond? --- Straightaway. I - I wasn't - I got the keys very quickly. That was all I was trying to do, was just get back up there and open the door, thinking that they would follow me. Because it's a bit of a process, opening the door. Like, you've got to do the top lock and ---
>
> **COUNSEL ASSISTING:** Mr Torrijos, is it a common thing, in your experience at night shift, to ask a senior officer for their keys to open a cell?--- It's not a common thing of opening a cell at night, no.
>
> Particularly asking for the keys from the senior officer so you can do that yourself?--- Um, I've taken keys off Kyle before, but in the circumstances, I definitely said, you know, "Cleveland's hanging" and he gave the keys ah, because he knew that I was on - to be going straight back up, you know, like, quickly. That is my thought on it, anyway.
> (underlining added)

750 In the interests of his client, counsel for Mr Mead-Hunter has properly emphasised that Mr Torrijos used the phrase "*pretty sure*" (underlined

[648] Exhibit 1, Volume 2.1, Tab 5.3, pp. 38-39

above) regarding his use of the word "*hanging*". Counsel submitted that: "*Mr Torrijos was plainly not certain that he used the word 'hanging' when he appeared before the CCC on 1 February 2024*."[649] However, a short time after Mr Torrijos used the phrase "*pretty sure*", he stated what I have also underlined.

751 In addition, Mr Torrijos' unambiguous evidence at the inquest was he had told Mr Mead-Hunter that Cleveland was hanging.[650] The only clarification he made was that he thought he had said Cleveland was "*fucking*" hanging.[651]

752 I have also noted that Mr Torrijos commonly uses the phrase "*pretty sure*", and not in the sense that he has a significant doubt about what he is saying. For example, during the course of his evidence at the inquest on 5 April 2024, he used this phrase when answering questions on no less than 16 occasions. Mr Torrijos repeated that same phrase again on three occasions before he completed his evidence the following day.[652]

753 The second reason I will refer to involved counsel for Mr Mead-Hunter's reliance on the following paragraph in the CCC report:[653]

> Having considered the totality of the evidence, the Commission is not able to be positively satisfied in either the affirmative or negative that the Acting Senior Officer understood from his interaction with [Mr Torrijos] that Cleveland was hanging.

754 After citing this paragraph, counsel used this heading in his written closing submissions: "*Like the CCC the Court cannot be satisfied Mr Mead-Hunter heard the word 'hanging'*".[654] With respect, that is not an accurate description of the conclusion made by the CCC.

755 The CCC was not able to find, in either the affirmative or the negative, that Mr Mead-Hunter "*understood*" from his interaction with Mr Torrijos that Cleveland was hanging. Used in the way it was in the CCC report, "*understood*" is not the same as the CCC not being satisfied (either in the negative or positive) that Mr Mead-Hunter "*heard*" Mr Torrijos say that Cleveland was hanging. This is a subtle, but nonetheless very important distinction.

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[649] Written closing submissions from Mr Mead-Hunter dated 6 May 2025, [52]
[650] Ts pp.136-137
[651] Ts p.136
[652] Mr Etherington had a similar mannerism with the phrase: "*Do you know what I mean?*"
[653] Exhibit 22, [234]
[654] Written closing submissions from Mr Mead-Hunter dated 6 May 2025, p.6

756 The Hon. former Commissioner McKechnie AO KC was well-known for his precise use of words during a long and distinguished legal career. I am satisfied the word "*understood*" was deliberately and carefully chosen in this part of the CCC report, and that a deliberate decision was made not to use or add the word "*heard*". The result is that the conclusion reached by the CCC would not be inconsistent with a finding made by the Court that Mr Mead-Hunter did hear Mr Torrijos refer to Cleveland's hanging.

757 **After a careful consideration of the available information, I am satisfied Mr Mead-Hunter heard Mr Torrijos say that Cleveland was hanging when he attended Mr Mead-Hunter's office at about 1.50 am on 12 October 2023. Accordingly, I make that finding.**

758 Having made this finding, it is necessary to consider why there was no sense of urgency displayed by Mr Mead-Hunter (as depicted on CCTV vision) when he made his way to Cleveland's cell after Mr Torrijos left his office with the keys.

759 As I have noted earlier in this finding, CCTV vision showed Mr Mead-Hunter attending Cleveland's cell about 40 seconds after Mr Torrijos had attended the cell, and about 67 seconds after Mr Torrijos had left his office.

760 Counsel assisting submitted, "*there is evidence to support a finding that Mr Mead-Hunter heard the word 'hanging' but dismissed its importance in his mind*", and that Mr Mead-Hunter, "*had dismissed the 'hanging' reference as just another frequently heard expression about hanging*."[655]

761 In his second affidavit to the Court, Mr Mead-Hunter denied these contentions and repeated what he would have done if he knew a detainee was hanging (which he had set out in his first affidavit). Namely, he would have been running to Cleveland's cell, he would have called the nurse on the way out of his office, he would have told the control room to call a Code Red and notify Casuarina that Unit 18 needed help, and he would have collected a specifically designed knife to cut a ligature.[656]

762 I am not satisfied I am able to accept the submission from counsel assisting regarding why Mr Mead-Hunter reacted in this way, even though I am satisfied he had heard Mr Torrijos say that Cleveland was hanging. That is because the information available relevant to this matter, when analysed in the context of Mr Mead-Hunter hearing all of what Mr Torrijos said, is

[655] Written closing submissions from counsel assisting dated 25 March 2025, [1213]
[656] Exhibit 82, [77]

equally consistent with Mr Mead-Hunter not appreciating (rather than dismissing) that there was an actual hanging incident involving Cleveland.

763 Consequently, having found that Mr Mead-Hunter heard all of what Mr Torrijos had said, I am satisfied he did not understand that to mean Cleveland was actually hanging.

764 **After a careful consideration of the available information, I am satisfied that Mr Mead-Hunter did not respond appropriately to Cleveland's incident. Accordingly, I make that finding. I am satisfied that the most likely explanation for Mr Mead-Hunter not immediately instigating the protocols for a hanging incident and his less than urgent response in following Mr Torrijos to Cleveland's cell was because he did not appreciate that an actual life-threatening hanging had occurred.**

765 Notwithstanding the above finding, I must make it clear I am satisfied that even if Mr Mead-Hunter had reacted differently and immediately instigated the protocols for a hanging incident, this would not have altered the ultimate outcome for Cleveland.

766 I acknowledge that the making of these findings against Mr Mead-Hunter has involved the drawing of inferences and I have applied the well-established principles that I have cited earlier.[657]

767 I also accept that it could be argued there is some inconsistency between the above finding against Mr Mead-Hunter and the conclusion made in the CCC report regarding this matter. I will therefore repeat what I said earlier in this finding: Although I must give careful consideration to the conclusions in the CCC report with respect to its investigation, I am not bound by those conclusions.

768 I have also noted that the Corruption and Crime Commissioner had the opportunity of observing Mr Mead-Hunter as he gave his evidence, an opportunity that I did not have. Although I did not have that benefit, I remain satisfied that I am able to make these findings.

769 The adverse findings I am satisfied can be made against Mr Torrijos, Ms Hayden, Ms Priestley and Mr McClennan are addressed below.

[657] ***Palmer v Dolman*** [2005] NSWCA 361 [41]

Mr Torrijos, Ms Hayden, Ms Priestley and Mr McClennan

1. The failure to wear radios on the night of 11 and 12 October 2023

770 Contrary to the Department's policies and procedures, no YCO wore a radio during the entirety of the night shift when Cleveland's incident occurred. That evidence was not disputed and has already been outlined above.[658]

771 **Mr Torrijos, Ms Hayden, Ms Priestley and Mr McClennan, did not dispute it was open for the Court to make a finding against each of them with respect to their failure to wear a radio for the entirety of the night shift on 11 and 12 October 2023. Accordingly, I make that finding with respect to each of these YCOs.**

772 However, I accept Ms Priestley would ordinarily wear a radio on night shift and that she actually commenced her shift on 11 October 2023 wearing a radio. She only took it off when she noticed other staff were not wearing radios as it was pointless if only one custodial officer was wearing a radio.[659] I am satisfied these facts reduce the level of criticism towards Ms Priestley's failure to wear a radio. Nevertheless, the finding against her is to remain as there is no information before me that she raised the matter of no other custodial staff wearing their radios with the acting Senior Officer or the other YCOs during the shift.

773 I have already indicated I was satisfied that had radios been used to raise the alarm then Cleveland's cell door would have been unlocked earlier. However, I reiterate that there was no evidence to support a finding that this would have made a difference to the ultimate outcome.

774 Ms Bain, the nurse on duty that night, was also required to wear a radio. However, she informed the Court she was told when she commenced working at Unit 18 that she did not need to wear a radio as staff were all in close proximity of each other.[660] There was no challenge to this evidence from Ms Bain and I am satisfied this was a reasonable explanation for her to not wear a radio. Accordingly, no finding has been made against her.

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[658] See: **ADVERSE FINDINGS, *The Department,*** *8. The failure by staff to wear radios on the night of 11 and 12 October 2023*

[659] Exhibit 1, Volume 2.1, Tab 8.1, [52]

[660] Exhibit 1, Volume 2.1, Tab 10.1, [27]-[31]

WAS CLEVELAND'S DEATH PREVENTABLE, PREDICTABLE AND PREDICTED?

775 Many witnesses who held senior positions in the Department were asked at the inquest if Cleveland's death was preventable:

- Dr Tomison accepted Cleveland's death was preventable.[661]
- Mr M Reynolds accepted Cleveland's death was preventable.[662]
- Ms Ginbey accepted Cleveland's death was preventable.[663]
- Mr Coyne accepted Cleveland's death was preventable.[664]
- Mr O'Siochain accepted Cleveland's death was preventable.[665]
- Mr Idowu accepted Cleveland's death was preventable.[666]
- Mr Mortley eventually accepted Cleveland's death was preventable (after he had first said it was not preventable and then said, "*likely preventable*").[667]

776 The factual circumstances in the hours leading up to Cleveland's incident need only be stated to appreciate just how preventable was his death. Mr Mortley's reluctance to acknowledge these obvious facts was most unedifying to hear.

777 Those circumstances were put to Dr Tomison during his examination:[668]

> And one of the primary ways that it was preventable, I suggest, was if the camera in his cell was functioning properly, then one would expect that the people in the control room would have seen him preparing to self-harm? --- Yes.
>
> And you would expect that if any person saw that, irrespective of what any COPP might say, empathetic human reaction would be to intervene? --- I have no doubt the staff would have intervened had they seen that on the CCTV.
>
> And do you accept the proposition that you can conclude his death was preventable because the camera was covered, and it had not been uncovered as it should have? --- Yes. I think they [sic-there] are probably

[661] Ts p.949
[662] Ts p.1797
[663] Ts p.2333
[664] Ts p.1897
[665] Ts p.2937
[666] Ts p.3321
[667] Ts pp.3010-3013
[668] Ts p.949

> other factors that will lead into why that incident occurred, but that is certainly a key factor.
>
> Well, it's as simple as that, isn't it? If the camera was working and was uncovered, the attempt at self-harm would have been seen and intervention occur? --- I expect that's most likely what would have occurred, yes.
>
> And that that analysis, in your mind – there might be other factors as well, but that analysis leads you to conclude, yes, I agree, his death was preventable? --- Yes.

778 Department witnesses were also asked to consider whether Cleveland's death was predictable.

779 I questioned Dr Tomison on this matter:[669]

> Just before we move on to that, you accept that Cleveland's death is preventable. Do you accept that it was predictable? --- To an extent, yes, your Honour.
>
> Only to an extent? --- It's hard – it's hard for me to say. We know that there were self-harming behaviours in that unit, and they were occurring on way too frequent a basis. So, in that sense, I guess you could say yes, it was potentially a predictable outcome.

780 Mr Royce, the current Commissioner, said he was aware of the concerns which had been expressed by Professor Morgan and Mr Ryan in their OCIS reports; in particular, that if the issues they had identified were not addressed, there was going to be a death in custody. Although Cleveland's incident did not occur when he was the Commissioner, Mr Royce acknowledged that the death of a young person in Unit 18 was predictable.[670]

781 Mr O'Siochain was asked whether he accepted the proposition that with what was going on in Unit 18 during 2023, it was predictable a detainee would die. He answered, "*I think there was a risk, yes*."[671]

782 Ms Ginbey did not agree that Cleveland's death was predictable, nor was the death of any detainee in Unit 18 predictable, because, as she explained: "*I believe that the safeguards we had in place would prevent such an incident*."[672]

783 Tragically, the death of a young person in detention had also been predicted by many people who had brought this to the attention of the Department.

[669] Ts pp.949-950
[670] Ts p.2627
[671] Ts p.2937
[672] Ts pp.2333, 2337

This included Professor Stanley who said that her research group predicted that a suicide would occur in a youth detention centre.[673]

784 On 21 September 2022, Mr Collins, in his capacity as Director of Legal Services, ALSWA, wrote a letter addressed to the Premier, the Attorney-General, the Minister and Ms Ginbey regarding the conditions at Banksia Hill and Unit 18. Mr Collins called for the transfer of detainees housed in Unit 18 back to Banksia Hill. The letter also stated: "*The time for a punitive punishment style approach to the detention of young people in WA has long passed.* ***If the current approach is persisted with, a death in custody is inevitable***." [674] (emphasis added)

785 During an interview on 23 September 2023, his Honour, Judge Quail commented:[675]

> …conditions in Unit 18 are still dire and need to be fixed urgently. There are currently 16 boys there who are locked down 23 hours per day. That has caused me many sleepless nights. I dread that a boy will suicide there, or a staff member be seriously harmed.

786 As I have already outlined above, on 28 September 2023, five days after his Honour's interview and 14 days before Cleveland's incident, ALSWA wrote to Ms Ginbey specifically about Cleveland and requesting that he be urgently transferred to Banksia Hill as "*the conditions in Unit 18 are negatively impacting his wellbeing.*"[676]

787 At the conclusion of his evidence, Mr D Reynolds said he wished to say something to Cleveland's family. This is what he said:[677]

> Can I extend my sincere apologies to you, all of your family, friends, and community for the sad passing of Cleveland. The death of a child is always unbearable, and I cannot imagine how much more difficult it is to bear when the death happened in circumstances which I respectfully think – it's not ultimately a matter for me – were preventable, predictable and predicted, when Cleveland was in the care of the State. I can understand why that burden will remain undiminished unless there is accountability for it and recognition of it by the State, and immediate systemic changes are made to reflect the law and proper notions of humane treatment for every child in care.

[673] Ts p.2881
[674] Exhibit 1, Volume 5, tab 1.5
[675] Exhibit 114, p.9
[676] Exhibit 1, Volume 5, tab 1.9
[677] Ts pp.912-913

788 **I am satisfied, to the required standard, that Cleveland's death was preventable. I am also satisfied, again to the required standard, that the death by way of suicide of a detainee in Unit 18 was not only predictable but had been predicted, and that the Department was aware of those predictions before Cleveland's incident on 12 October 2023. Accordingly, I make those findings.**

789 It was disappointing to hear Ms Ginbey's evidence at the inquest regarding her view as to the predictability of the death of a young person in detention as at the time of Cleveland's incident. After accepting that prior to Cleveland's incident she had knowledge of the concerns expressed by Mr Ryan, the ALSWA, Mr D Reynolds and Judge Quail of a death of a young person in detention occurring, and after agreeing they were people who were very qualified to express those concerns,[678] Ms Ginbey refused to accept it was predictable the death of a young person in detention would occur.[679]

THE QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF CLEVELAND

790 As already noted, I am required, in accordance with section 25(3) of the Act, to comment on the quality of the supervision, treatment and care of Cleveland whilst in the care of the Department.

791 At the completion of the oral evidence at the inquest, I said that for the purposes of section 25(3) of the Act, the Court would only be examining the supervision, treatment and care of Cleveland during his final period of detention in Unit 18 (i.e. from 17 July 2023 until the night of 11 and 12 October 2023).[680]

792 Although the findings below are limited to Cleveland's final period of detention, it should not be assumed that this means the supervision, treatment and care Cleveland received during any other period of his detention in Unit 18 was adequate.

793 The Department conceded that adverse findings were open with respect to its supervision, treatment and care provided to Cleveland during his final period of detention in Unit 18.[681]

[678] Ts p.2336
[679] Ts p.2337
[680] Ts p.4337
[681] Written closing submissions from the Department dated 6 May 2025, p.5

794 I am satisfied the responsibility for all the findings outlined below rests with the Department.[682] I am also satisfied that in most, if not all, instances of the Department's failings in its supervision, treatment and care of Cleveland can be linked to the lack of custodial staff in Unit 18.

Supervision of Cleveland in respect of self-harm or suicidal ideation

795 I am satisfied to the required standard that there was inadequate supervision of Cleveland while he was a person held in care at Unit 18 during his final period of detention. The Department accepted it did not adequately supervise Cleveland during his last period of detention in Unit 18.[683] I am satisfied that this inadequate supervision occurred whenever Cleveland was in his cell with the cell CCTV camera covered. From the information before the Court, I am satisfied this would have been most of the time during his final period of detention.

796 The inadequate supervision also extended to when Cleveland was not appropriately managed on ARMS in accordance with the ARMS Youth Manual on four occasions prior to his incident. The first three occasions occurred on 25 July, 26 July and 15 September 2023.[684]

797 The fourth and final occasion was following his threats to self-harm on the night of 11 and 12 October 2023.[685]

798 The Department also accepted it failed to intervene to prevent Cleveland's incident.[686] That concession was entirely appropriate. I am satisfied that had he been adequately supervised, it is almost inevitable the fatal outcome of Cleveland's incident would have been averted.

Treatment of Cleveland in respect of his solitary confinement and out of cell time

799 I am satisfied that Cleveland's treatment with respect to his excessive in-cell hours during the last time he was detained in Unit 18 fell so

[682] There are two findings in which the Department shared responsibility with an individual. One finding concerned the failure to adequately address the covering of cell CCTV cameras (Mr Coyne), and the other one related to the lack of an adequate number of custodial staff at Unit 18 (Dr Tomison).
[683] Written closing submissions from the Department dated 6 May 2025, p.29
[684] See: **ADVERSE FINDINGS, *The Department,*** *7. Other failures to comply with the ARMS Youth Manual regarding Cleveland*
[685] See: **ADVERSE FINDINGS, *The Department,*** *6. The failure to place Cleveland on ARMS during the evening of 11 October 2023*
[686] Written closing submissions from the Department dated 6 May 2025, p.29

substantially short of what would be considered appropriate that I have concluded it was inhumane.[687]

The overall treatment and care provided to Cleveland

800 I am satisfied that Cleveland did not receive adequate treatment and care during his final period of detention in Unit 18. As outlined above in my findings against the Department, this inadequate treatment and care extended to:

(a) The absence of an IEP for Cleveland;[688]

(b) The failure to adequately address the covering of cell CCTV cameras prior to 11 October 2023;[689]

(c) The failure to remove Cleveland from a cell with an obvious ligature anchor point (the damaged ceiling vent) prior to 11 October 2023;[690]

(d) The failure to provide water to Cleveland following his requests on the night of 11 October 2023;[691]

(e) Cleveland's lack of adequate access to mental health services and education;[692]

(f) Cleveland's lack of access to his YJO;[693]

(g) The failure to have adequate staffing numbers and to provide staff with appropriate experience at Unit 18;[694]

The lack of a trauma-informed environment in Unit 18

801 COPP 14.3 contained the following paragraph under the heading, "*Policy*":[695]

[687] See: **ADVERSE FINDINGS, *The Department,*** *2. Cleveland's excessive in cell hours*
[688] See: **ADVERSE FINDINGS, *The Department***, *1. The failure to prepare an Individual Engagement Plan for Cleveland*
[689] See: **ADVERSE FINDINGS, *The Department***, *3. The failure to adequately address the covering of cell CCTV cameras prior to 11 October 2023*
[690] See: **ADVERSE FINDINGS, *The Department***, *4. The failure to remove Cleveland from a cell with an obvious ligature anchor point*
[691] See: **ADVERSE FINDINGS, *The Department***, *5. The failure to provide water to Cleveland on the night of 11 October 2023*
[692] See: **ADVERSE FINDINGS, *The Department***, *9. Cleveland's lack of access to mental health services*, *10. Cleveland's lack of access to education*
[693] See: **ADVERSE FINDINGS, *The Department***, *11. Cleveland's lack of access to his YJO*
[694] See: **ADVERSE FINDINGS, *The Department***, *12. The failure to have adequate staffing numbers and to provide staff with appropriate experience of Unit 18*
[695] Exhibit 1, Volume 7, Tab 4.1.2, p.3

> Promoting a trauma-informed environment with consistent boundaries as well as ensuring young people are treated lawfully, humanely, fairly and equally, assist in providing a stable environment for young people placed at Unit 18.

802 COPP 14.3 became an operational policy for Unit 18 on 7 December 2022. I am satisfied that the information obtained by the Court regarding the haste with which Unit 18 was created, the lack of resources it had when it opened, and the ongoing problems it encountered, meant that the ideals set out in above paragraph were only ever going to be aspirational. And they remained precisely that during Cleveland's last period of detention.

803 At the inquest, Dr Tomison agreed there was no rehabilitation going on for someone like Cleveland in Unit 18 and that it was "*a nonsense to call that environment a 'trauma-informed environment'.*"[696]

804 One only has to examine the extensive period of confinement that Cleveland had in his cell by himself to appreciate the lack of rehabilitation and trauma-informed care provided to him during his final period of detention.

805 Irrespective of what its documents or policies may have said, I am satisfied that there was a failure by the Department to provide trauma-informed care to Cleveland in Unit 18 during his last period of detention.

An appropriate acknowledgement by Dr Tomison

806 Dr Tomison was recalled to give further evidence at the third tranche of the inquest. By this time, the Court had received a significant amount of evidence to support findings that the Department had failed in its supervision, treatment and care of Cleveland.

807 Dr Tomison acknowledged Unit 18 "*was never going to be a good option.*"[697] He agreed it was not fit for purpose in the long term, and it was not fit for purpose in the short term. He said he would frame the issue as Unit 18 "*was the best of a bad bunch*."[698]

808 Dr Tomison acknowledged that perhaps he had left it too long to make a decision to use an alternative site to Banksia Hill and he had been reluctant

[696] Ts p.1412
[697] Ts p.1338
[698] Ts p.1338

to do so. However, because of his failings and the Department's failings to act earlier, he was "*between a rock and a hard place*".[699]

809 Counsel for the Department asked Dr Tomison to explain what he meant by being between a rock and hard place. Dr Tomison said the rock was where the Department had started from. The hard place was deciding to have "*a temporary youth detention facility, knowing that there was no suitable site that was already set up ready to go.*" He said there was no good solution that he could see.[700]

810 At the end of his examination by Senior Counsel for Nadene Dodd, Dr Tomison made a frank acknowledgement which I am satisfied is clearly supported by the evidence with respect to Cleveland's final period in detention at Unit 18:[701]

> And would you agree with this, the State, through the Department of Justice, failed miserably in its obligation to care for Cleveland, specifically with respect to the conditions of Unit 18 generally? --- Yes.

811 Given the background of Unit 18 which the Court explored in detail at the inquest, I find that the manifestation of the Department's failure to provide an appropriate level of supervision, treatment and care to Cleveland can be traced back to 1 July 2022 when Dr Tomison chose Unit 18 as the best of a very poor list of options to urgently use as a second detention centre.

RECOMMENDATIONS

Introduction

812 This section of my finding outlines 14 of the 19 recommendations I have made after careful consideration of the proposed recommendations made by counsel assisting, counsel for the ALSWA and counsel for Nadene Dodd, and the written submissions from the Department in response to counsel assisting's proposed recommendations.

813 Some of the suggested additional recommendations from counsel for the ALSWA and counsel for Nadene Dodd fall within the recommendations I have made from counsel assisting's proposed recommendations. And there are other suggested recommendations raised by counsel for these two interested parties that I expect are either already implemented or have tried to be previously implemented by the Department.

[699] Ts p.1337
[700] Ts p.1486
[701] Ts p.1341

814 As to the balance of these additional proposed recommendations, although I have not formally adopted them, I would still invite the Department to consider them as it is clear to me that significant thought was given to their preparation by counsel with the objective of improving the welfare of Aboriginal detainees foremost in mind.

815 These further suggested recommendations from counsel for the ALSWA are found at page 117 of their written closing submissions dated 6 May 2025.

816 Those from counsel for Nadene Dodd are set out at pages 7-13 of their written closing submissions dated 7 May 2025. Specifically, I draw the Department's attention to the non-italicised portions under the headings:

(a) Alterations to Unit 18 if not immediately closed;

(b) Senior Positions pay and conditions;

(c) Addressing culture/leadership issues within the Department;

(d) Expansion of the Suicide Prevention Governance Unit and the management of high-risk detainees;

(e) Training and Support;

(f) Departmental Performance and Accountability; and

(g) Detention Offence Confinement.

817 This section of my finding also addresses two proposed recommendations by counsel assisting which I have determined the Court is not able to make as they involve legislative changes. In addition, I have outlined six proposed recommendations from counsel assisting that the Department has submitted have already been implemented and in one instance, will be implemented. Accordingly, I have not made any recommendations arising from these matters.

818 Finally, the remaining five recommendations I have made are dealt with under three separate headings. Four of these recommendations could have a significant impact if implemented. These recommendations cover (i) whether it is appropriate that the Department should continue to retain control over the supervision, treatment and care of young persons, (ii) the need for an independent agency to examine the manner in which Unit 18 came into the existence, and (iii) the future of Unit 18.

819 Critical to the first of these recommendations[702] is an examination of whether the Department is best equipped to care for detainees in youth detention who comprise 1% (and often less) of the entire population of the custodial estate under the current control of the Department.

820 However, I will first address the 14 recommendations (in no particular order).

Clothing worn by custodial staff in youth detention centres

821 As part of my preparation for the inquest, Ms Tyler and I made a scheduled visit to Banksia Hill on 11 January 2024.

822 One matter I noted during my visit was that detainees addressed custodial staff by their first names. I was advised that this was a conscious effort by staff to build rapport with the young people.[703] Although I regard that policy as a positive step, it was counteracted to a degree by some custodial staff wearing uniforms. Others were attired in more casual clothing that included Department-issued polo shirts. When I asked about this discrepancy, I was advised custodial staff had the option of wearing uniforms and although the wearing of less formal clothing was being encouraged, this was not presently a mandatory requirement. However, the model of care was working towards a greater level of informality regarding clothing from the YCOs through to the SMTs at Banksia Hill and Unit 18.[704]

823 Given the original purpose of Unit 18, the physical appearance of a place in which young persons are detained was the subject of considerable evidence at the inquest. Although the physical appearance of the clothing worn by custodial staff may not be as critical as the building and surrounds in which young persons are detained, I am firmly of the view that a universal friendlier appearance of the adults looking after detainees would be a welcomed improvement. The *Young Offenders Act 1994* (WA) sets out that the detention of a child is very different to the imprisonment of an adult. Logically, the space in which young persons are detained should not be staffed by adults dressed like prison officers.

[702] ***Recommendation No.15***
[703] Exhibit 1, Volume 1, Tab 48.4, p.13
[704] Exhibit 1, Volume 1, Tab 48.4, p.13

824 A proposed recommendation to this effect was made by counsel assisting.[705] The Department supported a recommendation to this effect and advised the Court that it was already "*in progress*".[706] In those circumstances, I will make the following recommendation:

> ***Recommendation No.1***
>
> **In order to enhance the environment of a youth detention centre, all custodial staff, including members of the SMT and seconded prison officers, should not wear uniforms and instead wear less formal attire such as polo shirts.**

Additional case managers

825 At the inquest, Ms Butt said there were significant deficiencies in the case management area in youth detention. This area is very important as it "*forms part of the rehabilitation and reintegration support services that are located at Banksia Hill and work across Banksia Hill and Unit 18*".[707] Ms Butt was asked what were the consequences of these deficits:[708]

> The case management role is very significant to anything that you would want to do in a model of care. It's a central position to supporting individual care to young people. And as you may have gleaned from the documents, being able to provide individual care is a key part of therapeutic care in a youth justice environment.
>
> And in your opinion, how does one cure that significant deficit? --- With additional case management resourcing.

826 Ms Butt's evidence substantiated two facts. First, case manager positions are crucial to what she has been asked to do in implementing a model of care. And secondly, the way to fix the deficit is to employ more case managers:[709]

> Do you accept that until both of those matters are addressed, the idea of being able to implement the model of care in the way that is anticipated is just not able to happen; they are so crucial? --- I would accept that we can implement components of the model of care, however we would still have an ad hoc approach to individual care for young people through that.

[705] Written closing submissions from counsel assisting dated 25 March 2025, p.332
[706] Written closing submissions from the Department dated 6 May 2025, p.129
[707] Ts p.4138
[708] Ts p.4138
[709] Ts p.4140

> How many case managers are available for the Banksia detainees at the moment approximately? --- So, my understanding is we have five permanent FTE.
>
> And how many do you need in order to do what you describe as this fundamental crucial role? --- So, my view is that we would need six further permanent FTE.

827 At the inquest, Ms Butt said that given the current juvenile detention population numbering in the mid-60s, if she had an additional six case managers made available: "*It would make a difference in that we would be able to provide comprehensive individual support to young people*."[710]

828 Ms Butt also identified that making these positions permanent rather than temporary would be more attractive to prospective employees. She also identified that the principal barrier to these additional case managers being employed is simply funding.[711]

829 Counsel assisting made a proposed recommendation to increase the number of case managers.[712] The Department's position regarding this proposed recommendation was: "*Supported in principle, subject to funding*".[713] In those circumstances, I make the following recommendation:

Recommendation No.2

In order to enhance the support provided to detainees, the Department, as a matter of urgency, applies for funding so that an additional six case managers can be employed at Banksia Hill.

If this recommendation is implemented, the Department should pay heed to Ms Butt's view that filling and retaining these positions would be more attractive if they were permanent positions.

Expanding the Suicide Prevention Governance Unit to include the youth estate

830 Until 2016, the Department's governance for suicide prevention was provided by the Suicide Prevention and Clinical Governance Team that was within the Department's Offender Services. However, from 2017,

[710] Ts p.4140
[711] Ts p.4140
[712] Written closing submissions from counsel assisting dated 25 March 2025, p.337
[713] Written closing submissions from the Department dated 6 May 2025, p.129

following a restructure, there was no team or branch overseeing the suicide prevention portfolio within the Department.[714]

831 In November 2022, approval was given to a proposal to re-establish a unit within Offender Services to address the suicide rates amongst prisoners. This led to the creation of the Suicide Prevention Governance Unit (SPGU).

832 The SPGU endorsed three essential components of suicide prevention: (i) clinical insight into risk behaviour, thereby creating effective strategies to mitigate risk; (ii) operational knowledge to implement suicide prevention policy in prisons; and (iii) Aboriginal cultural understanding of risk to benefit the largest vulnerable prisoner cohort.[715]

833 As can be seen from the wording of these components, the first priority for the SPGU has been the adult custodial estate. However, in 2023, a review by the SPGU recommended its expansions to include a youth specific clinician and a specific reference group to provide oversight and advice in relation to the management of detainees at high risk of suicide. Although these recommendations were accepted by the Department, no funding had been allocated for these youth-specific positions.[716] Consequently the SPGU has not formally entered the youth estate yet.

834 I am satisfied that this expansion is necessary for the SPGU to have a proper and relevant input into the youth custodial estate. For the reasons Mr Beck outlined in his letter to the Court, this input requires the additional resources that the SPGU review recommended: "*This reflects the fact that the youth estate has stand-alone legislation and separate ARMS and SAMS manuals which require individualised approach, and effective, dedicated governance.*"[717]

835 A proposed recommendation regarding the expansion of the SPGU as outlined above was made by counsel assisting in his closing submissions.[718] The Department's response was: "*Supported in principle, subject to funding.*"[719]

836 Despite this "*in principle*" support, Mr Beck gave evidence at the inquest that the recommendation to expand the SPGU into the youth estate, to his understanding, did not actually go up to the Minister to seek funding and that he believed it was stopped at the level of the Director General's

[714] Exhibit 25, p.1
[715] Exhibit 25, p.2
[716] Exhibit 25, p.2
[717] Exhibit 25, p.1
[718] Written closing submissions from counsel assisting 25 March 2025, p.330
[719] Written closing submissions from the Department dated 6 May 2025, p.129

office.[720] After giving this evidence, Mr Beck was asked these questions by Senior Counsel for Nadene Dodd:[721]

> And did you make any enquiries as to why it didn't go forward? --- Well, the explanation was on there that it wasn't - it wasn't seen to be a priority in the context of all the other priorities that were on that sheet.
>
> So you're saying, just so that I'm particularly clear, and more importantly, the coroner, you're saying that a recommendation to expand the SPGU's work to include a youth-specific clinician and all the other matters that you've referred to in your letter[722] were put up by the unit[723] and declined, on the basis it wasn't a sufficient priority? --- Correct.
>
> And what's your reaction to that, sir? --- I was very disappointed.

837 I share Mr Beck's disappointment. If Mr Beck's understanding is accurate, it also casts a shadow over the Department's "*subject to funding*" support for a recommendation from the Court with respect to this matter. A recommendation will never materialise if funding is not sought by the Department to implement the recommendation. I simply hope this is not an example of the Department failing to prioritise its care of a cohort that is always only ever going to be a fraction of its overall custodial estate.

838 I make the following recommendation:

> ***Recommendation No.3***
>
> **In order to lower the risk of suicide and thereby enhance the care of detainees, the Department, as a matter of urgency, seek funding for an expansion of the SPGU to include a youth-specific clinician and a youth-specific reference group to provide oversight and advice in relation to the management of detainees who are at high risk of suicide.**

Additional training for YCOs for the positions of Unit Manager and Senior Officer

839 It was disturbing to hear the unchallenged evidence from YCOs at the inquest that they received no additional formal training at the Corrective Services Academy before they took on the roles of Unit Manager and/or Senior Officer. It was bad enough that YCOs who were still on probation

[720] Ts p.2233
[721] Ts pp.2233-2234
[722] Exhibit 25
[723] The SPGU

were required to assume these important supervisory responsibilities, but to have received no formal training for those roles is of considerable concern. Unsurprisingly, Ms Ginbey accepted this was a very significant shortfall in how Unit 18 was operating.[724]

840 As to the proposed recommendation from counsel assisting that additional funding be provided for the training of YCOs for these positions,[725] the Department responded: "*Supported in principle, subject to funding.*"[726] In those circumstances, I make the following recommendation:

Recommendation No.4

In order to improve the operations of youth detention centres, the Department seeks the necessary funding to provide training at the Corrective Services Academy to YCOs for the positions of Unit Manager and Senior Officer.

The training of prison officers who move to the youth custodial estate

841 The size of the adult custodial estate dwarfs the youth custodial estate in Western Australia. The daily number of adult prisoners is currently at or above 7000 and the number of detainees in the youth estate has been considerably less than 100 in recent years.[727] Given those numbers, it was not surprising to hear at the inquest that staff from the adult custodial estate move to the youth estate (particularly when regard is had to the recent high attrition rate amongst custodial staff in the youth estate). However, what was surprising was the evidence I heard regarding the lack of training provided to custodial staff who make that transition.

842 The inquest heard that every member of the SMT at Unit 18 commenced their employment in the adult custodial estate.

843 Mr Mortley received no training from the Department before being asked to work in the youth custodial estate.[728] At the inquest, he said he was brought over from the adult estate because, "*there was a lack of experience in the youth space to be able to manage and so I was brought over to assist with that*."[729] This illustrated the problem with bringing staff from the adult

[724] Ts p.2320
[725] Written closing submissions from counsel assisting dated 25 March 2025, p.319
[726] Written closing submissions from the Department dated 6 May 2025, p.128
[727] Exhibit 111, p.3
[728] Ts pp.3004, 3017
[729] Ts p.3005

estate into the youth estate without any training. The pool of potential managers for the youth estate is inevitably drawn from the adult estate. The difficulty is exacerbated because the Department provides no training to facilitate that move. As Mr O'Siochain testified: "*There is a big difference between looking after children in detention as opposed to adults in prison*".[730]

844 Mr O'Siochain also did not receive any training when he went from the adult estate to the youth estate in a managerial position. At the inquest, he was very supportive of a training or bridging course being offered to those custodial staff that make this transition.[731]

845 Dr Cooney agreed:[732]

> I think having that real acknowledgment that the needs of young people are very different and the kinds of people who should oversee those facilities do need a different skill set, and different specialist knowledge about that cohort is an essential requirement.

846 Dr Cooney also said there was "*a lot of value*" in having:[733]

> … a recommendation, that the Department have a dedicated training program - not ad hoc training organised by a caring super or deputy super - but a dedicated training program that this is a career choice. If you want to manage youth detention facilities, you have to go and learn these skills and demonstrate that you've got that knowledge and skill.

847 Dr Cooney identified many benefits to this dedicated training program which included identifying those staff who actually want to work in youth estate rather than being told to work there, the opportunity to put together a specific teaching curriculum, and the ability to educate the future managers of youth detention facilities how to be role models and teachers for those whom they will be managing.[734]

848 The undisputed evidence from the inquest (which was consistent with the principles in the *Young Offenders Act 1994* (WA)) was the fact that there are vastly different considerations to be taken into account when looking after young persons compared to adult prisoners. The need for training and education regarding these differences should extend not just to prison

[730] Ts pp.2953-2954
[731] Ts pp.2953-2954
[732] Ts p.3499
[733] Ts p.3501
[734] Ts p.3501

officers coming into the youth estate but also to those holding managerial positions who transitioning from adult prisons into youth detention centres.

849 A proposed recommendation to that effect was made by counsel assisting.[735] The Department responded: "*Supported in principle, subject to funding*."[736] Accordingly, I make the following recommendation:

> ***Recommendation No.5***
>
> **In order to improve the operations of youth detention centres, the Department seeks the necessary funding so that mandatory and comprehensive training is provided by the Corrective Services Academy to those custodial staff moving from the adult estate to the youth estate. This training should be provided to prison officers and those in senior management positions who are making the transition.**

Addressing the level of neurological impairments in detainees

850 The Banksia Hill Project was a study undertaken by the Telethon Kids Institute[737] (the Banksia Studies), in collaboration with the Department and the Department of Communities. From May 2015 to December 2016, it assessed detainees in Banksia Hill for foetal alcohol spectrum disorder (FASD) and other severe neurodevelopmental impairments. It was the first study of its kind in Australia to assess this cohort of the population for neurocognitive disorders. It was, without a doubt, a seminal and groundbreaking study of young persons who have offended.

851 Comprehensive neurodevelopmental assessments of 99 detainees aged between 10 and 17 years were undertaken. Nearly 75% of those young persons were indigenous. Thirty-six (36%) of the young persons involved in the study were identified as having FASD. A staggering 89% had at least one severe neurodevelopmental impairment i.e. problems with memory, language, motor skills, cognition, attention, social and other skills. 65% had at least three severely impaired domains (out of nine neurodevelopmental domains assessed by the team), while 23% had five or more severely impaired domains.[738]

[735] Written closing submissions from counsel assisting dated 25 March 2025, p.321
[736] Written closing submissions from the Department dated 6 May 2025, p.128
[737] Now known as The Kids Research Institute Australia.
[738] Exhibit 95.2, p.1

852 These findings were published in 2018.[739]

853 The Banksia Studies established a significant number of outcomes. These included:[740]

- Identifying the highest known prevalence of FASD in a custodial/corrective setting worldwide, and provided evidence of an extraordinary and unprecedented level of neurodevelopmental impairment amongst sentenced youth in Western Australia.
- Highlighting the vulnerability of young people within the justice system and their significant need for improved diagnosis to identify their strengths and difficulties, and to guide and improve their rehabilitation.
- For many of the young people assessed, this was the first time they had had a comprehensive assessment to examine their strengths and difficulties, despite attending school, prior engagement with the justice system and, in many cases, prior engagement with Child Protection Services.
- Current custodial processes had not reduced recidivism or increased the chances of these young people becoming productive and law-abiding.
- The release of the evidence gathered represented a pivotal point and provided an opportunity to reassess and significantly improve the assessment, diagnosis, management and support of young people in contact with the justice system.

854 Of the 16 detainees in Unit 18 on 11 October 2023, 14 were diagnosed with multiple neurodevelopmental disorders, nine of whom were diagnosed with FASD.[741]

855 Mr O'Siochain had been working in the SMT at Unit 18 since January 2023. When he gave evidence at the inquest more than 18 months later, he said he had no knowledge of the work undertaken by the Banksia Studies, the material that had been generated by the project or what its research had shown. He had no sense of what percentage of detainees had significant neurocognitive disabilities. He had never been taught how to manage a person with such disabilities. As far as he was aware, no training in this

[739] Exhibit 95.2
[740] Exhibit 95.10, pp.1-2
[741] Exhibit 46, attachment PC 01

regard was provided to anyone moving from the adult custodial estate into the youth custodial estate.

856 To say I was disheartened to hear this evidence from Mr O'Siochain is an understatement. Although I was relieved to hear Mr O'Siochain agree that the lack of training for adult custodial staff transitioning into the youth estate was a serious deficiency.[742]

857 There is now an abundance of scientific evidence about the medical and related issues associated with young persons who are in detention in this State. The percentage of the detained cohort who exhibit these significant disabilities is overwhelming. Yet it was apparent that at the time of the inquest, this information was not being taught to the YCOs or those who manage and supervise youth detention centres. Although there was universal agreement that managing a child in detention is very different from managing an adult prisoner in custody, these differences were not reflected in the Department's preparation of its staff to work with young persons. This was despite the findings of the Banksia Studies having been published six years before the inquest.

858 Counsel assisting made three proposed recommendations in this area.[743]

859 The first of these recommendations was that all custodial staff in the youth estate be provided with detailed information about the findings by the Banksia Studies and how those findings impact working with detainees who have neurodevelopmental deficiencies. The Department's response to this proposed recommendation was: "*Supported. In progress.*"[744] As I am uncertain as to the extent of the "*progress*" the Department has made in this area, I make the following recommendation:

Recommendation No.6

In order to improve the care of detainees, all custodial staff (including those in supervisory or managerial positions) must receive as part of their training as a YCO or as part of their transition from the adult estate to the youth estate, detailed and comprehensive instruction and information of the findings made in the Banksia Studies, and how those findings inform and impact the care of detainees with neurocognitive disabilities.

[742] Ts pp.2994-2996
[743] Written closing submissions from counsel assisting dated 25 March 2025, pp.329-330
[744] Written closing submissions from the Department dated 6 May 225, p.128

860 Implementation of the above recommendation would require suitably qualified persons to train custodial staff in this field. Accordingly, counsel assisting's second recommendation was that funding should be provided to ensure instructors at the Corrective Services Academy are suitably qualified. The Department indicated that it "*supported*" this proposed recommendation and that it was "*under implementation*".[745] Consequently, I make the following recommendation:

> ***Recommendation No.7***
>
> **In order to effectively implement the Recommendation No.6, the Department should ensure there is ongoing funding to ensure the instructors at the Corrective Services Academy are appropriately qualified to provide the training as described in the above recommendation.**

861 The third proposed recommendation made by counsel assisting in this area concerned the provision of funding to enable all children appearing in the Children's Court to be triaged to determine whether they require a comprehensive assessment for possible neurocognitive deficits. This was the suggestion of Professor Stanley during the course of her evidence at the inquest,[746] Counsel assisting also proposed that funding be provided to enable that comprehensive assessment to be undertaken. The Department's response to this proposed recommendation was: "*Supported in principle, subject to funding.*"[747]

862 After careful consideration of this proposed recommendation, I have decided not to make it for three reasons.

863 First, there would be considerable expense involved just in the triaging stage if this recommendation was implemented. Although I was not able to find data as to the number of young people appearing in the Children's Court in any one year, for the year 2022/23 there were 7350 cases processed through the criminal jurisdiction of the Children's Court. A "case" referred to a young person processed through the Children's Court with one or more charges lodged on any one occasion.[748] This would mean that the number of young people appearing during that financial year would be considerably

[745] Written closing submissions from the Department dated 6 May 225, p.129
[746] Ts p.2882
[747] Written closing submissions from the Department dated 6 May 225, p.129
[748] Report on Criminal Cases in the Children's Court of Western Australia 2018/19 to 2022/23, p.1: www.wa.gov.au/system/files/2024-06/childerns-court-criminal-report-2018-2019-to-2022-2023.pdf

lower than 7350. Nevertheless, it would reflect a number well in excess of 1000.

864 Secondly, the Perth Children's Court already has options for young persons who appear before it to be assessed should there be concerns regarding any potential impairment or disability. One of those options is the In-Roads Pilot Program introduced in 2023 that is available to a young person who has pleaded guilty to all or most of their charges before the court and is facing an immediate term of detention.[749]

865 Thirdly, the Department has already begun the process of developing an assessment for young persons in custody that focuses on neurodevelopmental and mental health screening.

866 As Dr Cooney outlined in her statement dated 23 July 2024 to the inquest:[750]

> The Youth Detention State Forensic Mental Health Services are developing a screening and assessment process for young people in custody, focusing on neurodevelopmental and mental health screening. Once their service model and screening tool is finalised, the intention will be for every new admission to custody to be screened for neurodevelopmental and mental health disorders within the first week of their admission. The team have been piloting the screening tool, and have conducted a number of full multidisciplinary assessments for young people, where this has been indicated.
>
> In recognition of the clinical expertise available in the Department of Health specifically in the area of Child and Adolescent Mental Health, consultation commenced in October 2023 for the three mental health positions based in youth detention, which currently fall under Offender Services in the Department of Justice, to be filled by the Department of Health. This includes the one Clinical Nurse MHAOD[751] position, and two Aboriginal Mental Health Workers. … All parties have been supportive and thus the formal proposal for approval was submitted in early July 2024, for consideration by the Commissioner.

867 This is a commendable development. The collaborative efforts of the Department and the Department of Health are encouraging. I have therefore reached the conclusion that a recommendation that supports this initiative would have a greater prospect of being implemented as it is more cost

[749] https://childrenscourt.wa.gov.au/I/inroads.aspx
[750] Exhibit 58, pp.41-42
[751] Mental Heath and Other Drugs

effective than the triage process for all young people appearing in the Children's Court. Accordingly, I make the following recommendation:

Recommendation No.8

In order to enhance the care of detainees, the Department and the Department of Health continue their collaborative approach to have young persons who are placed in custody (including those on remand) screened for neurodevelopmental and mental health disorders with a follow-up assessment if required. Sufficient funding should be obtained to ensure this process is implemented on a permanent basis.

868 Finally, I should note that I see considerable merit in the submission from counsel for Nadene Dodd that there be "*an Aboriginal health/support worker*" present during these assessments.[752] The Department should ensure that every effort is made to have this person in attendance as it would certainly assist the process.

Extending mental health services at Unit 18

869 Ms Bain told the inquest that although there was a mental health team based in Banksia Hill, there was no such team at Unit 18. Instead, the team from Banksia Hill would attend Unit 18. Although there had been some improvements in the frequency of the attendance of members from that team in the period after Cleveland's incident, Ms Bain did not consider those improvements to be sufficient.[753]

870 Ms Bain also told the inquest there was an infrastructure problem in terms of providing mental health care to detainees in Unit 18 as there was insufficient space, and there was insufficient staff to deal with mental health issues.[754]

871 Ms Bain agreed that having a dedicated mental health practitioner with the Unit 18 nurse would provide significant support for the nurse and the detainees.[755]

872 The shifts presently at Unit 18 are of 12-hour duration. I have no doubt that the circumstances in which the sole nurse and custodial staff are rostered in

[752] Written closing submissions from counsel for Nadene Dodd dated 7 May 2025, p.9
[753] Ts pp.484-485
[754] Ts pp.483-485
[755] Ts p.482

Unit 18 can at times be an extremely demanding and stressful. Just as it would never be expected that a nurse would undertake custodial duties, so too is it unreasonable to expect a YCO to be sufficiently skilled to deliver prompt and adequate mental health care to a detainee.

873 From the evidence I have heard at the inquest, the need for mental health care to detainees in Unit 18 is constant. The workload for the single nurse on shift was such that nursing staff rostered at Unit 18 had already raised the question of, "*a nurse roving for incidents and then another nurse that can be solely for attending to their health requirements, so updating their immunisations, any external appointments, any health concerns, general health needs of the detainees.*"[756]

874 It is almost inevitable that most, if not all detainees transferred to Unit 18 have mental health issues requiring an appropriate level of mental health care. I am satisfied that the resourcing to meet that need in Unit 18, when Cleveland was there was inadequate. Had a mental health team member been available on those days shortly before Cleveland's incident when he was requesting to see a psychologist, that person may have been able to see him. From the evidence I heard from Ms Bain and Mr MacDonald, these inadequacies were still present at the time of the inquest.

875 All prisons and youth detention centres in this State provide a mental health service, yet crisis care units that are staffed seven days a week by mental health specialists only exist in the adult prison estate.[757]

876 The only health service provider who is on duty at youth detention centres seven days a week and 24 hours per day are clinical nurses. Mental health practitioners, including Aboriginal health and mental health practitioners, are only "*available by referral, request and/or triage on specialised consultation days.*"[758] This simply highlights the deficiencies in the provision of mental health services to young persons in detention when compared to adult male and female prisoners. Given the findings from the Banksia Studies, this is very concerning.

877 Counsel assisting put forward a proposed recommendation to the effect that if Unit 18 was to remain open, a mental health team member must be based there at all times i.e. seven days a week and 24 hours per day.[759] In its

[756] Ts p.482
[757] These three prisons are Casuarina, Hakea and Bandyup Women's Prison: https://www.wa.gov.au/organisation/department-of-justice/corrective-services
[758] "COPP 3.1 Access to Health and Psychological Services - Youth Detention Centres", version 5.0, p.4: www.wa.gov.au/organisation/department-of-justice/corrective-services/commissioners-operating-policies-and-procedures-prisons
[759] Written closing submissions from counsel assisting dated 25 March 2025, p.341

response, the Department said: "*Supported in principle, subject to funding*."[760]

878 From the information obtained by the Court from the Department, it is evident that the number of detainees in Unit 18 has generally diminished since Cleveland's death. Given the Department's support is "*subject to funding*", I'm not minded to make a recommendation a mental health team member needs to be there seven days a week and 24 hours a day. Instead, my recommendation will be confined to the presence of this person during the day shifts. I will also not specify that the person should be a mental health nurse as I am well aware of the difficulties the Department has experienced for a number of years recruiting such nurses. I have therefore described this person as "*a mental health team member*". The Department should aim to fill the position with an indigenous person. Accordingly, I make the following recommendation:

Recommendation No.9

Should Unit 18 remain open until the completion of the proposed youth detention centre, and in order to maintain an appropriate level of mental health care to detainees in Unit 18, the Department is to seek urgent funding for the allocation of a mental health team member to be based in Unit 18 for day shifts seven days a week.

Remuneration for health service and allied health service providers working in prisons and youth detention centres

879 At the inquest, Mr Royce was invited to suggest possible recommendations for the Court to consider. Mr Royce responded as follows:[761]

> The difficulty I face that I believe is going to have to be sorted through, and this might be the avenue, is in the attraction and retention of professional staff in the custodial environment. And that's across, but certainly in the youth space, we are struggling, like the rest of Health in Western Australia, for psychologists, nurses, doctors. The remuneration plan doesn't fit with what they're entitled to in other parts of government, and that has led us to a position where we're constantly having to compete when we're taking care of some of the most vulnerable people in the state. We are in direct competition with other health providers, with external providers, and that is making it difficult. I have the positions given to me by government. I'm struggling to fill them, and they are critical.

[760] Written closing submissions from the Department dated 6 May 2025, p.130
[761] Ts pp.2651-2652

> So you need more money to fill those places? --- I need proper remuneration that aligns to the profession they're from, so that, across government, we're not in direct competition.
>
> So the task you've been given can't be fulfilled with the resources you've been given? --- We are – we are fulfilling and getting resources. It is extremely difficult. We have to go far and wide, because it is a difficult and complex environment to work in, in the correctional facilities. It is tough work, and they do a fantastic job, but when they're not getting the same opportunities as people in their profession just by working for, say, the Health Department, then it's easy for them, after a bad time, to go and find a different job. I would rather keep them with me.
>
> So what is the recommendation that you would ask his Honour to reflect upon? --- For me, it's a reset of the health providers and the allied health providers in the correctional institutions, and align their – their pay grades to the Department of Health.
> (underlining added)

880 I accept that the remuneration for professionals in the public sector will rarely match the salaries available for commensurate positions in the private sector. However, what surprised me was the evidence from Mr Royce that health service providers (including allied health service providers) working in correctional facilities are paid less than those holding the same positions in the Department of Health. It is therefore hardly surprising that the Department cannot fill these positions, and then retain those people who take up these positions.

881 I therefore completely agree with Mr Royce's view that a "*reset*" is desperately required. If the Department persists with providing lower remuneration to its health service and allied health service provider positions compared to corresponding positions in the Department of Health, its struggle to gain and retain staff in these positions will remain. Unless a suitably qualified person seeking employment in the public sector has a strong desire to work in a custodial environment, I expect most will choose the Department of Health over a correctional facility offering the same position every time; particularly when they discover the renumeration is better. That must change and my resolute view is that change can only begin if the discrepancies with the comparative remunerations between the Department and the Department of Health are addressed.

882 Given the undisputed fact that the provision of adequate health and mental health care is essential in the adult and youth custodial estates and the perception (rightly or wrongly) by potential applicants that there are added dangers working in those environments, there is a compelling argument that the remuneration should be higher than the equivalent positions in the

Department of Health. But I fear that might be a bridge too far should I make a recommendation to that effect.

883 I also note that there would be a justifiable sense of grievance amongst the health service and allied health service providers in the adult custodial estate if a recommendation by the Court regarding remuneration parity with the Department of Health was confined to those health and allied health service providers in the youth custodial estate. I am only too aware from past inquests that the recruiting and retention of health service and allied health service providers in the adult estate remains a longstanding and unresolved issue.

884 A proposed recommendation that reflected the evidence from Mr Royce was made by counsel assisting.[762] As to the Department's position regarding this proposal, the Court was advised: "*Decision for other entity; supported in principle.*"[763]

885 I have difficulty understanding why the Department would say it is a "*decision for other entity*". This other entity was not identified. If the other entity is the State Government, then one would not expect the government to act unless it received a submission from the Department seeking additional funding to address the inequity in its remuneration packages when compared to the Department of Health, and how that impacts on its ability to fill vacant positions.

886 Nevertheless, as it is supported in principle by the Department, I make the following recommendation:

Recommendation No.10

In order to improve its care of prisoners and detainees, the renumeration and pay structures of health service and allied health service providers in the adult and youth custodial estates should be, at the very least, commensurate with those of comparative health service and allied health service providers in the Department of Health. The Department should seek urgent funding to address this imbalance.

[762] Written closing submissions from counsel assisting dated 25 March 2025, p.342
[763] Written closing submissions from the Department dated 6 May 2025, p.130

The implementing of youth carer roles within youth detention centres

887 In the OICS Report of May 2023, one of Mr Ryan's recommendations to the Department was to: "*Reimagine and establish a youth care role - separated from youth custodial officers - to support and guide young people in every aspect of their day in custody.*"[764]

888 Mr Ryan cited a Spanish youth detention agency that follows a model of care which has staff playing three distinct roles; namely, social educators, a technical team (comprising of psychology, health, social workers, reintegration workers) and security staff. Social educators were described as:[765]

> Qualified to degree level and guided by the technical team, they support young people throughout every aspect of their day, from getting up in the morning to when they go to bed and are included in classes, vocational training and leisure activities. They are at the heart of our approach and genuinely care about the young people they work with.

889 Mr Ryan endorsed such an approach in Western Australia, stating it "*would be innovative and revolutionary, with the potential to transform the kind of care and engagement that could be offered to young people.*"[766]

890 Counsel Assisting proposed a recommendation that mirrored the one made by Mr Ryan: "*The Department implements youth carer roles within youth detention facilities.*"[767]

891 In its response to Mr Ryan's recommendation, the Department stated it would not be supported, maintaining:[768]

> … the role of youth custodial Officers (YCOs) is to provide primary care and management, as well as maintain the safety and security of young people in detention. As the MoC[769] continues to be implemented and embedded, so will the role of the YCOs who will work closely with non-uniform staff, such as the Aboriginal Youth Support Officers (AYSO), to provide a range of supports and services that guide the young people through their day, including through the provision of meaningful activities and ensuring their welfare and wellbeing whilst in custody.

[764] Exhibit 20, p.17
[765] Exhibit 20, p.17
[766] Exhibit 20, p.17
[767] Written closing submissions from counsel assisting dated 25 March 2025, p.333
[768] Exhibit 20.2, p.5
[769] Model of care.

892 As to counsel assisting's similarly worded proposed recommendation, the Department submitted: "*Supported and implemented by way of existing YCO roles.*"[770]

893 I have difficulty accepting that the Department has implemented what Mr Ryan and counsel assisting had proposed. Clearly what Mr Ryan had in mind was that this youth carer role was to be separate from YCOs, and with appropriate tertiary qualifications to undertake the role. They would also have more intensive interaction with a detainee then an AYSO would be able to offer.

894 It is my view that such an extensive additional support would be of considerable benefit to detainees in Unit 18 should it remain open until the completion of the second youth detention centre. I am also firmly of the view that Cleveland would have benefited significantly from such a carer.

895 In those circumstances I make the following recommendation:

Recommendation No.11

Should Unit 18 remain open until the completion of the yet-to-be-built youth detention centre, and in order to provide the necessary support to detainees in Unit 18, the Department seeks funding for the allocation of youth carers, separate from YCOs, to support and guide detainees in every aspect of their daily activities in detention.

The implementing of a shorter shift system for custodial staff in youth detention centres

896 In the OICS Report of May 2023, Mr Ryan identified the need for major reform regarding the 12-hour shift system for custodial staff in youth detention centres.[771] As Mr Ryan outlined:[772]

> There needs to be innovation to reshape the workforce to make the job safer and more meaningful for staff and more effective in the provision of care and rehabilitation for young people. Such reforms should also improve staff retention and attract new recruits. The new proposed operating philosophy and service model specifies that young people should reliably have at least 10 hours, preferably more than 12 hours, out of cell per day (Nous Consulting, 2022, p.42 Stock Standard 1.2.1). It also

[770] Written closing submissions from the Department dated 6 May 2025, p.129
[771] Exhibit 20, pp.17-18
[772] Exhibit 20, p.18

> stipulates that rosters be designed to promote greater continuity and consistency between young people and staff (Nous Consulting, 2022, p.59 Standard 3.1.1). This is a major component in a balanced approach to safety and security. It points to best practice in other states indicating that this can be achieved through eight-hour shift systems (Nous Consulting, 2022, p.32).

897 Although Mr Ryan recognised that the current 12-hour shift system was popular with many staff as it reduced attendance to 10 shifts in 21 days and attracts a shift allowance, he noted "*it also limits continuity of care and is not how youth-facing roles should be organised*".[773]

898 Mr Ryan was of the firm view that a "*mixed-shift system*" was critically needed, "*with those working with young people in eight- or 10- hour shifts, working four to five day shifts per week.*"[774] Mr Ryan suggested that it may be feasible to pilot such a system with current graduates from the Corrective Services Academy.[775] Mr Ryan recommended that the Department: "*Develop and implement a mix-shift system to maximise consistency and continuity of care for young people.*"[776] Counsel Assisting proposed a similar recommendation, namely that the Department "*develop and implement a shorter shift system for custodial staff in youth detention.*"[777]

899 In its response dated November 2024 to the recommendation from Mr Ryan, the Department stated that it was "*Supported in Principle*".[778] However, in its submission to the almost identical recommendation proposed by counsel assisting, the Department stated it:[779]

> … has made a considered decision that a 12 hour shift length is appropriate having regard for the most efficient and effective use of resources. Shorter shifts are not favoured by staff and would require more staff to implement. Shorter shifts may also impact on detainees by making it more difficult for detainees to form relationships with YCOs. Furthermore, changing routines can impact the regulation of behaviours and moods of detainees and may result in increased lockdowns with more shift changes because of the handover process required. Currently, with 12-hour shifts, handover takes place outside of the hours in which detainees can be out of their cells. Accordingly, the Department considers that the likely adverse impact on detainees and staff weighs against the making of this recommendation.

[773] Exhibit 20, p.18
[774] Exhibit 20, p.18
[775] Exhibit 20, p.18
[776] Exhibit 20, p.18
[777] Written closing submissions from counsel assisting dated 25 March 2025, p.333
[778] Exhibit 20.2, p.6
[779] Written closing submissions from the Department dated 6 May 2025, p.107

900 I note there is a degree of supposition in this response from the Department. One way of determining whether there is any credence to these potential concerns raised by the Department would be to run a pilot program to see if the benefits outweigh the perceived negatives cited by the Department. In those circumstances, I make the following recommendation:

> ***Recommendation No.12***
>
> **In order to determine whether more effective care can be provided to detainees, a pilot program be introduced by the Department that has a mixed-shift system in place for custodial staff working eight or 10 hour shifts, four to five days per week.**

Support for detainees transitioning from detention into the community

901 At the inquest, ex-Children's Court President, Mr D Reynolds, spoke of the lack of resourcing and support for when a young person was released into detention back into the community.[780] He stressed the importance of a transition plan:[781]

> … there needs to be a transition, post-release, in the community. So there must be supports when the person transitions from detention into community.
>
> Ongoing support? --- Yes. Very crucial that - and right from the word go, that there are supports and arrangements within the community to provide the necessary supports that that young person needs.
>
> And you would agree that that should be able to be tied back into the therapeutic and rehabilitative treatment within a prison [sic - a youth detention centre] so that a child being well managed with a carer can talk and plan for the future - talk about and plan for the future, which is then to the extent that the State can assist? --- Yes.
>
> Implemented post-release? --- Yes. Absolutely. There needs to be thought, whilst they're in detention, as to what happens when they're - and these are the case management people. That's what they - that's what they do. So, when they're released from detention they need to be transitioned.

902 This subject matter is one that Mr Collins, the Director of Legal Services at the ALSWA, is very passionate about. He is a lawyer who has acquired considerable knowledge of the experiences Aboriginal people have with

[780] Ts pp.903-905
[781] Ts pp.904-905

the justice system, having worked in this area in several jurisdictions in Australia since 1995 and having held his present role for 20 years.

903 As to the benefit of detainees receiving individualised case management when they are released from detention from people who are outside of government, Mr Collins said:[782]

> I think for me, one of the key approaches that government need to consider, moving forward, is to get away from the fact that it has all the answers. Because the reason we are here, and history tells us that governments don't have all the answers. And on many levels in the justice setting, government and the system have comprehensively failed Aboriginal people and continue to do so. …
>
> Getting back to caseworkers, there are lots of good people working in the system. So, don't get me wrong. But they are part of the system. And I think what I have - what has worked with our Youth Engagement Program, for example … is the Aboriginal connection is absolutely critical. But they are not part of government. They are not part of the problem. And building, as I have talked about, that rapport underpinned by an understanding of their family, their community, their culture, gets results.
>
> But it has got to be not only a holistic and therapeutic and rehabilitative model, it needs to be individual person focused. It might seem like a big exercise. And it might seem to be a costly one. But it pales into insignificance in relation to the financial cost of locking people up. Because in my experience, young people who are locked up for long periods of time inevitably come back if they are young enough. But if they are too old, they will end up in jail, adult jail, serving ever-increasing sentences of imprisonment for ever more serious offending. The loss to - the loss in terms of their own lives and to their families and to their community is beyond calculation in my view.
>
> If you can - if you can develop culturally informed processes, which involve Aboriginal community-controlled organisations, and empower communities, you give yourself a chance. At the moment, it is all one-way traffic. Because government holds all the - holds the whip hand so to speak.

904 When asked by counsel for the ALSWA of the value in having a focused caseworker in constant and regular engagement with a young person at all levels of their life after release from detention, Mr Collins answered:[783]

> It could be a game changer. But I think the focus needs to be on lifting families up in a culturally sensitive, capacity building way, rather

[782] Ts p.728
[783] Ts pp.731-732

> than - rather than a deficit model, rather than focussing on what is wrong and what you are not doing right. …
>
> Because I think one of the major failings with the justice system, especially in the juvenile justice space, is what's done with children after they leave detention. I think it's a grave failing which in turns sets up reoffending and a return to detention which comes, as I've said, at a terrible cost on all sorts of levels.
> (underlining added)

905 I later asked Mr Collins the following questions:[784]

> For detainees once they've been released from detention. You're saying that ideally that should be an Aboriginal caseworker? --- Yes, absolutely, your Honour.
>
> And not part of the government? --- No. To work in tandem with youth justice, absolutely, but I think that separation, your Honour, that independence from government is critical in terms of relationship building.
>
> So how could that happen? --- You give the resources to the ALS.
>
> Right, so it would be under the umbrella of the ALS? --- Yes, absolutely, we could do it. … But they [ALSWA staff] could work hand-in-glove with youth justice to try and support young people in all the areas. And it provides an opportunity which I think hasn't been properly explored before, and even if you save one life from going back to detention, I think it's worth it.
>
> Yes. And it would be an intensive program for a caseworker. Are you suggesting one-on-one or would a caseworker have a number? --- The caseworker would work with - so the Youth Engagement [Project] team in Perth, for example, each youth engagement worker has between 10 and 15 clients. They provide a degree of mentoring and assistance to the young person, but their role is to, in essence, plug the young person into, if the person needs mental health counselling, to find the right person, to take them to the appointment, to sit with them. If the young person is keen on AFL football, they might get them some football boots, get them a mouthguard, take them to the games, take them to training. So we don't actually provide the service but we make sure that the person participates in them in a way that's meaningful and culturally appropriate for the young person.

906 The Youth Engagement Program (YEP) that Mr Collins referred to is operated by the ALSWA and provides case management services to young people who are appearing in the Children's Court by providing support and referrals to enable them to comply with court orders and improve their

[784] Ts pp.732-733

wellbeing. The assistance that is provided includes accommodation, education/training, substance abuse, health, family issues, Centrelink, transport, and support for youth justice-related appointments.[785] The YEP mentored about 106 young people in 2023.[786] It currently does not provide services to detainees upon their release from detention.

907 I see considerable value in extending the YEP so that it provides support to young people being released from detention. I note that the State Government has very recently provided funding to the YEP to extend its current services to Geraldton. In its media release dated 9 October 2025, the government said:[787]

> ALSWA's highly regarded Youth Engagement Program (YEP) has this month been extended to Geraldton, providing culturally secure support to Aboriginal young people.
>
> The expansion builds on YEP's success in Perth and the Kimberly, where the program has helped reduce reoffending and improve youth wellbeing through mentoring, culturally safe case management, court support, and practical assistance to help young people integrate into community support networks. …
>
> These supports are designed to reduce the risk of further contact with the criminal justice system and promote long-term positive outcomes for young people in their communities.

908 This is a ringing endorsement by the State Government of the success of the YEP and I have no doubt its expansion to provide case management services to detainees being released from detention would see a similar positive outcome. It is clear from Mr Collins' evidence at the inquest that the ALSWA would enthusiastically embrace the extension of its YEP services so that it includes detainees being released from detention. However, that cannot be done without further government funding.

909 Counsel assisting proposed the following recommendation: "*That funding be provided for support services and mentors to help transition young people from detention back into the community.*"[788] The Department's response to this proposed recommendation was: "*Supported in principle, subject to funding.*"[789]

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[785] https://wayouthservicesdirectory.org.au/service/youth-engagement-program/
[786] Exhibit 46, p.1
[787] https://www.wa.gov.au/government/media-statements/Cook%20Labor%20Government/New-youth-bail-support-services-launched-in-the-Mid-West-20251009
[788] Written closing submissions from counsel assisting dated 25 March 2025, p.331
[789] Written closing submissions from the Department dated 6 May 2025, p.129

910 I am encouraged that the Department has given in-principle support to this important proposed recommendation. As Mr Collins made clear in his evidence, if the YEP was to extend its services into this area it would need to work with the Department to achieve its objectives.

911 Given the support of the Department to this proposed recommendation and the support of the ALSWA to provide the necessary services if it has the funding to do so, I make the following recommendation:

> ***Recommendation No.13***
>
> **To reduce the risk of reoffending and to assist with the reintegration of detainees back into the community, that funding be provided to the ALSWA's Youth Engagement Program so that it can extend its case management services to detainees being released from detention. The Department should support any application made to the State Government for such funding.**

912 Of course, it will never be known that if Cleveland had the support of a YEP caseworker, whether his cycle of returning to detention would have ended before he was detained for the final time. However, I am certain that the risk of that occurring would have been reduced.

Proposed recommendations that suggested legislative changes

913 Counsel assisting proposed two recommendations that involved either amending current legislation or introducing legislation by the State Government. The first concerned an amendment to the *Inspector of Custodial Services Act 2003* (WA) and the other concerned the introduction of legislation that enshrined the Mandela Rules and the Beijing Rules.[790]

914 In its response to these two proposed recommendations, the Department submitted: "*There is limited utility in a Coroner recommending legislative amendment, such change involving policy considerations which are the province of government not the judiciary.*"[791]

915 In support of that submission, the Department cited ***Irfani v State Coroner*** [2011] WASC 270 [41] – [42] where McKechnie J agreed with the proposition that whether or not legislative changes should occur "*involves*

[790] Written closing submissions from counsel assisting dated 25 March 2025, pp.343-344
[791] Written closing submissions from the Department dated 6 May 2025, p.109

policy considerations which are the province of government, not of the judiciary." Accordingly, I am satisfied that the Court should not make recommendations that propose legislative changes. Nevertheless, the evidence I heard from Mr Ryan as outlined below regarding the need for the first proposed recommendation was persuasive.

916 The OICS Report dated March 2022 was in respect of the inspection of Banksia Hill in December 2021. This was the inspection which led to Mr Ryan taking the unprecedented step of serving a Show Cause Notice on the Department.[792] Mr Ryan's evidence at the inquest was that after tabling this report to Parliament, he heard nothing further about it. He added:[793]

> It is frustrating that, you know, you made comment about no teeth. That is a frustrating aspect of the job. But if you are truly independent, you have to be at arm's length. And if you have teeth to enforce things to be done, then you would become part of the delivery of those things.

917 There is merit to the argument that there ought to be a requirement that, in certain circumstances, a relevant agency be required to respond to what a watchdog body is recommending. Otherwise, the risk is that what happened in 2022 with respect to the OCIS Report referred to above, will be perpetuated i.e. there is no meaningful response. The problem was neatly summarised by counsel assisting in a question to Mr Ryan at the inquest:[794]

> You can find the problem. You articulate it. You produce the evidence to show there is a problem. The Department says there is a problem. You identify concerns about lawfulness. No one responds to that. And nothing really seems to change. Is there a better way of doing this?

918 There is a better way of doing it and it was one that was identified in 2023 by the Disability Royal Commission and which led to it making Recommendation 8.8:[795]

> The Western Australian Government should introduce and support legislation amending the *Inspector of Custodial Services Act 2003* (WA) to provide the Inspector with a discretion to demand a response from the Department or other relevant agency, within the specified time, to recommendations of the Inspector included in a report to Parliament. This

[792] Exhibit 19
[793] Ts p.809
[794] Ts p.809
[795] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*, Executive Summary, p.273: www.disability.royalcommission.gov.au/publications/final-report-executive-summary-our-vision-inclusive-australia-and-recommmendations

> should include the steps (if any) taken by the agency in response to the recommendations and an explanation of why steps have not been taken (if that be the case).

919 The Department has advised the Court that the State Government's response to this recommendation from the Disability Royal Commission was "*that it was accepted in principle*".[796]

920 The findings from the Disability Royal Commission were published over two years ago. It is my understanding no amendment reflecting this recommendation has been made or is proposed to be made to the *Inspector of Custodial Services Act 2003* (WA).

921 I will simply note that from the evidence I heard at the inquest, this recommendation from the Disability Royal Commission is of considerable merit. If it was adopted, it would be welcomed by not only the current Inspector of Custodial Services, but I suspect, all those inspectors who are appointed after him. It is clear to me that considerable work is undertaken by the Inspector of Custodial Services and their staff in the preparation of OCIS reports and the making of recommendations.

922 As to the second proposed recommendation by counsel assisting regarding legislative measures: Australia is a signatory to the Mandela Rules and the Beijing Rules. In short, these Rules provide that any prisoner or detainee must have at least two hours out of cell time in any 24-hour period. However, this stipulation has not been enshrined in legislation in Western Australia and is therefore not legally enforceable.

923 The evidence from the current Director General and Commissioner at the inquest made it clear that the Department considers it is only bound to comply with State legislation, and it is not bound by any international obligations or standards as reflected in the Mandela Rules or Beijing Rules.[797]

924 Mr Royce told the inquest he understood the obligations Australia had accepted by being a signatory to various international arrangements. However, he drew a distinction between being "*obliged*" and "*bound*". Mr Royce said he was bound by State legislation and obliged to have regard to international obligations.[798]

[796] Written closing submissions from the Department dated 6 May 2025, p.109
[797] Ts pp.2654-2657-2659 (Mr Royce) pp.2681-2682 (Ms Maj)
[798] Ts p.2662

925 Ms Maj sat throughout the evidence of Mr Royce and said that in substance, she did not disagree with anything he had said.[799]

926 Ms Maj confirmed that the Department is required to comply with State legislation and that while Australia may be obligated to comply with international obligations, she and the Department are not required to do so. She agreed this was a very technical distinction. However, Ms Maj also said that her expectation was that because these international obligations involved "*fundamental human rights*", she would expect the Department to comply with them.[800] Given Ms Maj's evidence, it was a little disappointing to read that the Department's response to counsel assisting's proposed recommendation was "*Decision for other entity*".[801]

927 The evidence at the inquest clearly demonstrated that the standards outlined in the Mandela Rules and Beijing Rules had not been met on a regular basis by the Department before and during Cleveland's last period of detention in Unit 18. I am firmly of the view that it is desirable for the health, safety and wellbeing of not just detainees but also staff in youth detention centres that such standards be always met. Nevertheless, the Department will only consider it bound to meet such standards when they are enshrined in State legislation. However, as I have already determined, the Court is unable to make a recommendation to that effect.[802]

928 However, what the Court can do is recommend that the Department incorporates the Mandela Rules and Beijing Rules into its COPPs. Accordingly, I make the following recommendation:

Recommendation No.14

In order to enhance the care of detainees, the Department amends the relevant COPPs to mandate the requirement that detainees who are not confined to their cells for breach of discipline are to receive, at the barest minimum, two hours out of cell time in every 24-hour period.

929 I acknowledge that Regulation 79 of the *Young Offenders Regulations 1995* (WA) would be complied with if a detainee who is the subject of a confinement order is given a mere solitary hour out of their cells during a

[799] Ts p.2681
[800] Ts pp.2681-2682
[801] Written closing submissions from the Department dated 6 May 2025, p.130
[802] ***Irfani v State Coroner*** [2011] WASC 270 [41]-[42]

24-hour period. That is because of the way the Department has determined how long "unlocked hours" will be i.e. just under 12 hours.

930 However, if the Department uses that as a reason not to implement this recommendation, then it is hardly offering detainees a trauma-informed, culturally safe and therapeutic approach to their care.

Proposed recommendations that the Department says have been implemented

931 There were a number of proposed recommendations by counsel assisting that the Department submitted have already been implemented.[803] Each of these proposed recommendations I would have made but for the Department's submission they have been implemented. I will briefly outline what six of these intended recommendations would have been.

932 The first concerned the proposed recommendation that if Unit 18 was to remain open, arrangements should be made for detainees to engage in confidential in-person meetings with their lawyers that are longer than one hour. This arose from the evidence of Mr Collins at the inquest that the time allowed for professional visits by ALSWA lawyers to see their clients was inadequate.[804] Although the Department did not confirm how these extended meetings would be implemented, information before the Court indicated they would be facilitated by the detainee at Unit 18 being taken to Banksia Hill for an extended meeting.[805] If that is the process then I question whether this is a practical resolution of the matter as it would presumably take staff away from Unit 18 to arrange that. Mr Collins also raised the issue of detainees not wanting to undergo that process as it is very disruptive.[806]

933 Nevertheless, I hope this arrangement has led to improvements. If the ALSWA remains unhappy with this procedure I would expect its concerns would be raised with the Department and consideration be given to how further improvements can be made.

934 The second proposed recommendation was that for the time Unit 18 remained a youth detention centre, the Department was to provide the OICS, on a monthly basis, a copy of each confinement order made in Unit 18 for that month.

[803] Written closing submissions from the Department dated 6 May 2025, pp.128-129
[804] Ts p.726
[805] Exhibit 52, p.2
[806] Ts p.714

935 The benefits of such an arrangement are obvious. Information regarding the time out of cells for detainees is invaluable to the Inspector of Custodial Services. It should ensure that the repetitious use of confinement orders that occurred during Cleveland's last period of detention is not repeated.

936 Although the Department had initially said this practice had been implemented,[807] Senior Counsel for the Department later clarified that although the Court had been provided this information at its request, "*it hasn't yet commenced with the Inspector, but the intention is for that to occur*" (underlining added).[808] As I expect the Department will carry out its intention, I have considered there is no need to make a recommendation. I have little doubt that if this has not yet occurred (five months since the Department's Senior Counsel made that clarification), the OCIS will draw the Department's attention to this part of my finding.

937 The third proposed recommendation from counsel assisting that the Department has said it has implemented regarded the need for a model of care to exist at Unit 18 if it was to remain open for the foreseeable future. I accept the Department's submission that this has been implemented. For reasons I have already outlined above, I regard that measure as imperative.

938 The fourth proposed recommendation concerned the CCC report noting there was confusion between the YCOs who gave evidence before it, "*as to what contact with a young person constituted a welfare check.*"[809]

939 Evidence about the importance of appropriate care for detainees' mental health was extensive throughout the inquest. It cannot be stressed enough of the need for a physical observation of a detainee where there is a concern as to their level of risk, rather than simply speaking with them through a cell call. Counsel assisting suggested a recommendation that the relevant COPPs be amended to specify that a cell call with a detainee does not constitute a welfare check.

940 The Department supported this proposed recommendation and advised the Court that it has already been implemented.

941 The fifth proposed recommendation that the Department indicated has already been implemented concerned the second youth detention centre to be built.

[807] Written closing submissions from the Department dated 6 May 2025, p.128
[808] Ts p.4433
[809] Exhibit 22, p.33

942 Tension between security issues of hardening the sites of youth custodial centres and the need for what Mr Ryan has called "*trauma-informed custodial care*"[810] has been a constant in the youth custodial estate for some time. I completely agree with counsel assisting's submission that it is trite to say that "*such care should be the cornerstone of the youth estate*".[811]

943 Nevertheless, the evidence I heard at the inquest clearly established that during Cleveland's last period of detention the therapeutic principles which should be the foundation for the care of detainees were sadly lacking. Counsel assisting put forward this recommendation: "*The proposed construction of the new purpose-built youth detention centre must have rehabilitation, trauma-informed and culturally appropriate care foremost in mind.*"[812]

944 If these three principles do not underpin not just the construction, but also the staffing and model of care of the yet-to-be built youth detention centre, I fear that history will inevitably be repeated.

945 At the risk of stating the obvious, I would expect that the planning for the second youth detention centre would be developed in close consultation with Aboriginal community-controlled organisations.

946 The final proposed recommendation from counsel assisting that I will address concerned having mental health support on standby following a significant event for a detainee. Counsel assisting gave the example of a court refusing bail. This example had parallels with the situation Cleveland found himself in on the afternoon of 11 October 2023.

947 Despite all the hardships Cleveland was already enduring in Unit 18 during his final period of detention, the afternoon before his incident had more difficulty and disappointment for him. As I have already outlined, Cleveland was taken from his cell for a video link appearance in the Children's Court regarding his bail application. The matter was adjourned for eight days to enable further information to be obtained.

948 The Court had information suggesting Cleveland thought he may have been released on bail before 11 October 2023.[813] However on this day, he was simply returned to his cell after his court appearance without any offer of support regarding what would have been a disappointing outcome for him.

[810] Exhibit 30.5, p.2
[811] Written closing submission of counsel assisting dated 25 March 2025, p.332
[812] Written closing submission of counsel assisting dated 25 March 2025, p.333
[813] Exhibit 2

949 Mr Collins addressed this matter in his evidence at the inquest:[814]

> For children, for young people, video links where substantive matters are dealt with, for example, bail applications can be incredibly distressing and difficult and traumatising for young people, because what they see and hear on a video link may involve, put bluntly, trashing their families as unsuitable for them to live with on bail. That's okay to some degree. I'm talking about the prosecution here but what happens when they get off the video link? They're on their own, they return to their cell and they're ruminating over the disparaging of their family. At least if you have an in-person court attendance, there's scope for the lawyer to go down and offer some words of consolation, encouragement and so on. Doesn't happen with video links. Can't do it.

950 Although the Department has said that mental health support being on standby following a significant event for a detainee has already been implemented, it did not provide any details as to what exactly that support involved. If the Department is saying implementation has occurred by simply referring to the fact that there should always be someone from the mental health team at a youth detention centre during office hours, I do not regard that as adequate.

951 There must be a proactive position taken so that contact is initiated by the mental health team whenever it is suspected a detainee may be adversely affected by information they have received. Waiting for the detainee to request support should not be how it occurs. To initiate this proactive approach would most likely require input from those with first-hand knowledge of the event e.g. custodial staff.

RECOMMENDATION REGARDING THE MANAGEMENT OF YOUTH DETENTION IN WESTERN AUSTRALIA

The evidence from the inquest

952 Dr Tomison concluded his first examination by counsel assisting at the inquest with an acknowledgement that radical change was necessary in the structure of youth detention. He said that although it would be difficult, it can be done, and it will be of immeasurable value to all concerned to bring about such change:[815]

> Do you accept that, having done nearly seven years as the DG, your simple message is the present arrangement has to change? --- Yes.

[814] Ts p.485
[815] Ts pp.1273-1275

> And if the present arrangement is going to change, that requires political will? --- Yes. It will be a significant investment.
>
> …
>
> Because if we don't change the current arrangement, the longstanding difficulties that have been exposed in this inquest are likely to continue ebbing and flowing, responding to crisis and the like? --- Yes. And I think that's a likely pattern, based on the history.
>
> …
>
> So, there's no doubt about the problem. The question is, is there a preparedness at a political level to say to the community, "If we want to look after these young people, this is what we're going to have to do, because the current system is nowhere near adequate enough"? --- Yes, and there are a lot of other benefits that would flow from a system like that for the community.
>
> Such as? --- The welfare of young people improves, the welfare of families improves. You've got – I will be very, you know, economically focused. You've got a workforce that is actually ready to be able to work and be a productive member of society, and is not disadvantaged, and hopefully all the benefits of working, having employment will flow from that. That's just one simple one, but what you would see is with a good preventative system, you get less mental health concerns, you get less physical health concerns, you get less addictions, … better employment options, probably greater attendance at school, those sort of things. You will see the flow on, but I'm not going to suggest to the court that's an easy thing, all that I just talked about. It hasn't been done very well in the Western world really, not in the – the sort of – the Commonwealth countries and America, Canada, those sorts of places. It's hard.
>
> It is hard, but it is doable? --- I think it's worth the effort, absolutely. I don't think it will be perfect, there will be mistakes made, but I think it is actually – if you really want to make a change, that would be what I think is what is required.

953 Dr Tomison was aware of the evidence from others who had suggested there was a need for youth justice to be separated from the rest of Corrective Services and have a stand-alone structure.[816] He thought this was generally a good idea, because it would give youth justice a better focus if it was not part of a very large department.

954 However, Dr Tomison suggested the reform should go further. He suggested a better approach would be to have a wraparound service from a range of service providers, such as Health, both physical and mental, and Education and Housing, to intervene in a meaningful way in the lives of these young people. He observed that currently the Department is often

[816] Ts p.1270

focused on crisis response, rather than prevention and diversion (which, I note, are supposed to be primary objectives of youth justice). Dr Tomison said:[817]

> I'm not going to suggest this work is easy, because it is not. The longer you leave it until a young person is exhibiting issues, the harder it is, but you really need that sort of cohesive, holistic service to make a difference. Now, at varying times, I think it's fair to say the Department has got good support from the Mental Health Commission, from Child Protection Services and others, but it's not the same as actually having them in the one spot, if you like, under the one leadership.[818]

955 Senior Counsel for the ALSWA asked Dr Tomison:[819]

> Can I suggest that, bearing in mind the other answers you've given already about this, that it's – for instance, it would be unsatisfactory and not sufficiently adequate to have a collection of secondees from other departments into a new unit – that the effect of what you're saying is that the radical solution that could be put on the table would be a new department, not just a new unit? --- I think so. I've seen a number of structures where you use secondments. They can work to an extent, I think. If you want to make a really embedded change, you need a different structure.

956 At the inquest, Professor Morgan considered it was time to set up a separate department for youth justice.[820] He prefaced that opinion by observing, based on his time as the Inspector of Custodial Services, that:[821]

> … the Department lost sight of the fact, in my view, that they were dealing with children. We have people who are youth custodial officers. They're basically mini prison officers. We had prison officers working in the environment; we lost a child-centred focus. And I think the starting point, I would say, is let's first of all remember that whatever we do, we must treat children as children. And if that's the starting point, then an awful lot will flow from that. Some of them, yes, they're verging on the point of young adulthood, but they're still very young adults.

957 Mr Beck was well qualified to express an opinion on this topic. He had worked with young people in the United Kingdom before coming to Australia 20 years ago. He has been the Superintendent of Hakea Prison. He has run Acacia Prison in the private sector. He has worked in several other Australian jurisdictions and also New Zealand. Mr Beck was

[817] Ts p.1272
[818] Ts pp.1271-1272
[819] Ts pp.1350-1351
[820] Ts p.742
[821] Ts pp.739-740

eminently qualified to express a well-informed view regarding this matter based on his personal experiences.

958 Mr Beck commenced as Deputy Commissioner, Women and Young People, in about July 2020. In early 2021, he commissioned a report from Ms Jan Shuard.[822] Ms Shuard was a former Corrections Commissioner in Victoria. Mr Beck said that after he commenced as the Deputy Commissioner, he had observed certain things at Banksia Hill which suggested the culture needed to change. These observations included that the written policies did not reflect what was occurring, the high use of force (greater than anything he had previously seen, even in adult prisons) and that Banksia Hill "*was operating like a prison, in terms of control*" and "*was not operating in a way that was restorative … which supported young people to develop and grow and become the best people they could be.*"[823]

959 Mr Beck continued:[824]

> What I saw was an underlying culture that existed, which was as a consequence of the prisons coming in and running the facility. That was what I saw. And that was why I commissioned the report. And – because I wanted to change the culture. And you can't come in and just say, don't do that; do this. Because that change has to be accepted by the staff group.

960 Mr Beck summarised the findings from Ms Shuard's report:[825]

> So, in summary, there was a lack of leadership in the ISU. There was a lack of clarity around policy. There was an overemphasis on – there wasn't a strong emphasis on – on good behaviour incentives. It was all about what they could take away from the juvenile.

961 Mr Beck described that when the Department was updating its COPPs:[826]

> Banksia Hill had been left behind in that process because the Department often didn't recognise youth justice as being part of the Department.

962 When asked to explain this comment, Mr Beck said:[827]

> What I mean by that is that youth justice, in many respects, has been left as an island on its own without support corporately and without support within the Department.

[822] Exhibit 87.3
[823] Ts pp.2156-2157
[824] Ts p.2157
[825] Ts p.2157
[826] Ts p.2159
[827] Ts pp.2159-2160

> …
>
> It gets overwhelmed by the adult state, but there was also resources that were taken out of youth justice and Banksia Hill …
>
> …
>
> So, in the past, Deputy Commissioner for Offender Services had reached across to look after youth justice. So, it was very much isolated and expected to function in its own right, and it wasn't supported, in my opinion, by our corporate structures within the Department that, in my opinion, were chaotic.

963 Mr Beck completely agreed with the description that the youth custodial estate was not just the poor cousin to the adult estate, it was the completely neglected relative.[828]

964 When asked to consider the possibility of taking youth justice out of the current arrangement, Mr Beck was a supporter: [829]

> What I can tell you is that WA is the only jurisdiction that has youth justice incorporated within a Corrective Services environment.
>
> And there's good reason why other jurisdictions don't have it within Corrective Services, because when you do that, you overlay adult thinking and adult responses to a child's needs.

965 Mr D Reynolds was also a strong supporter of the separation of the youth custodial estate, principally on the basis that the number of young detainees is such a tiny percentage of the work of Corrective Services. Consequently, "*the culture within youth justice is overwhelmed by adult prison. So, the Department is overwhelmed with an adult prison mentality*."[830]

966 In his written statement to the inquest, Mr M Reynolds set out the position around Australia regarding the separation of youth justice from adult Corrective Services.[831] Consistent with Mr Beck, he noted Western Australia is the only jurisdiction where they are not separate. At the inquest, he said: "*For me, we needed to move away from a punitive model to a care model … I don't think that youth custody belongs in a detention service like Corrective Services. It's just the wrong fit.*"[832]

967 In response to questions from me, Mr M Reynolds said:[833]

[828] Ts p.2160
[829] Ts p.2160
[830] Ts p.881
[831] Exhibit 50, p.38
[832] Ts p.4076
[833] Ts pp.1814-1815

> And suffice to say, you are a very strong proponent of, in one of several ways, separating youth justice from Corrective Services? --- Yes, your Honour.
>
> Right. Well, I can indicate to you that Professor Morgan, the ex-inspector of Custodial Services, is a strong proponent of that, as is ex-Children's Court President Denis Reynolds, and --- ? --- I didn't always – I didn't always agree with those two learned gentlemen, your Honour, but in this case, I've been lockstep with them.
>
> …
>
> Your Honour, if I could, I would even suggest not in Justice – I still don't think necessarily Youth is a Justice process. So, I know a couple of the states – New South Wales and Victoria – actually have Youth still in Justice, but not Corrections. I would go further; I would put it into Communities.

968 Professor Stanley said she was a strong supporter of separating the youth estate from the adult estate.[834]

969 Mr Marney was a supporter of such change. He said: "*I would be of [the] firm view that a therapeutic model of care is only feasible in an environment that is divorced from adult corrections facilities, so a separate entity*."[835]

970 Dr Watson was another strong supporter of separating the youth estate from the adult custodial estate. He observed the mental health needs of adults were quite different to young people. His view was that the issues of complex trauma as they affect young people tend not to "*come to the attention of mental health services*", which are predominately for adults.[836] Dr Watson continued:[837]

> So therefore, the needs of an adolescent brain are very different to that of an adult brain. Okay? So, the mental health needs of a young person don't always sort of sit with your major mental illnesses because it's a very different picture and it's depression, anxiety, complex trauma, particularly with indigenous people, and neurodevelopmental disorders and so forth. So, I think there's a really clear demarcation around illness patterns and presentations.

971 In his evidence, Dr Watson described his experiences with the South Australian model. In short, that model is: "*Corrections run the facility, Health runs the health services and Education runs the education*

[834] Ts pp.2867-2868
[835] Ts p.4020
[836] Ts p.3639
[837] Ts p.3640

services".[838] Dr Watson described this as a more seamless and consistent provision of services across the community and in the youth detention centre, which has the benefit "*that young people are not telling their story different times to different organisations and there can be seamless care also around physical health as well*".[839]

972 At the inquest, Dr Wojnarowska's examination by counsel assisting concluded with her being asked to consider two issues; namely, what should be the role of the Department of Health in youth justice and how should that involvement be initiated. Her answers suggested a radical transformation was required. It would involve the permanent onsite presence at a youth detention centre of a Child and Adolescent Mental Health Service.

973 In answer to the first question, Dr Wojnarowska said:[840]

> In my view, the Health Department should be the leading department in providing mental health services for people within the justice system. The majority of other states in Australia have that particular way of providing services. It should be integrated. And as I've already pointed out, that – services should consist of various professionals that are employed by Health Department.

974 In answer to the second question, she said:[841]

> So, the pathway should be from - from the beginning, from the admission, assessment, triaging and then assessment by the multidisciplinary team with - who would have all the information that are available to Mental Health electronically that Justice does not have access - and Mental Health does not have access - or limited access to Justice electronic notes. So, it's all fragmented. So current delivery to fragmented - to children who had fragmented life is almost mirrored by delivering fragmented services to them.
>
> What you're suggesting is a radical transformation as to how [the Department of] Health would be involved? --- Yes.

975 Dr Wojnarowska identified what she said would be the multiple benefits from such a presence. She agreed that in terms of the mental health of the detainees, Unit 18 "*is a very, very poor place for them to be*" and that it

[838] Ts p.3631
[839] Ts pp.3645-3646
[840] Ts p.1933
[841] Ts p.1933

should "*be replaced by a facility that caters for young, very traumatised children who require special care*."[842]

976 As can be seen from the above outline of the evidence, there is a sound argument that the time has come for the structure of youth justice in Western Australia to reflect what the experienced experts have been advocating for a considerable time, and to reflect what exists in every other Australian jurisdiction.

977 Dr Cooney is in the unique position of being an experienced manager in youth detention and a trained psychologist.[843]

978 There was a cautionary note about Dr Cooney's thinking in respect of youth justice becoming a stand-alone or separate arrangement from the Department. At the inquest, Dr Cooney said she would "*personally support a full analysis*" of this suggestion, recognising "*it's a more complex issue that would need to be unpacked.*"[844]

979 Dr Cooney was then asked:[845]

> Dr Cooney, can you understand how people might feel frustrated at the apparent inertia in this State in terms of youth justice and detention? --- Yes.
>
> For now, 11 years before Cleveland's death, and now 12 years since the last time children got put in an adult prison at Hakea, very, very experienced and sensible people have been advocating in this space for a long time that there has to be a serious rethink about how this is done? --- Yes.
>
> And now, Cleveland is the first to die in youth detention, and we know that he's not the only one. Can you understand that a suggestion that there needs to be another consideration, and we need to look at what's happening elsewhere, just sounds like more inertia? The evidence, I suggest, is there, and that is evidence of how it operates around the country differently. The medical evidence is there. As a psychologist, you know all about the Banksia Studies, don't you? --- Yes, absolutely.
>
> …
>
> And they have been saying, I suggest, for years that the way this is being done is just so counterproductive? --- Yes, and I'm not disagreeing. So, I think significant change is required, but does that involve youth justice sitting totally separate? I don't know.

[842] Ts p.1934
[843] Ts p.3497
[844] Ts pp.3497-3498
[845] Ts pp.3498-3499

980 In response to questions from me, Ms Butt said:[846]

> I would support a recommendation that identifies - and very clearly, the evidence shows that there - there needs to be a separation for what occurs for adults and what occurs for children. The challenge that we have as part of the Corrective Services stream is that, while there's increased focus on Model of Care, increased focus on what we're trying to do through youth justice, we are still within the adult stream and have to, I guess, draw attention to that agenda as opposed to it's an automatic consideration if it were a child-centric stream.
>
> …
>
> And I think the other thing is that, you know, when we're talking about trauma-informed care, and we use a whole range of words and things around that - it's really about identifying that children are at the centre and children are vulnerable for a range of reasons. And we need a service system that identifies that first. And then the other components follow that.[847]

The size of the youth estate compared to the adult estate

981 The population of the youth custodial estate hovers around 1% of the population in the whole custodial estate. It is therefore understandable how it can be overshadowed in such circumstances.

982 A striking example of how youth justice has been dwarfed is the evidence from Mr M Reynolds about his learning that the recruiting process focused on the adult estate rather than the youth estate, with the consequence that recruiting for the latter had not occurred. This led to a continuation of the systematic failure of the Department to provide adequate staffing.[848]

983 The Commissioner is the Commissioner for all Corrective Services, not just the Commissioner for Youth. It is not difficult to understand how the youth estate gets lost in such a system. If it was a stand-alone arrangement, one would expect the person at the top of the executive structure, who would only have youth justice as their concern, to be fully informed about all the issues affecting youth justice, as and when they arise; rather than reporting to a person who is responsible for a structure managing over 8,000 adult prisoners.

984 The uncontroverted evidence is that the approach to the detention of children is fundamentally different to the approach to the imprisonment of adults. It is a far more nuanced approach that requires a greater emphasis

[846] Ts pp.4176-4177
[847] Ts p.4177
[848] Ts p.1515

on the underlying causes of offending, most notably the extraordinarily high rate of neurodevelopmental disorders in young persons that has been established by the Banksia Studies.

985 The observation by Ms Butt about the identification of the different agenda in respect of children is sound. If youth justice was separate, there would be no need within that organisation, in words of Ms Butt, to "*draw attention*" to the different agenda in respect of children because it would be "*an automatic consideration if it were a child-centric stream*."[849]

Previous consideration to separate the youth estate from the adult estate

986 Mr Beck recalled a time before he was at the Department when "*a lot of work*" was devoted to facilitate youth justice transitioning out of the Department and into the Department of Communities.[850] However, it was Mr Beck's understanding this work ceased when it was realised that the provisions of the *Young Offenders Act 1994* (WA) prevented it from happening.[851] I would expect this issue could have been overcome by making the necessary amendments to this Act.

987 Mr M Reynolds also recalled, prior to his commencement as Commissioner, consideration being given to moving the Department's youth prevention and diversion functions to the Department of Communities, with youth detention remaining with the Department. He understood that did not proceed due to the difficulties with splitting the responsibility under the *Young Offenders Act 1994* (WA).[852]

988 I am uncertain whether Mr Beck and Mr M Reynolds were recalling the same plan or two separate plans. However, if their recollections are accurate, then at least one effort has already been made to have Western Australia more aligned with every other jurisdiction in the country.

What should be the Court's recommendation?

989 Although Western Australia will often take pride in how it operates differently to other Australian states and territories,[853] it would be very difficult to contend that its management of youth justice in recent times is a source of pride.

[849] Ts p.4177
[850] Ts p.2159
[851] Ts p.2160
[852] Exhibit 50, p.39
[853] One obvious example is the conspicuous lack of poker machines in Western Australia when compared to other states and territories.

990 Counsel assisting made a proposed recommendation that youth justice was not to remain part of the Department, or at the very least, that it becomes a stand-alone division within the Department.[854]

991 Given the significance of the Court making a recommendation that youth justice be removed from the Department's control, I set out in full the response from the Department:[855]

> The establishment and broad structuring of departments, including the allocation of which minister is responsible for each department, are matters for government. Following Cleveland's death, on 1 July 2024 the Department established a separate Youth Directorate within Corrective Services, splitting the former Women and Youth People Directorate. This has resourced the youth estate with a dedicated Deputy and Assistant Commissioner and enabled them to focus on the individual interests and needs of youth justice. The Department considers there to be significant opportunities in having youth justice remain within Corrective Services (as a separate directorate) because of the opportunity for shared resources such as training facilities, allowing for a much greater economy of scale. The Department considers that improvements are more likely to be readily experienced by real, substantive change tackling areas of difficulty in youth justice within the existing structures of the Department rather than the proposed machinery of government change. This is reflected in that fact that other Australian jurisdictions which do not have youth justice within Corrective Services face the same difficulties in managing youth detention as have been experienced in Western Australia.[856] Machinery of government changes can have unintended consequences in that they can disrupt essential service delivery and core functions as attention shifts to administration structure and personnel movements.

992 Not surprisingly, the Department submitted that it did not support the removal of youth justice from its management. As to the alternative recommendation that it become a stand-alone division within the Department, it said: "*Supported, implemented.*"[857] The Department has said this part of the proposed recommendation had been implemented as there is now a separate Youth Directorate within Corrective Services that has a dedicated Deputy Commissioner and Assistant Commissioner. However, that change falls well short of what I had in mind for youth justice becoming a stand-alone division within the Department.

993 The Department submitted there are "*significant opportunities*" in having youth justice remain where it is "*because of the opportunity for shared*

[854] Written closing submissions from counsel assisting dated 25 March 2025, p.319
[855] Written closing submissions from the Department dated 6 May 2025, p.108
[856] The Department footnoted the evidence of Ms Butt at Ts pp.4173-4174
[857] Written closing submissions from the Department dated 6 May 2025, p.128

resources such as training facilities, allowing for a much greater economy of scale."[858] It said that improvements are more likely to be experienced with substantive change tackling areas with difficulty in youth justice within the Department, "*rather than the proposed machinery of government change.*"[859] This optimism for improvements and real change may be considered by some within the wider youth justice estate to be unfeasible given the Department's past management of youth justice.

994 The Department also contended that other Australian jurisdictions face the same difficulties in managing youth justice as had been experienced in Western Australia. In addition, it said that machinery of government changes can have unintended consequences in disrupting essential service delivery and core functions.[860]

995 After a careful consideration of the submissions from the Department regarding this matter, I am not convinced the youth custodial estate ought to remain within its management. When the immediate past Director General and Commissioner are very supportive of youth justice being separate from the adult custodial estate that, in itself, provides a compelling argument that there needs to be change. Their opinion aligns with that of Mr Beck, who still works with the Department, whose evidence on this topic I found most compelling.

996 However, and not without some hesitation, I have decided not to make a recommendation that youth justice be removed from the Department. One reason for this decision is that the Court was only able to explore this matter to a limited degree. For example, I was not able to fully investigate and hear evidence in any great detail regarding the management of youth justice interstate. Nor did the Court obtain the views of those government agencies that would potentially be involved in managing all or a part of youth justice should it be transferred from the Department.

997 Secondly, I have noted Dr Cooney's evidence that she would support "*a full analysis*". I have also taken into account Ms Butt's support for a recommendation that identifies the need for a separation "*for what occurs for adults and what occurs for children*", and her acknowledgment of how the "*adult stream*" may impact the current structure to the detriment of the youth estate.

[858] Written closing submissions from the Department dated 6 May 2025, p.108
[859] Written closing submissions from the Department dated 6 May 2025, p.108
[860] Written closing submissions from the Department dated 6 May 2025, p.108

998 Given the above, I am firmly of the view that this is an issue that requires further investigation. I therefore make the following recommendation:

> ***Recommendation No.15***
>
> **A forum be established comprising of relevant government entities (e.g. the Department, the Department of Communities, the Department of Health, the Department of Education, the Department of Housing and Works, the Mental Health Commission) and stakeholders (e.g. ALSWA, the Children's Court, the OCIS, the Commissioner for Children and Young People, the Kids Research Institute Australia, Aboriginal community organisations such as Derbarl Yerrigan and Social Reinvestment WA) to consider whether youth justice should remain entirely within the Department's responsibility and that a report of its findings be prepared for the State Government to consider.**

999 This was not a recommendation proposed by counsel assisting in his written closing submissions. Consequently, on 3 October 2025, the Court invited the Department to respond to it.[861]

1000 On 23 October 2025, the Department made the following submission:

> **This is a matter for Government.**
>
> The Department maintains the position set out in its First Submissions at [490(a)].[862] The decision to establish a cross-agency forum of this sort is ultimately a determination that will need to be made by Government. If such a forum was established, the Department would positively engage with it, and provide information, including as to the changes that have been implemented across the youth estate and have been noted by oversight agencies.
> (bold type in the original)

1001 Strictly speaking, the Department is correct when it submits that the establishing of this forum is a matter for government. Nevertheless, it must be noted that the role of government agencies is to provide advice for the purpose of assisting the government to make decisions.

1002 As the Department has indicated it would "*positively engage*" with such a forum if it was established, it should not idly sit by and wait for a decision

[861] Email from the Court to the SSO dated 3 October 2025
[862] The text of the Department's response is set out in [991] in this finding

to be made by government. I would strongly urge the Department to advise the State Government that, as has apparently been previously considered by the Department,[863] it is time to examine whether (i) the management of youth justice should be the sole responsibility of the Department and (ii) a restructuring should be implemented that is aligned with one or more of the systems in other Australian jurisdictions.

1003 If the Department is of the view that the best option for the management of youth justice in Western Australia is for it to remain solely within its control, it should have no fear putting forward that view in a cross-agency forum.

1004 The creation of this forum would provide something that has not, as I understand it, been done before in this State: a comprehensive and thorough analysis to ensure young persons who are detained in Western Australia are cared for in such a way that they are provided with the best prospects for rehabilitation and to become responsible adults. Sadly, the environment that Cleveland found himself in during the last three months of his life did not reflect those principles.

1005 I have not included in the recommendation the entity tasked with the responsibility for establishing this forum. Although that would ultimately be a decision for government, logically it would be the Department. Although the Department may lack the motivation to take on that role, I was encouraged by the evidence from those presently holding senior positions within the Department (Mr Beck, Dr Cooney and Ms Butt) that strongly indicates they would support the need for such a forum.

1006 For what it is worth, my view is that Mr Beck would be a standout candidate to chair such a forum.

1007 Finally, I should add that I have also considered the aligned proposed recommendation from counsel assisting, which read "*that the Department of Health assumes the responsibility for care and treatment of detainees with mental health issues*."[864] For the reasons advanced by Dr Wojnarowska that are outlined above, there is a cogent argument in support of the Department of Health assuming that responsibility. However, if the forum is established, I would expect that option would be considered.

[863] Ts pp.2159-2160; Exhibit 50, p.39
[864] Written closing submissions from counsel assisting dated 25 March 2025, p.338

RECOMMENDATION REGARDING THE MANNER IN WHICH UNIT 18 CAME INTO OPERATION

Introduction

1008 The Court heard considerable evidence regarding why and how Unit 18 came to be established. As I have already outlined above, one of the reasons why this evidence became relevant by the completion of the first tranche of the inquest was in order for the Court to understand how Unit 18 came to be operating in such deplorable conditions for its staff and detainees by the time of Cleveland's last detention.

1009 I must stress that I have deliberately refrained from expressing my own conclusions or findings from the information the Court has received that is referred to in this section of my finding. Such conclusions would have to be made by another agency. Where appropriate, I have simply stated such conclusions or findings may be open or could be made or argued based on the information the Court had received. In so doing, any such comment I make "*lacks the attribute of being conclusory necessary for it to constitute a finding*".[865]

Concerns about the youth custodial estate had been expressed since 2012

The reports of the Office of the Inspector of Custodial Services

1010 I have already referred to the reports prepared by the two Inspectors of the OICS, Professor Morgan and Mr Ryan. It is now appropriate to provide greater detail from those reports to emphasise the nature, extent and frequency of the warnings and concerns expressed by the OCIS to the Department regarding its management of the youth custodial estate. The evidence suggests that these matters had been raised since 2012.

1011 Professor Morgan's statement summarises the concerns he was expressing. The concluding remarks in his statement include:[866]

> [4.7] It is, of course, the young people who have acted up and caused damage. But it is significant that, in 2013, very few staff thought the detainees were a cause of the riot:
>
> The top four factors were staff shortages, lockdowns, the amalgamation and poor leadership…. [B]uilding weaknesses ranked much lower, 'detainee characteristics' was rarely mentioned, and few staff believed that 'lack of defensive tools' was a factor. [citing *Directed Review into*

[865] ***Commissioner of Police v No Respondent*** [2020] SASCFC 64, [97]
[866] Exhibit 28, pp.36-37

> *an Incident at Banksia Hill Detention Centre on 20 January 2013*: Report 85 (2013), para [3.29].
>
> In 2017, the dominant sentiments among staff were, again, their deep feelings of disconnect and disrespect from leadership. [citing *Behaviour Management practices at Banksia Hill Detention Centre* (2017), p 23].

[4.8] There are many victims of this chronic chaos and dysfunction. The young people. Their parents and families. Staff on the ground and local management, most of whom have tried hard to make the system work. And many people in higher level positions who have tried to drive reform and improvement but have been thwarted by bureaucracy or politics. The trauma and damage also extend to people who have encountered the system, including advocates, support workers, lawyers and inspection staff.

[4.9] There is no doubt that young people's behaviour reflects the way they are treated. Governments and Departments know this full well when it comes to parents and families. They remove children from families if they believe they are at risk of abuse or harm. <u>If a parent locked a child in a small, spartan room with little or nothing to do for 23-24 hours, the child would be removed. The parent would also face prosecution. Even more so if the young person had disability, as is usually the case in youth detention.</u> [citing the President of the Children's Court in *SOWA v BPA* 8 February 2023].

[4.10] <u>But when it comes to children in the ultimate form of State care, the government does not consider this to be abuse.</u>
(underlining added)

1012 The Court received three reports from the OCIS when Mr Ryan was the Inspector of Custodial Services which predated Cleveland's incident.[867]

1013 Exhibit 18 was the OCIS report in respect of the inspection of Banksia Hill in April 2021. It identified many issues which were relevant to the commencement of Unit 18.

1014 In its Executive Summary it stated:[868]

> We have previously opposed the practice of locking young people in cell for the purpose of staff training, but this practice continued in 2020. Despite the lockdown, Banksia Hill had fallen behind in some key training

[867] Exhibits 18-20
[868] Exhibit 18, p.v

> areas. We maintain that locking young people in cells is not the best model.

1015 It also identified the problem of involving prison officers in the youth custodial estate and the difficulties around the provision of a model of care in the youth estate:[869]

> A team of three adult custodial prison officers continued to be stationed at Banksia Hill. Significantly, unlike youth custodial officers (YCOs), they could be authorised to use chemical spray on young people in custody. We do not support permanent stationing of prison officers in a youth custodial facility. We believe the assistance of prison officers should be used as a temporary response to an emergency situation. The centre's approach to behaviour management was not consistent. Senior managers and YCOs had different views about the role of the Intensive Support Unit (ISU). This highlighted the fact that behaviour management and the ISU need to be at the centre of an operational model and philosophy for Banksia Hill.

1016 The first recommendation from this report was to develop and implement an operational philosophy for Banksia Hill.

1017 Exhibit 19 was the OCIS report in respect of the inspection of Banksia Hill in December 2021. This is the inspection which led to the Show Cause Notice.

1018 The concerns in relation to the Show Cause Notice were considered.

1019 This report did identify the concerns with the Department's approach to international law:[870]

> The provision of one hour of exercise and fresh air for detainees in confinement or segregation is contrary to the United Nations Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules), which requires at least two hours of out of cell time in a 24-hour period (UNODC, 2015). These standards are also made applicable to youth detainees under Rule 27 of the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules) (UNODC, 1985).
>
> Rule 67 of the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules) also expressly prohibits cruel, inhuman or degrading disciplinary treatments including closed or solitary confinement (UNODC, 1990).
>
> While Australia supports the Mandela Rules, they have not been enshrined in legislation in Western Australia and are therefore not legally

[869] Exhibit 18, p.vi
[870] Exhibit 19, p.ix

> enforceable. Despite this, they provide clear moral guidelines for the treatment of prisoners and detainees in custodial settings.

1020 Exhibit 20 was the OCIS report in respect of the inspection of Banksia Hill and Unit 18 in February 2023. In his overview in this report, Mr Ryan noted: [871]

> We have produced many reports on Banksia Hill over the years. It has been the most heavily scrutinised custodial facility in the state, and for good reason. This is due to the inherent risks of safely accommodating young people with complex needs in detention and also because of its history of significant instability. The problems have been well defined and do not need repeating in detail here. What is worth stating, however, is that there is no quick fix.
>
> The current staffing crisis is the immediate issue. Our report sets out the situation as we saw it in February this year. Much of what is written arises from not having sufficient numbers of custodial staff available each day to safely operate Banksia Hill and Unit 18 on a normal daily routine. This has led to increases in lockdowns, critical incidents, staff assaults, significant infrastructure damage and self-harm attempts. Despite these challenges, we noted the considerable efforts of management and staff in both facilities trying to get detainees out of cell each day for as much time as possible given the daily staffing numbers.

1021 This report developed a recommendation made in the report after the 2021 inspection:[872]

> In our 2021 inspection report for Banksia Hill (Report 141) we made a recommendation to 'embed an additional welfare focussed, non-custodial workforce to supplement the existing workforce in the ISU and Cue Unit at Banksia Hill Detention Centre'. The Department's response supported the recommendation as an existing initiative, pointing to the work being done to develop a new operating philosophy and service model. We have progressed this idea in more specific detail in this report with recommendation 6 relating to the establishment of a specialist youth care role to work alongside custodial officers. This would not be a major departure from what has previously been in place with officers having a youth welfare focus. The Department's response indicated in-principle support for this recommendation, again referring to the work being done as part of the new model of care that is being implemented.

1022 This report made certain observations about self-harm:[873]

[871] Exhibit 20, pp. iii-iv
[872] Exhibit 20, p.iv
[873] Exhibit 20, p.3

> For almost 18 months leading up to our inspection, the rates of self-harm and attempted suicide among young people in custody were unprecedently high. There had been a significant rise in recorded incidents of self-harm and attempted suicides from September 2021 and numbers have remained high ever since.

1023 The report continued:[874]

> Given the significant increase in self-harm and attempted suicide risk over the last 18 months, we were concerned to find mental health and psychological services not operating at their best. There was limited mental health screening of young people when they entered custody and there were no policies or procedures for prioritising assessment by the psychiatrist. This was compounded by restrictions on psychiatric services, which at the time of the inspection were only available via video link for those aged 16 years and over. Furthermore, regular meetings between mental health clinicians and the psychology team were not being held. We understand that after our inspection a new psychiatrist had commenced and there was no age restriction on who could be seen.

1024 The report reflected the evidence heard in the inquest:[875]

> We heard that two-thirds of the custodial workforce had less than 18 months' experience. And unit manager and/or senior officer positions were often filled by staff without relevant training or having undergone a selection process to determine their suitability.

1025 The report noted that staff had campaigned to argue the current ratio of 1:8 was unsafe:[876]

> The ratio of staff-to-young people should not be conceived primarily as a matter of safety. No other Australian jurisdictions maintains (sic) such a high ratio for its frontline detention staff.

1026 The report noted major reform on several fronts was required:[877]

> Major reform is needed to break the cycle. There needs to be innovation to reshape the workforce to make the job safer and more meaningful for staff and more effective in the provision of care and rehabilitation for young people. Such reforms should also improve staff retention and attract new recruits. The new proposed operating philosophy and service model specifies that young people should reliably have at least 10 hours, preferably more than 12 hours, out of cell per day (Nous Consulting, 2022, p. 42. Standard 1.2.1). It also stipulates that rosters be designed to promote

[874] Exhibit 20, p.4
[875] Exhibit 20, p.11
[876] Exhibit 20, p.16
[877] Exhibit 20, p.18

> greater continuity and consistency between young people and staff [citing the work of Nous]. This is a major component in a balanced approach to safety and security. It points to best practice in other states indicating that this can be achieved through eight-hour shift systems [citing the work of Nous].
>
> We acknowledge the 12-hour shift system is popular with many staff as it reduces attendance to 10 shifts in 21 days and attracts a shift allowance. However, it also limits continuity of care and is not how youth-facing roles should be organised [citing the work of Nous]. A mixed-shift system is critically needed at Banksia Hill, with those working with young people in eight- or 10-hour shifts, working four-to-five-day shifts per week. It may be feasible to pilot such a system with the current recruitment schools on graduation.

1027 The concerns articulated in these reports were repeated by Professor Morgan and Mr Ryan in their respective oral evidence at the inquest.

1028 Professor Morgan said:[878]

> I think it is really hard for me to summarise. There is a lot of detail in the report that I prepared. But in essence, the Department kept having a stop/start approach. So, there wasn't consistency in the approach. And consistency is vital with young people. Banksia Hill never really recovered from the riot, but more fundamentally than that, from the mismanaged amalgamation process that preceded the riot. There were no other places to take young people.
>
> …
>
> It was just a constant cycle of dysfunction and disorder, followed by partial recovery, followed by another bout of dysfunction and disorder.
>
> …
>
> But the other aspect to this that kept kicking in was there were many changes of leadership at the top. And each time the new leader came in, they wanted to do things differently. So, instead of actually having a consistent approach to developing the new one-stop shop, we had new commissioners and other people coming in and saying, we are going to start again. So, staff were all over the place. They had different operating models. They actually didn't know, really, what the primary governing document was any more. And so, I would end up repeating recommendations. And I know even my successor repeated the same recommendations, year in, year out.

[878] Ts pp.738-739

1029 Counsel for the Department put to Professor Morgan that he was not suggesting it was particular individuals who were responsible for the failings he had identified, and Professor Morgan agreed:[879]

> I would say it is about systemic and cultural failure.
>
> …
>
> I am not really interested in who the individuals are. I mean, the problem is that they are – and the problem is, when you change in the way that they have done over the years, you lose – you lose the history. I mean, it is actually sad to think that I am probably the only one who has really got the history of all of this. It should not be that way.
>
> …
>
> I am talking about it in generic terms, the Department and that refers to Department of Justice now, formerly Department of Corrective Services. No, it's about the failure of the government department, which has now been renamed.

And later:[880]

> Perhaps the question is, do I believe that the superintendents, over time, have done their best? Yes. By and large, they have. And they have always wanted – in my experience, the superintendents have always wanted to get an active regime. That is not where the problem is laying.
>
> …
>
> Put bluntly, the staff on the ground generally tried to do the best they could, but because there were constant reorganisations in the Department, constant attempts to reinvent the wheel, come up with new models of care or whatever the terminology was. And they never got there. So, the staff actually were doing their best. But they became increasingly disaffected. So, one of the extraordinary features over my time was – and I lost count – but the number of people who were superintendents at Banksia Hill, all of whom ended up leaving because of their conflict and problems with head office, not because of their conflict and problems with the children.

1030 During his examination, Mr Ryan said that it was a constant theme of Professor Morgan's reports and his own reports, that the amalgamation of Rangeview into Banksia Hill was to be lamented because sentenced and remanded detainees are fundamentally "*very, very different*":[881]

> Rangeview being the remand centre, there is a rapid churn. The average time that young people might be in might be days or a few weeks. They are often coming off the street. They are volatile. They are unhappy,

[879] Ts p.769
[880] Ts p.773
[881] Ts p.796

> disturbed. And they need a different level of intensive support and stabilising, I guess. If you look at a sentence facility, which is what Banksia Hill used to be, those young people are going to be there for several months. They can engage in training and education. They are likely to be more settled. And fortunately, they may well no longer be under the influence of alcohol or drugs. And you can engage them more in a more stable routine. They can attend education. They can start to do courses. There can be better relationships built with the staff, the youth custodial officers and the other support and welfare staff. So, they are very different needs and very different mix. When you put both of those together, it does enormously increase the challenge of running a centre like that.

1031 Mr Ryan expanded upon the comments in his reports in respect of Australia's international obligations and the Department's attitude in that regard:[882]

> Well, what was your response when you read that, what did you think? --- That they were saying that they may have been under a moral obligation to comply with those international rules but not a legal obligation to comply with them.
>
> And what did you think about that as a response? --- I thought it was inadequate.
>
> Why? --- Well, those rules, particularly the Mandela Rules and the Beijing Rules, are the internationally accepted minimum standards that countries such as Australia have signed up to. I think there's an absolute moral imperative to comply with them, and that will be particularly important in the coming years when the optional protocol for the Convention Against Torture is implemented throughout Australia. Because that is the test. And that will be the measure we will be measured against.

1032 Mr Ryan said that reform and improvement would require political will. As he explained:[883]

> There are so many areas that are not fit for purpose. But the Department has never had the budget or the support from government to make the necessary improvements.
>
> Yes. And the work of Professor Morgan over his 10 years and the work of you in your first five years, reflected in the various reports you have both written, that has been a constant theme of what you are writing, hasn't it? --- Yes. It has.
>
> That the facilities you have got are not fit for purpose. They are not up to scratch. They have to be improved? --- Yes. That is correct.

[882] Ts p.799
[883] Ts pp.800-801

> And that requires resourcing? --- Yes. It does.
>
> And that requires preparedness from governments of whatever political persuasion to commit to doing that? --- Yes. It does.
>
> And it requires a Department that is open and honest and transparent to acknowledge the shortfalls and be prepared to go and get the resources to fix it? --- Yes. It does.
>
> And it requires a Minister and a Department to listen to the watchdog year after year after year, saying these problems exist. They are serious. Thankfully, no one has died. But it is getting worse. And it has to be fixed. It requires political will, doesn't it? --- Yes. It does.
>
> And it requires a Department that is prepared to be open to change and to focus on the critical things? --- Yes, and they have to be resourced to do that.
>
> That's right, but there are many moving parts. The government has to put in the resources? --- Yes.
>
> It has to have the political will to do that? --- Yes, it does.

1033 Mr Ryan told the Court of his understanding of the positive outcomes internationally in youth detention facilities that have fully embraced a therapeutic and trauma-informed model of care. He identified one in Spain, one in the Republic of Ireland and another in Colorado:[884]

> The key difference in all of these is that they are based on dealing with each individual on the basis of their individual needs, and they're dealt with in a trauma-informed way. So, in other words, those facilities are run by clinicians. They're run by educators, by counsellors, by psychologists.

1034 Counsel for the Department took Mr Ryan to the fact that there was "*a self-perpetuating cycle*" and "*something had to be done*" and then asked:[885]

> And then, as it turns out, Unit 18 was subsequently opened, and you characterised that – or I think you agreed with the proposition that it was a wholly inappropriate space that was utilised? --- Yes, that's correct.
>
> That's right. To the best of your knowledge at that time, so we're now talking about July '22, was there any better option at that time? --- No, there wasn't.
>
> **CORONER:** But does that make it right, then, for them to be housed in Unit 18? --- No that doesn't.

[884] Ts p.802
[885] Ts p.839

1035 Mr Ryan's answer is open to be accepted. Counsel for the Department put nothing further to Mr Ryan to challenge his answer and went to another topic.

The Hon. Denis Reynolds

1036 The Court also received evidence from the Mr D Reynolds who was President of the Children's Court of Western Australia from 2004 until his retirement in 2018.[886] He had been a judicial officer since 1984.

1037 Exhibit 13 was a copy of two articles by Mr D Reynolds. The first was a paper delivered on 27 September 2022. The second was an article published in April 2023: "The Unlawful Management of Banksia Hill and Unit 18, Casuarina Detention Centres", *Brief* (April 2023).

1038 Mr D Reynolds described in his paper the test case which he heard in March 2013. The Children's Court wanted to hear submissions as to whether it could take into account the conditions in which young detainees were being held when sentencing those young people. The decision was that the Children's Court could do so. The Department was separately represented and put an argument that the conditions could not be taken into account. The Department did not appeal the decision to the Supreme Court.[887]

1039 The Children's Court then put into place a structure that came to be known as the Detention Management Reports. Mr D Reynolds said that the Department repeatedly asked the Children's Court to cease requiring the production of the Detention Management Reports, but the Children's Court continued to require them.[888]

1040 These reports are still being requested by the Children's Court. It is how the practices of the Department, for example in terms of OOCH, have been uncovered in recent years. Such reports can only be required by the Children's Court in respect of remandees, not sentenced children.

1041 As noted later in these submissions, the Department provided some information to the inquest about the population profile of Unit 18. That data has been analysed by Professor Morgan and Mr D Reynolds in their joint report which was exhibit 105.2.

[886] Ts p.870
[887] Ts pp.873-874
[888] Ts p.875

1042 Their joint opinion is that the data produced by the Department reveals that after Cleveland's death there was a very significant increase in the percentage of detainees in Unit 18 who were sentenced, rather than on remand. This had the effect of reducing the number of detainees in Unit 18 about whom the Children's Court could require the Department to provide a Detention Management Report.

1043 Mr D Reynolds was asked to respond to the view that the difficulties which had arisen at Banksia Hill over the last few years are primarily because the children are different to what children were like in the past:[889]

> I think at the core of the issues that you're dealing with is a false premise. The false premise is that the children that have been sent to Banksia and subsequently to Unit 18, that the children are inherently bad.
>
> …
>
> That is behaviour that is the product of children being inherently bad. Whereas my firm view is that the children we're talking about are vulnerable children – the most vulnerable children in our community. They've got neurodevelopmental conditions. They've suffered lives of trauma. They've got layers of trauma. So, they come to be in a detention centre with all of those issues.
>
> …
>
> But when you have those children who are confined – solitary confinement for anything in excess of 20 hours a day but there are lots of cases where there are 23 hours a day, 24 hours a day, consecutive days, over prolonged periods of time. That treatment of these vulnerable young children, I'm of the firm view, is the cause of behaviours, which include the extensive damage, the threats and the assaults against the staff. So, the children are no different to when I started in 2004, when I finished in 2018 and now. The children are no different.

1044 When questioning Mr D Reynolds, counsel for the Department noted the opinion expressed above and then asked: "*Whether detainees have been doing different things over time?*". Mr D Reynolds responded:[890]

> In my time, kids were realising that they could – they get away, remove parts of walls, remove what were fixtures in the place, use them to then cause further damage, get up through the roofs, all that sort of stuff. Yes, that – that was all happening.

[889] Ts pp.871-872
[890] Ts pp.911-912

1045 Since his retirement, Mr D Reynolds has been a public advocate for reform in the youth justice space in Western Australia. Like the two Inspectors described above, he gave compelling evidence.

Judge Quail, President of the Children's Court

1046 His Honour has been the President of the Children's Court since 2020.

1047 Judge Quail did not give oral evidence to the inquest. However, his views on certain matters were received as exhibits during the inquest.

1048 In his statement, Professor Morgan noted what Judge Quail had been saying in various published decisions in the Children's Court:[891]

> [3.69] The current President of the Children's Court has frequently stated that detainees' behaviour is linked to the way they are treated. I endorse his views. Lockdowns and boredom – the hallmarks of Unit 18 in October 2023 - are a particular problem.

1049 At footnote 7 of his statement, Professor Morgan cited three particular decisions.

1050 On 23 September 2023, Judge Quail was interviewed for an article subsequently published in the Law Society's *Brief* in October 2023.[892] The article explained various initiatives being undertaken by the Children's Court. However, it commenced with a sombre observation and a prescient warning by his Honour:[893]

> Many readers will know that **the Court has been very critical of detention conditions for young people in Banksia Hill Detention Centre and Unit 18.** The *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* last week published their final report and recommendations. Chapter 3 deals with our youth detention crisis and I very much hope the government read the report and act on it. Banksia Hill, I am pleased to see, has been improving over the last 3 months **but conditions in Unit 18 are still dire and need to be fixed urgently. There are currently 16 boys there who are locked down 23 hours per day. That has caused me many sleepless nights. I dread that a boy will suicide there, or a staff member be seriously harmed**. (emphasis added)

1051 This interview was given less than three weeks before Cleveland's incident.

[891] Exhibit 28, p.24
[892] Exhibit 114
[893] Exhibit 114, pp 8-9 of the article in *Brief*

The ALSWA

1052 As already noted, Mr Collins is the Director of Legal Services at the ALSWA. He told the Court that a significant majority of the detainees moved on 20 July 2022 were clients of the ALSWA and a significant majority of those subsequently sent to Unit 18 have been the clients of ALSWA.[894]

1053 The ALSWA has been writing frequently to the Department to voice concerns and make complaints about how their clients are being treated and the conditions within Unit 18.

1054 Attached to the statement of Mr Collins[895] were many such letters. Similar letters appeared in the initial coronial brief.[896] Much of that correspondence went unanswered and without an explanation for there being no response.[897]

1055 Mr Collins told the Court that the regular three-monthly meetings between the ALSWA and the Commissioner ceased in mid-2022 when the ALSWA commenced the first of the two proceedings before Tottle J. Mr Collins said there had been no meaningful dialogue between the ALSWA and the Department since then in respect of longstanding issues. He said he had made no approach to the Department about returning to the previous practice.

1056 Irrespective of why and by whom the practice of the meetings ceased, the resumption of such regular dialogue would be a good thing for both the ALSWA and the Department to undertake. Any discussion about systemic issues can only assist in creating the safest environment for detainees and staff. The safer the environment, the better the chance of avoiding another tragedy.

1057 In response to questioning by Senior Counsel for the ALSWA, Mr Collins explained some of the circumstances that made it particularly difficult for young Aboriginal detainees. These included: [898]

- "*Dislocation from and separation from culture, community and country for those young people can never be underestimated*."

[894] Ts p.700
[895] Exhibit 46
[896] Exhibit 1, Volume 5, Tab 1
[897] Ts p.696
[898] Ts pp.719-720

- "*The vast majority of young people in Banksia Hill and Unit 18 don't get visits in person from family. That issue is particularly acute for young people from regional and remote areas*."
- The lack of visiting is not because the family does not care, "*it's a reflection of their social circumstances. Most families don't have the financial means to be able to make the long trek, from wherever they live, to Perth to see the young person*."
- "*So, they don't have any personal interaction via a personal visit for the entirety of the time that they're in Banksia Hill or Unit 18. And that is an incredibly common experience for these young people*."

1058 Mr Collins said it was his long and personal experience that those responsible for the care and custody of these detainees gave insufficient weight to these matters and there was no careful calculation in terms of what arrangements should be made.[899]

1059 Mr Collins highlighted the risk:[900]

> So, there's a serious risk with a lot of these young people that they don't have any communication of a meaningful nature with family in the community, so that they're on their own. And the psychic pain of being on your own in a cell as an Aboriginal person where family is your life and that social connectedness is so important is devastating, and it is extremely deleterious, in my experience, to their mental health.

A potential missed opportunity by the Department

The events of the second half of 2021

1060 There is evidence available that could support a conclusion the Department failed to respond in any meaningful manner to these problems. The identified problems remained and grew in size, complexity and intensity. If there had been a meaningful response which addressed and arrested the concerns identified above, such a response may have produced better outcomes, and these would have been observed and documented by Mr Ryan in the OICS Report in May 2023.[901] Such better outcomes did not occur. To the contrary, it may be open to contend that the problems worsened.

[899] Ts p.720
[900] Ts pp.719-720
[901] Exhibit 20

1061 The undisputed evidence is that the chronic staffing shortages continued, resulting in the young people remaining in their cells for extended and increasingly frequent periods of lockdowns. Concerns were expressed that the Department was not complying with the law as it managed these young people. It was said the Department was not complying with the *Young Offenders Act 1994* (WA) and its Regulations. It was said the Department was not complying with the obligations found in international law because of Australia being a signatory to various international instruments.

The Show Cause Notice from Mr Ryan to the Department

1062 In December 2021, an extraordinary event occurred; the OCIS issued a formal Show Cause Notice to the Department. At the inquest, Departmental witnesses who were in senior positions at the time of the Show Cause Notice agreed it was a very significant event.[902]

1063 The initiating letter from Mr Ryan was the Show Cause Notice and it included the following passages:[903]

> I am concerned that a number of detainees held in the Intensive Support Unit (ISU) at the BHDC are being denied their statutory rights as set out in the *Young Offenders Act 1984* (YOA), relevant Departmental policy (i.e. BHDC standing order 9a) and the relevant United Nations Standards for the treatment of prisoners and detainees (i.e. the *Mandela Rules*, *Beijing Rules* and the *Havana Rules*). Consequently, in accordance with section 33A of the Act, **I have formed a reasonable suspicion that:**
>
> 1.**There is a serious risk to the care or welfare of detainees held in the ISU at the BHDC**; and
>
> 2.**That detainees are being subjected to cruel, inhuman or degrading treatment in the ISU of the BHDC**.
>
> …
>
> Specifically, I am concerned that detainees who are being held in the ISU of the BHDC are regularly not receiving their minimum rights for time out of cell, and further because of that failure, they are being treated in a manner that is cruel, inhuman or degrading. Our analysis suggests that detainees have responded to this treatment with an increase in challenging and dangerous behaviours, including assaults, serious self-harm attempts and suicide attempts.
>
> …

[902] Dr Tomison: Ts p.979; Mr Beck: Ts p.2185; Ms Ginbey: Ts p.2585
[903] Exhibit 30.1, pp.1-2

> I am concerned that most of the factors evident in the current situation at the BHDC are very similar to those that existed prior to the 20 January 2013 riot and the significant disturbances on 4 and 5 May 2017, that have been well documented in several reports by my Office.
> …
> Given my level of concern, I am seeking assurance that all possible steps are being taken to address the current situation at the BHDC.
> (emphasis added)

1064 The letter attached a draft report recently prepared by the OCIS in respect of the ISU at BHDC. The concerns expressed in the Show Cause Notice repeated the themes found in the earlier reports by Mr Ryan and by his predecessor, Professor Morgan.

> Detailed analysis of out of cell hours for detainees in the ISU demonstrate that, at times, their human rights have been breached. Throughout November 2021, analysis identified several days where three detainees did not receive their minimum out of cell time under both the Department's SO9a policy and the *Mandela Rules* (UNODC, 2015). These findings are consistent with our previous report on out of cell hours in 2018.[904]
> …
> The confinement of detainees in this manner contradicts Rule 44 of the *Mandela Rules*, which stipulates solitary confinement within a cell should not exceed 22 hours in a day (UNODC, 2015). Solitary confinement of children constitutes 'cruel, inhuman or degrading treatment' and is 'strictly prohibited' under the *Havana Rules* (UNODC, 1990).[905]
> …
> Similar findings in relation to out of cell hours in the ISU at BHDC were reported by OICS in 2018. The two detainees subject of that review were also being managed under CAPSPs[906] and were similarly found to have been held in conditions that were in breach of the *Mandela Rules* and *Havana Rules*. OICS recommended legislative amendments to the confinement provisions under the YOA and the Regulations. The Department supported the recommendation in principle but there has been no change to date.[907]
> …
> Detainees face long periods of time alone in cells that are often in a poor state and are small in size. This typically leads detainees to act out and increasingly there are more detainees self-harming.[908]
> …

[904] Exhibit 30.2, p.1
[905] Exhibit 30.2, p.2
[906] Personal Support Plan (Change of Accommodation)
[907] Exhibit 30.2, p.3
[908] Exhibit 30.2, p.5

> Threats of self-harm and actual incidents of self-harm in the ISU have increased to its highest levels in October and November [2021].[909]
>
> …
>
> Attempts at suicide have been a relatively rare occurrence at Banksia Hill with only one occasion recorded in 2020 and one incident occurring in February 2021 and May 2021.[910]
>
> …
>
> It is fortunate that Banksia Hill has never had a death in custody or suicide. However, the likelihood of this remaining the case is becoming increasingly smaller as incidents of attempt suicide continue to increase.[911]

Was there a failure by the Department to respond appropriately to the Show Cause Notice?

1065 The Department was statutorily obliged to make a formal response. In that response the Department said, in a letter signed by Dr Tomison:[912]

> I do not necessarily believe the factors currently affecting service delivery at BHDC are the same as those that led to the 2013 and 2017 disturbances.[913]
>
> …
>
> … for the past six months BHDC has been managing a cohort of detainees who have presented with very complex needs and who have been involved in a number of incidents of damage to infrastructure, fence climbs, assaults of staff and self-harm and suicide attempts. These young people are very difficult to manage safely, which has been our focus.[914]
>
> …
>
> The increasing number of critical incidents has been exacerbated by the inherent infrastructure issues present at BHDC: it was not designed as a fit- for-purpose youth detention centre for remanded and sentenced youth. Further, there have been staff shortages, which I am working to overcome, which have led to increased time in cells for detainees; and more frequent Centre-wide lockdowns as a result of increased number of critical incidents.
>
> The ISU is not in a good physical state and the architecture is not conducive to providing the best therapeutic response that benefits the detainees who are housed there.[915]
>
> …

[909] Exhibit 30.2, p.6
[910] Exhibit 30.2, p.6
[911] Exhibit 30.2, p.7
[912] Exhibit 30.3, p.2
[913] Exhibit 30.3, p.1
[914] Exhibit 30.3, p.1
[915] Exhibit 30.3, p.1

> As a consequence, the operational capacity to provide a stable environment and structured daily routine for all young people, (including young people with trauma or mental illness, complex and challenging behaviours or those at acute risk of self-harm or suicide) is impacted. Further, the current infrastructure does not allow for adequate separation and targeted responses to each cohorts' particular needs.
>
> These problems are more evident when the Unit is full and holds cohorts of individuals who have very complex needs, as has been the case since mid-2021.

1066 It was open on the evidence before me that the response of the Department to the Show Cause Notice was not adequate in the circumstances in two respects.

1067 First, the language used in the written response dated 23 December 2021 failed to address the gravamen of the concerns raised by the OCIS.

1068 Secondly, that the Department failed to escalate these concerns in a manner to the Minister which indicated, in the language found in the evidence at the inquest, that "*this was the straw that broke the camel's back, that whatever needed to be done, now had to be done*."[916]

The Inspector of Custodial Services writes to the Minister

1069 Mr Ryan was not persuaded by the Department's response and on 21 January 2022, he wrote to the Minister. His letter included:[917]

> The Department's detailed submission in response to the Notice provides some welcome evidence regarding longer term plans for the centre generally, and the ISU specifically. It confirms and expands on previous verbal advice provided to me by both Dr Tomison and Acting Commissioner Reynolds. We have recommended some of the proposed changes and infrastructure upgrades in previous inspection reports, while other proposed upgrades appear to continue the project of target hardening the centre that has been ongoing since the 2013 riot.[918]
>
> …
>
> Notwithstanding the comprehensive response, **I have concluded that there is an overreliance on security mechanisms, physical and personnel, to address the concerns highlighted in the preliminary draft inspection report**. There appears to be at this stage a limited focus on the social, emotional and welfare needs of the young people despite several references to trauma-informed custodial care. For example, in reflecting on time out of cell, the Department has concentrated on the

[916] See Dr Tomison: Ts pp.988-989; Mr M Reynolds: Ts pp.1522-1524
[917] Exhibit 30.5, p.2
[918] Exhibit 30.5, p.1

> physical amount of time a young person is spending out, rather than whether that time is meaningful and socially and emotionally enriching.[919]
> …
> However, I am also of the view that **an appropriate balance between security and welfare responses must be achieved**. **There needs to be an immediate circuit breaker. I understand and accept that staff and detainee safety is a paramount consideration, but I also believe there is an opportunity to have both a security and welfare response.** One does not necessarily have to be a precursor to the other. This could perhaps be achieved through supplementing the custodial workforce with a non-custodial service provider, to ensure the statutory rights and welfare needs of the young people are being met.
> (emphasis added)

The Minister's response

1070 The Minister responded on 8 March 2022 which was prepared by the Department. In the final draft of the response, the Department had written that the Minister expressed confidence in the Department in the following terms:[920]

> I am confident that the Department understands the current issues and has a clear plan to address the concerns you have raised.
> …
> I am satisfied it is doing all it can to alleviate the pressures at Banksia Hill in the immediate and long-term period.

1071 When the Minister's formal response to Mr Ryan was signed and sent to Mr Ryan, the Minister had removed the two sentences quoted above.

1072 The Minister's response included:[921]

> The difficulty in managing this cohort has been exacerbated by the infrastructure deficiencies at BHDC. As you and I have previously discussed, **BHDC was not designed as a fit for purpose youth detention centre and its design and layout create a number of challenges in managing detainees**.
> …
> The proposed works include funding to upgrade fencing, install anti-climb roof treatment and install additional security measures to Jasper Unit.
> …
> I recognise that BHDC is also under pressure partly due to staffing shortages.

[919] Exhibit 30.5, p.2
[920] Exhibit 66
[921] Exhibit 30.6, pp.1-2

> …
>
> I note you are broadly supportive of the approach the Department is taking. Your suggestion for an immediate circuit breaker to supplement the custodial workforce with a non-custodial service provider is currently being explored by the Department.
> (emphasis added)

1073 This response did not address the concerns expressed by Mr Ryan. There was no mention of Mr Ryan's concerns about the breach of international obligations. Indeed, the Minister's letter (which it must be remembered was drafted by the Department) repeated the emphasis upon security, both physical and personnel, the very emphasis which Mr Ryan had reported as the wrong focus.

1074 The statutory regime of the OCIS did not enable Mr Ryan to do anything further. He duly submitted his report to Parliament, where it lay for the obligatory 30 days.

Dr Tomison's reflections on the Show Cause Notice at the inquest

1075 Dr Tomison had been forewarned by Mr Ryan that a Show Cause Notice may be issued. He acknowledged that such a Notice was a significant matter.[922] Dr Tomison personally discussed the Notice with the Minister before the Department provided its formal response.[923]

1076 The message he was giving to the Minister was that the Department had been in very frequent communication with the OCIS in the five or six months leading up to the Show Cause Notice. The OCIS was telling the Department there were problems and the Department was telling the OCIS it was trying to deal with them. Dr Tomison was experiencing a sense of frustration because "*as the Head of Agency I can't improve this situation. In fact, it's deteriorating around me, and I can't stop it*."[924]

1077 The response by the Department to the Show Cause Notice had Dr Tomison's personal imprimatur. He had read both the letter and the accompanying report.[925]

1078 It was put to Dr Tomison that in retrospect it was the wrong decision in December 2021 not to go to the Minister and tell him in effect: "*This is the straw that is breaking the camel's back … whatever has to be done has to*

[922] Ts p.979
[923] Ts p.982
[924] Ts p.984
[925] Ts p.985

be done. We are at the end of the line." In response to that proposition, Dr Tomison said: "*In hindsight, I would agree. At the time, living it, it was different.*"[926]

1079 Dr Tomison explained he was reluctant to make the move "*to actually decant young people into a non-youth detention facility, recognising Hakea, Casuarina, anywhere like that would not be anything like a proper youth detention facility*."[927]

1080 Dr Tomison accepted the Department's response to the Show Cause Notice in respect of Mr Ryan's concern that the Department was acting unlawfully was to the effect the Department rejected the proposition that it was not complying with the law, and as the international obligations which it was said to be breaching are not enshrined in State legislation, the Department was complying with State legislation.[928] He agreed that response could have been framed better.[929] Dr Tomison accepted that in December 2021, the international obligations applied to the Department.[930] Dr Tomison agreed it was "*just wholly inappropriate for any government department, let alone the Department of Justice*" to respond in such manner.[931]

1081 Dr Tomison agreed that the Department prepared the draft for the Minister to make his formal response to Mr Ryan's office. Dr Tomison saw the final draft before it went to the Minister. He agreed the letter the Minister sent by way of formal response was silent on the question of whether the Department was acting unlawfully, was silent on addressing the allegation the Department was in breach of State legislation and was silent on the allegation the Department was breaching international obligations. He agreed it must have been a conscious decision on his part not to respond to those allegations in the draft letter. He accepted in hindsight that the Minister's response should have dealt with those allegations.[932]

1082 The Department's response in December 2021 to the Show Cause Notice, identified what areas it was working on to reduce the staffing problems. Dr Tomison agreed those areas had been within the control of the Department from 2017 (when he became Director General) and during all of that time criticism was being made about staffing problems.[933]

[926] Ts p.988
[927] Ts p.988
[928] Ts p.994
[929] Ts p.995
[930] Ts p.995
[931] Ts p.995
[932] Ts pp.996-997
[933] Ts p.1190

1083 When the Department responded to the Show Cause Notice, it acknowledged that the environment in the ISU at Banksia Hill was not therapeutic.[934] Dr Tomison thought this had been the Department's view from the latter half of 2021.[935] In the Department's response to Mr Ryan, Dr Tomison accepted that the Department acknowledged it would not meet its statutory requirements until there were capital works undertaken at the ISU.[936]

1084 In the Department's response to Mr Ryan, it expressed the view that the current Crisis Care Unit was not designed to minimise trauma, that the cells were poorly designed, there was no appropriate area for support or counselling, and it will require a new building to be designed for this specific purpose.[937]

Why it could be contended this was a missed opportunity

1085 It may be open to find that the Show Cause Notice was a missed opportunity for the Department to have done more. Greater urgency could have been expressed by the Department to the Minister. It could be contended this was the occasion when serious consideration ought to have been given to what was referred to in the evidence at the inquest as "Plan B". That is: "What are we going to do if we have to remove some detainees from the Banksia Hill site, and where are we going to put them?"

1086 It may be open to conclude that the Department did not do anything meaningful in the first half of 2022 to address the concerns which had been documented during the preceding decade and as recently as December 2021.

1087 It may be open to find that the only meaningful action by the Department was the convening of the meeting on 25 May 2022 by Mr Beck. The information before the Court is that thereafter nothing of any meaning was done by the Department in respect of a "Plan B" until the announcement by Dr Tomison on 1 July 2022, to his inner circle, that the Department would utilise Unit 18 as a youth detention centre.

1088 Dr Tomison said that as he now reflected on what was happening in Banksia Hill leading up to the establishment of Unit 18, he accepted it could

[934] Exhibit 30.4, p.14; Ts p.1192
[935] Ts p.1193
[936] Ts p.1194
[937] Ts p.1194

be fairly described as cruel and unusual punishment. He agreed it could be described as "*institutional or systems abuse of a child*."[938]

1089 Dr Tomison agreed "*there is no doubt that what was happening in the first half of 2022 at Banksia Hill was institutional abuse of those children*."[939] He agreed that this description could also apply for the latter months of 2021.

1090 Dr Tomison said that by December 2021 it would be fair to say an increasing number of children at Banksia Hill were the subject of institutional child abuse and there was certainly institutional abuse for the "*overwhelming majority of the children*" at Banksia Hill in the first half of 2022.[940]

1091 In response to questions from me, Dr Tomison said that his comment about institutional child abuse had the ISU at Banksia Hill as its focus, "*but I also recognise at the times that have been talked about, other young people would have been locked down at different points across the site, but predominantly it was the ISU focus, I guess.*"[941]

1092 This was clarified in counsel assisting's examination of Dr Tomison by focusing upon a point in time and the fact of how much time detainees generally were spending in their cells:[942]

> And in undertaking the exercise of trying to find that point in time, would you say it is fair to say that certainly by December '21, that would have been a fair characterisation, namely, that if not all, then an overwhelming majority of the children in Banksia could so be described? --- It's hard for me to just straight conclude that. By December '21, we had a lot of young people in the ISU, and certainly the – there were excessive confinement hours there. I can't recall now how often the rest of the site was locking down, but I'm going to assume it was quite often, because I just – I'm losing track of times and what happened at varying points. So, I – I'm – I'm happy to say, or I'm – I – I would say, will say, from late 2021, out of cell hours were reduced. The confinement was too long for too many young people.
>
> And that, you accept, is institutional abuse of those children? --- Yes, essentially, I think it is.

[938] Ts pp.1010-1011
[939] Ts p.1011
[940] Ts p.1011-1012
[941] Ts p.1012-1013
[942] Ts pp.1013-1014

1093 I make no finding or comment as to the accuracy or otherwise of these concessions from Dr Tomison regarding the existence of "*cruel or unusual punishment*" and "*institutional abuse*" at Banksia Hill before the opening of Unit 18. Given the well-understood legal connotations to these phrases, to do otherwise would infringe the provisions of section 25(5) of the Act. They are matters for another time and place.

1094 Dr Tomison now accepts, "*there was insufficient planning around this Plan B, the using of Unit 18 and that that manifested itself in the absence of a whole lot of things in Unit 18.*"[943]

1095 It may be open to conclude that this concession was properly made by Dr Tomison and that there was insufficient planning by the Department for a second youth detention centre. It may be open to find that this planning should have been undertaken, at the very latest, following the Show Cause Notice.

Lack of consideration for a second youth detention centre

What was Dr Tomison doing, or not doing?

1096 In Dr Tomison's response to the Show Cause Notice, he told Mr Ryan that the infrastructure of Banksia Hill was not designed as a fit for purpose youth detention centre for remanded and sentenced youth. In his evidence, Dr Tomison agreed with the views expressed by Professor Morgan and Mr Ryan, that it was undesirable to have sentenced detainees and remandees within the one facility. He agreed it was a fundamentally flawed model to have both groups in the one place:[944]

> But the issue does not go away. It is a fundamentally flawed model? --- Agreed. I've seen Banksia working really well, but the underlying issue won't change.
>
> If the fundamental flaw manifests itself, it is inevitable it will manifest itself in quite extreme ways: January 2013, May 2017, Banksia in the last few years? --- Yes.
>
> During your term as DG, although you and the Department are aware of this fundamentally flawed model, you don't seek additional money from the government or urge the government to change the model, because it's not a high priority? --- Frankly, I also don't think it would become – I don't think it would have success.
>
> Because there would be no political appetite for it? --- Essentially.

[943] Ts p.1023
[944] Ts p.1059

1097 Dr Tomison said the Department would always have liked a second youth detention centre during his tenure so that the sentenced detainees could be separated from the remandees. He did not think there was an appetite for a second site while Banksia Hill was stable.[945]

1098 The infrastructure review which occurred in late 2023, is Cabinet in Confidence. However, Dr Tomison confirmed what had been in the published media, namely, that the new facility is not, "*designed just for remandees. I expect a lot of the people who would go into such a proposed unit will be remandees but not all*."[946] Dr Tomison agreed that such a new facility "*gets back to the same problem: that you've got remandees and sentenced detainees together in the one facility*".[947] This portion of Dr Tomison's examination concluded with counsel assisting asking:[948]

> Banksia Hill hasn't got a capacity to deal with them with respect to that matter [providing them with the therapeutic care that they require] has it? --- This goes back to the ISU discussion. If the ISU is full, I don't think it has got the capacity to do a good job of looking after the therapeutic needs of young people.

1099 Dr Tomison was examined closely about his state of mind in early 2022. He said he had senior staff and unions saying to him by that time, that it was necessary to move the very disruptive detainees off site to a higher security facility which would need to be gazetted as a youth detention centre.

1100 He said he raised this with the then Commissioner (Mr M Reynolds) and the then Deputy Commissioner (Mr Beck). He said that the three of them, as the senior management, decided that would not be done at that moment in time for two principal reasons; namely, the precedent it will set and secondly, the belief the Department can manage what it is doing.[949]

1101 Mr Beck organised the meeting on 25 May 2022 for the express purpose of canvassing what "Plan B" may look like. There is evidence from Ms Ginbey that there was a clear message coming from Dr Tomison that there was no appetite for a second youth detention site during the first half of 2022.[950]

[945] Ts p.1056
[946] Ts p.1057
[947] Ts p.1058
[948] Ts p.1058
[949] Ts p.1065
[950] Ts p.2347

1102 Dr Tomison was asked if he accepted this proposition:[951]

> By early 2022, it appeared to you that you were now no longer able to manage the site [Banksia Hill] by the actions taken by the Department? --- Yes. I was becoming deeply – well, I was deeply concerned.

1103 Dr Tomison agreed that "*by early 2022*" he meant January or February. He agreed that in those months, the Department was preparing what would become the Minister's formal response to the Show Cause Notice, which was sent by the Minister to Mr Ryan on 8 March 2022. Dr Tomison agreed there was nothing in the Department's communications to the Minister during the preparation of that formal response which advised the Minister of the view that the Department was no longer able to manage Banksia Hill.

1104 During this part of Dr Tomison's examination, the final draft of the letter being prepared by the Department for the Minister[952] had been identified in evidence but was yet to be produced to the Court:[953]

> Hopefully. We're going to have it at some time. And I've asked are we going to see in that document the expression of what you've just told his Honour was your view? --- No, you won't.
>
> And I'm asking can you explain to his Honour why you wouldn't be letting the Minister know that that was your view, where your department is preparing his formal response to the extraordinary state of affairs that the Show Cause Notice had set up? --- No, I can't.
>
> Do you accept that if the Minister is not being told that is your view, that is a very serious matter? --- Yes.
>
> Can you explain? Was it a deliberate, conscious decision not to tell the Minister? --- No, it was not.
>
> Well, what's the explanation for the Minister not being told? --- I don't know. I do know that I was keeping the Minister informed as to what was happening at Unit 18.
>
> No, no? --- Sorry
>
> Please, Dr Tomison. Focus on this. We know that you are preparing paper for the Minister on this very issue. So, your mind is turned to the issue. What's the explanation for why the Minister is not told? --- I do not have an explanation for it.

1105 Dr Tomison disavowed any possibility that the reason the communications to the Minister in January and February 2022 were silent about any view Banksia Hill could not be managed was that such communication would

[951] Ts pp.1066-1067
[952] Exhibit 66
[953] Ts pp.1067-1068

require an acknowledgement that the Department, even if it had the ability to manage Banksia Hill in December 2021, had now lost the ability to manage the site. In rejecting that proposition, Dr Tomison asserted: "*I kept my Minister fully briefed*."[954] That led to the following questions by me:[955]

> Well, you clearly haven't. By your own admission, you haven't. You didn't inform him until June of 2022 of the fact that Banksia Hill couldn't be managed. Whereas you had formed that view by early 2022? --- Well, I formed that view – I had that fear. I'm not sure, your Honour, what term is correct. But I certainly kept him informed of what was happening on that site and I understand what you just said to me.
>
> I'm just a little lost as to understand why you weren't bringing this to the Minister's attention well before June of 2022? --- I may not have – I'm going to say I did not raise it as in, "We need a second site" with the Minister. I certainly had meetings with him regularly where I said, "This is what's happening at Banksia right now. This is what we are attempting to do".
>
> But you're not expecting the Minister to propose a second site, are you? --- No. I wasn't.
>
> No. That information has to come from you? --- Yes.
>
> And it just seems to be there's a delay – a number of months. And, you see, the importance of this – and Mr Crocker will get to this at some point – but the importance of this is that I'm sure it's going to be put to you that there was completely insufficient time to prepare Unit 18 for the influx of detainees on 20 July. So here was a way out for the Department – to bring this to the Minister's attention earlier than that so that proper planning can be done to ensure that Unit 18 was a safe environment to house detainees? --- I …
>
> Because the evidence I have heard to date is that it was completely unsafe to have these young people in Unit 18? --- I understand, your Honour. I think – it's a very big step to gazette a second site, as you would be aware. It has only happened once before. I think I had real concerns about what was the right time to do that. And I understand what you've said. And – yes. I think we missed an opportunity to plan better to open Unit 18. And I'm not happy at all. I will accept that my delay in sort of raising the issue later, when it was even more urgent, is a serious mistake. I'm not sure what else I can say.

Ms Ginbey was concerned from late 2021

1106 There is no controversy about the critical dates of Ms Ginbey's employment with the Department. She returned as Assistant Commissioner to the

[954] Ts p.1070
[955] Ts pp.1070-1071

Women's and Young People Directorate in late 2021. In mid-June 2022, she replaced Mr Beck as the Deputy Commissioner. She remained in that position until 8 July 2024.

1107 On 11 February 2022, Ms Ginbey emailed Mr M Reynolds and Mr Beck itemising what she thought were the preferred options, identifying what she considered were not the preferred options in respect of any emergency response to move the young people from Banksia Hill. Ms Ginbey was writing as the Assistant Commissioner, "*addressing the problem of what are we going to do if we have to move some young people from Banksia*".[956]

1108 The response Ms Ginbey received from Mr Beck "*was that there was not an appetite for that to occur and that remained the case even after the workshop of 25 May*".[957] As a result of receiving this message, Ms Ginbey "*downed tools on that topic*". Ms Ginbey agreed that if she "*had got a different message after the email of 11 February, the frenetic pace of what we know happened in July may well have been better managed because [she] would have had a much greater lead up time*."[958]

1109 Ms Ginbey acknowledged she was aware of the various criticisms made of the Department during the course of the inquest. She accepted there was validity in some of those criticisms and on other occasions did not accept such criticism was valid, or it was valid only in a qualified sense.

1110 Ms Ginbey accepted as valid the following criticisms:

(a) "*[T]he provision of out of cell hours and services for young people in custody have not been as they should be*."[959]

(b) From at least the end of 2021, until July 2024 (when Ms Ginbey became responsible only for Adult Women's Prisons), "*it is entirely valid to criticise the Department for failing to comply with its obligations in relation to out of cell hours.*"[960]

(c) "*[T]hat the Department was slow to understand the legislation and regulatory framework, and it took two decisions of the Supreme Court to make it clear to the Department what it could and could not do.*"[961]

[956] Ts p.2347
[957] Ts p.2347
[958] Ts p.2349
[959] Ts p.2295
[960] Ts p.2295
[961] Ts p.2296

(d) That having been told by the Supreme Court what legally was required to be done, the Department, although attempting very hard to comply, failed.[962]

(e) In December 2021, when the Department received the Show Cause Notice from the OICS, it was a missed opportunity for the Department to say this is "*the straw breaking the camel's back; we have to go to the Minister and say whatever it takes, has to be done*."[963]

(f) Related to the above, "*the missed opportunity in December '21, is that that was the time when a second site, 'Plan B', should have been articulated and planning for it commenced*."[964]

1111 It would seem the Department had a crisis on its hands in mid-2022. The behaviour of some detainees in Banksia Hill had created serious problems, most if not all of whom had at least one significant neurocognitive disability. It may be open to contend that this behaviour was the result of how the Department managed these detainees and that keeping them in their cells for extended periods of time over an increasingly long period was a primary causal factor in their behaviour.

1112 A primary reason the lockdowns were occurring (and were as severe as they were) was because of inadequate staffing provided by the Department. It was the Department's responsibility to staff Banksia Hill adequately and it was acknowledged at the inquest that it failed to do so. It could be contended that as of 2021, there was no other explanation for the inadequate staffing arrangement other than a failure on the part of the Department.

1113 Ms Ginbey accepted that to a large degree, the crisis the Department found itself in as of July 2022, was of its own making.[965]

1114 Counsel assisting put to Ms Ginbey:[966]

> The principal reason they had to be moved [to Unit 18] was the Department had failed in its responsibility to be able to look after them. You agree? --- The Department had failed in that Banksia Hill was unable to safely manage them and the vulnerable detainees who were also held at Banksia Hill.

[962] Ts pp.2295-2296
[963] Ts p.2311
[964] Ts pp.2311- 2312
[965] Ts p.2349
[966] Ts p.2346

> Well is that a yes to the proposition I put? --- It's a partial yes. There had absolutely been a lack of planning and investment in youth custody for a significant period of time. The situation that we found ourselves in late 2021 and early 2022 was a product of that, absolutely.

1115 By failing to address, in a meaningful manner, this consistent and evolving staffing problem, it could be argued it was inevitable that there would be a crisis point reached in the management of Banksia Hill. When that inevitability was imminent, it appeared that there was no appropriate "Plan B", only a hastily conceived plan to use Unit 18. A contention could be made that the young people were not moved to Unit 18 for their benefit, they were moved because the Department could see no other option because it had not planned for any other option.

1116 However, Ms Ginbey did not accept the proposition that the reason the young people were moved to Unit 18 was not for their benefit, rather they were being moved, "*because the Department had a crisis that they had not planned for.*"[967]

Ms O'Connell was also concerned

1117 Ms O'Connell was aware of the long-standing concerns expressed by the OICS. She said she had her own concerns from early 2021 about what was happening at Banksia Hill, adding that her greatest fear was a detainee was going to die.[968]

1118 Ms O'Connell was involved in preparing the Department's response in December 2021 to the Show Cause Notice. She was also asked to draft the response for the Minister to respond to the letter from Mr Ryan in January 2022.[969]

1119 There is a conflict in the evidence between Ms O'Connell's perception of what Mr Beck was or was not doing, and what Mr Beck told the inquest was his attitude to various matters. Ms O'Connell said she did not believe Mr Beck was taking the information being given to him seriously.[970] This is inconsistent with the evidence Mr Beck gave as to his appreciation of the youth justice issues generally.

1120 Ms O'Connell said that in early 2022, it was her opinion:[971]

[967] Ts p.2330
[968] Ts p.1581
[969] Ts p.1577
[970] Ts p.1574
[971] Ts p.1583

> From the reviews that I was doing, it was clear that not enough was being done and not enough was happening quick enough to circumnavigate the issues that were presenting at that time.

1121 She identified the principal matter to address was more staff.[972]

1122 Ms O'Connell said that during 2021 and 2022, she and Ms Ginbey had discussed both the need for a new purpose built second youth detention centre as well as the need to have a "Plan B" if Banksia Hill "*falls apart completely*".[973] She and Ms Ginbey had identified the characteristics needed for any "Plan B" in a short term. These were that such a "Plan B" had to be "*safe and secure*", have "*all of the services that are necessary*" and "*that whatever it looks like, it has to ensure that these young people are out of cell for all of the time that is available to them*."[974]

1123 She said these concerns were expressed by her to Ms Ginbey and Mr Beck and that Mr Beck's response was to fix the infrastructure around Jasper Unit at Banksia Hill and the additional strengthening of that unit in terms of security would calm things down and help move through the "*ebbs and flows so to speak, of the different occurrences occurring at different times.*"[975]

1124 There was no specific planning beyond a focus on strengthening Jasper Unit. Ms O'Connell agreed that a lot of work would be required to be done if "Plan B" involved putting young people at a different location and the implementing of such a plan could not happen overnight.[976]

The need for a second youth detention centre is eventually considered

The meeting on 25 May 2022

1125 As to the meeting on 25 May 2022, its agenda was Exhibit 87.1. It was prepared on the instructions of Mr Beck, who was then the Deputy Commissioner of Women and Young People.[977] It was described as a contingency planning meeting. The attendees of that meeting included senior executive figures from across the adult and youth custodial estates.

[972] Ts p.1584
[973] Ts pp.1592-1594
[974] Ts p.1591
[975] Ts p.1595
[976] Ts p.1595
[977] Ts p.2153

1126 Mr Beck has read his handwritten notes onto the transcript.[978] These were "*a shorthand version of the advice I was being given around how we could use another facility*."[979]

1127 Some weeks before this meeting, Ms Ginbey described there was "*another meeting that we had at Banksia Hill where we looked at strategies to manage the evolving crisis that was occurring at that centre*."[980] At about this time, advice was sought from the SSO.[981] It is apparent from the heavily redacted pages of Ms Ginbey's notebook for the period around and on 25 May 2022, that there was considerable involvement by the SSO in the provision of legal advice to the Department. Numerous pages of Ms Ginbey's notebook have been redacted upon production to the Court. Ms Ginbey acknowledged that advice was being sought from the SSO.[982]

1128 Prior to the meeting on 25 May 2022, Units 15 and 16 at Casuarina had been assessed and determined as unsuitable. Ms Ginbey did not know who had undertaken that assessment but agreed she had made a note to that effect.[983]

1129 Ms Ginbey said that the realistic options left on the table after the meeting on 25 May 2022 were threefold, namely, Melaleuca, Wandoo and a unit of Casuarina but not necessarily Unit 18.[984] Ms Ginbey understood Adult Male Prisons (AMP) were to look at the Casuarina option.

1130 She said she and Mr Budge went and inspected Wandoo and Melaleuca on 1 July 2022 but came to the view neither site was suitable. They were not directed to undertake such inspections, rather they had done so on their own initiative because of something said to them some days earlier at the Superintendents' conference. After the inspections, Ms Ginbey and Mr Budge were at Banksia Hill when they were summonsed back to the Department's city office for a meeting with Dr Tomison. Ms Ginbey asked Ms O'Connell to attend the meeting. None of these invited attendees had any inkling of what Dr Tomison was about to announce to them.

1131 When asked why there had been no inspection of Wandoo or Melaleuca during the five weeks after the meeting on 25 May 2022, Ms Ginbey said: "*I'm sorry. I can't answer that. It wasn't something I was leading. My*

[978] Commencing: Ts p.2170
[979] Ts p.2171
[980] Ts p.2354
[981] Ts p.2355
[982] Ts p.2356
[983] Ts pp.2357-2358
[984] Ts p.2358

assumption would be that there was still some resistance in regard to taking that option."[985]

1132 Since February 2022, Ms O'Connell was the Acting Director of Youth Custodial Operations. That position sits in the Women and Young People's Directorate.

1133 Ms O'Connell attended the meeting on 25 May 2022. She said the meeting was called by Deputy Commissioner Beck and she attended purely as an observer. She said she understood the purpose of the meeting was:[986]

> … just to hear from the other Deputy Commissioners as to what options they believed would be available in the event that we were no longer able to accommodate any young person at Banksia Hill'.[987]

1134 She understood the meeting was "*for Mr Beck to get the thoughts of the other Deputy Commissioners around the question of, 'What's our plan B?'*."[988]

1135 After the meeting, Ms O'Connell said Mr Beck asked her to prepare a document. This was referred to as the column document.[989]

1136 After preparing this document, Ms O'Connell provided it to Mr Beck and Ms Ginbey. She was not asked by either of them to do anything further in relation to the document.

1137 Ms O'Connell's evidence at the inquest was that: "*I didn't see the 25 May meeting as being pivotal in the formation of the Department in opening Unit 18.*"[990]

1138 That contrasts with the evidence of Dr Tomison who said that after this meeting concluded (a meeting he did not attend), the information that came back to him was that if a second site was needed, it would most likely be one of the new units at Casuarina Prison.[991] Ms O'Connell did attend the meeting but appears not to have been left with the same sense as conveyed to Dr Tomison.

[985] Ts p.2359
[986] Ts p.1558
[987] Ts p.1558
[988] Ts p.1558
[989] Ts pp.1561-1562
[990] Ts p.1568
[991] Ts p.1242

1139 Ms O'Connell gave evidence that her team was not asked to do anything after the meeting. This is consistent with Ms Ginbey's evidence that she did not need to do anything because there was no appetite for it.[992]

1140 Dr Tomison said he was supportive of the planning workshop on 25 May 2022.[993] Mr Budge and Mr Beck gave contrary evidence. It may not be possible to conclude which version is to be preferred; however, it may not matter very much.

1141 Senior Counsel for Mr Beck examined Dr Tomison in relation to his knowledge of the meeting on 25 May 2022. In light of the evidence that Mr Beck said he had been told by Mr Budge not to go ahead with the meeting because Dr Tomison was opposed to the idea of moving the detainees to another site, Dr Tomison accepted it was possible that he was not in fact aware of the meeting before it happened and only became aware of it afterwards.[994]

1142 Dr Tomison agreed that after this meeting "*the ball was in [his] court*"[995] in terms of a decision whether a second site was needed.

1143 Dr Tomison accepts, that in retrospect, this meeting on 25 May 2022:[996]

> … was a lost opportunity to set in train the planning to use one of the new units at Casuarina, that waiting another month or so meant [he and the Department] lost that opportunity of having an extra month to get ready.

1144 Dr Tomison acknowledged that in the early part of the calendar year 2022 until the middle of that year, the Department was facing a number of increasing difficulties at Banksia Hill, including staffing difficulties, an increase in the number of lockdowns, an increase in the period of lockdowns, further physical damage to the site, further loss of staff and an increasing number of staff being lost to health or stress related matters.[997]

1145 Dr Tomison accepted it was a valid criticism that: [998]

> [T]he decision to use a second site was made way too late, and the principal consequence of that was there was just no real time to get a wholly unsuitable site ready to receive young people.

[992] Ts p.2365
[993] Ts p.1245
[994] Ts pp.2834-2835
[995] Ts p.1243
[996] Ts p.1244
[997] Ts p.1247
[998] Ts p.1248

1146 Dr Tomison said that the truth of the matter was moving the initial group of young people to Unit 18 would make the Department's job of managing Banksia Hill so much easier.[999]

What took place after the meeting on 25 May 2022

1147 As already noted, after the meeting on 25 May 2022, Ms O'Connell was asked to prepare a document she called the column document, which was Exhibit 80. It is different to the Options Assessment document that was attached to Dr Tomison's statement.[1000]

1148 The inquest received evidence that Dr Tomison was of the view in the first half of 2022 that there would be no consideration of a second site; rather the focus of the Department was on ensuring that Banksia Hill could be remedied to accommodate what was occurring at that site.

1149 Ms Ginbey was examined about the events after the meeting on 25 May 2022 and in particular why there was no further investigation of the three realistic options identified at that meeting. Such questioning was the first time Ms Ginbey had ever been asked about such events.

1150 Ms Ginbey's explanation for this inaction was that Mr Budge and Mr Beck were telling her "*there is no appetite.*"[1001] for further work to be done on the topic. Ms Ginbey understood this message, passed on by Mr Budge and Mr Beck, could have come from only two sources, either Dr Tomison or the Minister.

1151 Questions could be legitimately asked why after the crisis meeting of 25 May 2022 when three realistic options were identified that nothing was done in any meaningful way during the month of June to address or consider further those three options.

1152 The Court received no evidence of what, if anything, AMP was providing, or was asked to provide, to those who were considering what was to be done about any possible "Plan B" in respect of youth detention. One inference that could be drawn from the absence of any evidence as to what AMP was doing in this regard is that it had not been asked to do anything meaningful in this regard.

1153 The Court had direct evidence from Ms Ginbey that the other two realistic options left on the table after the meeting of 25 May 2022 (Melaleuca and

[999] Ts p.1250
[1000] Exhibit 1, Volume 6.1, Tab 1.6; Ts pp.1564-1565
[1001] Ts p.2365

Wandoo) were not actively pursued or investigated during June 2022. Ms Ginbey's evidence is that a serious concern expressed to her by Wade Reid, the then Superintendent of Bankia Hill, in late June 2022 was the catalyst for her and Mr Budge to inspect those two other sites and come to a view about their suitability as the site for "Plan B".

1154 It may be open to contend this was another illustration of inertia on the part of the Department. Having convened such a critical meeting on 25 May 2022, nothing further was done for a month.

1155 The information available to the Department at the time of the meeting on 25 May 2022, was that there were more than 200 prisoners in the two units at Casuarina Prison, which had been identified as the likely sites if a decision was to be made that the second facility was required.[1002]

1156 Dr Tomison, when he was making the decision to recommend the creation of a second youth detention centre at Unit 18, believed there were no adult prisoners in that unit. It is remarkable that Dr Tomison never informed himself correctly as to the true facts concerning Unit 18's occupancy. Whatever thinking he was undertaking after 25 May 2022 and before 1 July 2022, it could be argued it was not particularly thoughtful or detailed.

Dr Tomison's decision-making process on 21 and 22 June 2022

1157 The next key dates identified in the evidence are 21 and 22 June 2022. Dr Tomison says these are key dates in his recollection as they were the dates of the major disturbances at Banksia Hill.

1158 As noted earlier, there is a significant dispute between Dr Tomison on the one hand, and Ms Ginbey and Mr Budge on the other, about the events of late of June 2022.

1159 Dr Tomison says he reached a particular conclusion on 21 June 2022 and conveyed his thinking to the Minister on 22 June 2022.

1160 Dr Tomison told the Court he had come to a view by 21 June that Unit 18 would need to be considered. He arranged for his office to contact the Minister's office on that day, to give the Minister a "heads up" that at the scheduled meeting between him and the Minister for the following day, he proposed to raise the question of Unit 18 with the Minister.

1161 As is apparent from elsewhere in the evidence, the most basic and preliminary enquiry was never made of AMP, namely: "Is Unit 18 occupied

[1002] Exhibit 80 (the document prepared by Ms O'Connell on the day after this meeting).

and if so, by how many adult male prisoners and how long would it take for those prisoners to be relocated?". As noted, Dr Tomison's decision and announcement to utilise Unit 18 was against a background that he believed the unit was empty. It would appear this erroneous belief was not corrected until Tuesday 5 July 2022 when Ms O'Connell printed out the relevant data and ascertained there were 113 adult male prisoners in Unit 18 as at that date.[1003]

1162 Ms Ginbey says her recollection is that the topic of alternative sites was raised with her by Mr Reid in late June 2022. This was at a conference of Superintendents in Perth and there is corroboration of the fact that a Superintendents' conference occurred on 28 and 29 June 2022.[1004]

The meeting on 1 July 2022 and the plan to use Unit 18

1163 On Friday 1 July 2022, Dr Tomison advised Mr Budge, Ms Ginbey and Ms O'Connell of his decision that Unit 18 would be utilised as a youth detention centre. It is appropriate to describe this group as the "inner circle". Mr Budge was present because Mr M Reynolds had been on personal leave for extended periods during 2022, and during his absence Mr Budge was the Acting Commissioner. Ms Ginbey had commenced as Deputy Commissioner, Women and Young People in mid-June 2022. Ms O'Connell continued to work closely with Ms Ginbey and can fairly be described as "Ms Ginbey's right hand person".

1164 Ms O'Connell described her attendance with Mr Budge and Ms Ginbey at the meeting with Dr Tomison on 1 July 2022.[1005] She said the meeting had been called without any notice and she attended the meeting expecting "*to be issued with something big to start working on*."[1006]

1165 Ms O'Connell described Dr Tomison as appearing "*quite flustered*" during the meeting and that he announced the decision in terms like "*the decision has been made that Unit 18 will be gazetted as a youth detention centre and I wanted to inform you all the Minister will be making announcement*."[1007] She said that it appeared to her that Mr Budge and Ms Ginbey were as shocked as she was at what they were being told.[1008]

[1003] Exhibit 94, pp.125-126
[1004] Exhibit 136.1, agenda item 2.7 (the papers accompanying the Minister's meeting with Dr Tomison on 6 July 2022).
[1005] Ts p.1588
[1006] Ts p.1588
[1007] Ts p.1588
[1008] Ts p.1589

1166 Ms O'Connell explained her reaction at what she was told:[1009]

> I think it took me back a bit that, like this is serious stuff. This is not, you know, something that just happens. You don't just create a detention centre overnight and place young people in. I think I had gone into a bit of shock as well that the workload that sits in behind this is huge. And I am probably in a bit of a panic because I know that a lot of that work falls on me.

1167 As noted, there is a difference between Dr Tomison and Ms Ginbey on the issue as to when he says he told her of his decision to use Unit 18 in this way and consequently asking her to commence work on the Briefing Note which would need to be prepared for the Minister.

1168 Dr Tomison's evidence is that he made this request of Ms Ginbey on or about 21 or 22 June 2022,[1010] whereas her evidence is that he made this request of her during the meeting on 1 July 2022.[1011]

1169 There is evidence to support a conclusion that Ms Ginbey's recollection is to be preferred. The earliest draft of what became the Briefing Note is dated 5 July 2022. Ms Ginbey agreed it is unlikely that if she had been asked on 21 or 22 June 2022 to commence the drafting of such a document, the earliest draft of it would not have been prepared until 5 July 2022.[1012]

1170 The evidence suggests Dr Tomison's recollection on this issue is wrong, the objective documentary evidence supports Ms Ginbey's recollection that she was asked to commence the drafting of the Briefing Note when she was told by Dr Tomison of his decision to use Unit 18 as a youth detention centre. This is most likely on Friday 1 July 2022.

1171 The overall evidence is likely to support a conclusion that the first time Ms Ginbey (and also Mr Budge and Ms O'Connell) became aware that Unit 18 had been selected as the second youth detention centre was when they were advised by Dr Tomison on 1 July 2022.

1172 On Saturday, 2 July 2022 Ms Ginbey and Ms O'Connell met. They began workshopping a list of what needed to be done.

1173 Over this weekend, Dr Tomison prepared a set of notes he provided to the Minister for the Minister to use when he attended the Cabinet meeting on

[1009] Ts p.1596
[1010] Exhibit 1, Volume 6.1, Tab 1, p.10
[1011] Ts pp.2406 and 2408
[1012] Ts p.2409

Monday, 4 July 2022. As privilege was claimed for these notes, the Court did not have access to them.

1174 It is not known whether the Minister in his discussions with Dr Tomison prior to the matter going to Cabinet, made any enquiry of Dr Tomison as to whether Unit 18 was immediately available. A reasonable inference that could be made is that if Dr Tomison expressed any view about the immediate availability of Unit 18, it would have been consistent with his mistaken belief that Unit 18 was empty.

1175 It may be open to question how a decision as momentous as the one to utilise Unit 18 can be considered and made in the mistaken belief that it was empty and thus immediately available for whatever needed to be done. This could be seen as another example of the Department's dysfunctional nature.

1176 On the afternoon of 4 July 2022, the Minister publicly announced the State Government's decision to utilise Unit 18 as a youth detention centre.

1177 When this public announcement was made, there was no date set for the opening of Unit 18. Those involved closely in the preparation of Unit 18 simply kept working as hard as possible and waited to be told when the move would occur.

1178 There was much to be done before Unit 18 could open as a youth detention centre.

1179 It was necessary to change the legal identity of Unit 18. It had been one of four units recently constructed at Casuarina as part of Project 512. This was a project to provide 512 additional beds at Casuarina Prison. Four new units (Unit 15, 16, 17 and 18) were built, each with a capacity of 128 beds. Each unit had four wings (A, B, C, D) and each wing had 16 cells, with each cell built to accommodate two men.

1180 To alter the legal status of Unit 18 from being part of Casuarina to being a youth detention centre, two broad changes were needed. The first was to remove Unit 18 from the legal institution known as Casuarina Prison and the second was to put Unit 18 back as a youth detention centre for the purposes of the *Young Offenders Act 1994* (WA). Both changes needed to be made by a gazettal process.

1181 As noted earlier, Unit 18 had 113 male prisoners in it when the decision was made to use it as a youth detention centre. Those prisoners needed to be relocated within the adult custodial estate before any physical preparation for the reception of young people could commence.

1182 The last of the adult prisoners were removed on Sunday, 10 July 2022. As noted, the first time the Directorate of Women and Young People had access to Unit 18 to commence any physical preparation was the morning of Monday, 11 July 2022.

1183 The 17 young people were moved from Banksia Hill to Unit 18 on the morning of Wednesday 20 July 2022. This meant there was only nine days to convert a 128-bed accommodation block in an adult male high security prison into an appropriately equipped, stand-alone youth detention centre that was suitable and safe to receive young people detained under the *Young Offenders Act 1994* (WA).

1184 What did and did not occur between 1 – 20 July 2022 in the preparation of the building known as Unit 18 to receive young people, was the subject of much oral and documentary evidence at the inquest. To provide the necessary basis for my recommendation at the end of this section, this material must be examined in detail.

1185 The proper preparation of Unit 18 as a youth detention centre was a multifaceted task. It required attention to many things including:

- The physical environment of Unit 18. This included the cell accommodation, the recreational area, the provision of adequate office space to deliver all the services and facilities to be provided.
- The provision of a competently trained and adequately staffed custodial workforce, which complied with all the legislative requirements. And also, the provision of a non-custodial workforce who would be able to deliver the services and facilities necessary for the safe, efficient and effective operation of a youth detention centre.
- The provision of a documented process, understood by all staff (custodial and non-custodial) detailing the operational practices and procedures of Unit 18.
- The provision of a physical and therapeutic environment to keep safe all detainees and especially those subject to ARMS, particularly those on level 1 ARMS i.e. those requiring continuous observation because of a high risk of self-harm or suicide.

The conversion of Unit 18 into a stand-alone youth detention centre

The preparations for "standing up" Unit 18

1186 Ms Ginbey was responsible for coordinating the preparations for "standing up" Unit 18.[1013]

1187 On 1 July 2022, when Dr Tomison told Ms Ginbey that Unit 18 was to be utilised, he said she had "*one week to establish the new unit*".[1014] Ms Ginbey recalled being in a state of shock as she realised what she was being asked to do was an impossibility.

1188 Ms O'Connell said that Mr Budge and Ms Ginbey were tasked with undertaking what needed to be done to establish Unit 18. Mr Budge set up meetings of what was described as the working group or planning group which subsequently met on 6 July 2022.[1015]

1189 Ms O'Connell confirmed that on 8 July 2022 the working group was told the first time the Youth Directorate could get in to Unit 18 to do any work was 7.00 am the following Monday, 11 July 2022. At the same meeting, the group was told "*scope is at capacity*".[1016] Ms O'Connell agreed, "*that by 8 July, whoever was responsible for scope and assessing capacity must have had an end date in mind*".[1017] She said that when the meeting was told on 8 July 2022 that scope was at capacity, she had no recollection of anyone asking "*When is the end date?*".[1018]

1190 Ms O'Connell agreed that those in the working group had noted it would be necessary to ensure that all COPPs specific to how Unit 18 was to be run, should be in place. Ms O'Connell agreed that when Unit 18 opened that had not been done.[1019]

1191 Ms O'Connell said that she was aware Unit 18 had adult male prisoners in it, and they would need to be moved before any work could be done to prepare Unit 18 for the young people.[1020] This is in stark contrast to Dr Tomison's belief that when he decided to use Unit 18, it was in fact empty.

1192 Although Dr Tomison thought that he learnt the correct position regarding the occupancy of adult prisoners in Unit 18 by the last few days of June,[1021] that cannot be correct as he was still under a mistaken belief as to the

[1013] "*Standing up*" was the phrase used by many Department witnesses to describe the task of making Unit 18 operational.
[1014] Ts p.2410
[1015] Ts p.1607
[1016] Ts p.1627
[1017] Ts p.1629
[1018] Ts p.1629
[1019] Ts p.1625
[1020] Ts p.1629
[1021] Ts p.1128

non-occupancy of Unit 18 when he met with Mr Budge, Ms Ginbey and Ms O'Connell on 1 July 2022.

1193 Dr Tomison's recollection is that, "*we were pushing ourselves to try and use Unit 18 as soon as possible once we have had gazettal*."[1022]

The record keeping of the preparations

1194 The only collective record the Court received regarding the preparation of Unit 18 is a series of documents made by Ms O'Connell. There were six of them,[1023] and they reveal the state of preparations as at the following dates: 8, 11, 12, 19 and 22 July 2022 and 3 August 2022.

1195 These so called "action trackers" record what Ms O'Connell heard or was told about various matters during the preparation for the opening of Unit 18.

1196 Although Ms O'Connell accepted these action trackers were not an official record and their accuracy was not checked by others,[1024] an examination of these documents reveals many things, including the issues being addressed in such preparation, any difficulties experienced in such preparation, what was or was not planned for Unit 18 and who knew what and when.

1197 Before describing what is revealed in these action trackers, it should be noted that the task given by the Department to Mr Budge, Ms Ginbey and Ms O'Connell (and the others involved in the preparation of Unit 18 for its opening as a youth detention centre) was uniformly agreed to be grossly unreasonable. The task and associated timeframe of nine days was described or accepted by witnesses to be:

> Ridiculously short;[1025]
>
> Herculean … not ideal, not desirable;[1026]
>
> Entirely unreasonable.[1027]

1198 Ms O'Connell described the chaos and lack of planning at this time in the following terms: [1028]

[1022] Ts p.1167
[1023] Exhibits 51.1 – 51.6
[1024] Ts pp.1690-1691
[1025] Ts p.2635 (Mr Royce)
[1026] Ts p.2676 (Mr Royce)
[1027] Ts p.2413 (Ms Ginbey)
[1028] Ts p.1629

> So, is this working group doing work not knowing when it's expected that the place will open? --- Well and truly.
>
> That sounds like a pretty chaotic system, doesn't it? --- Well and truly, it was, yes.
>
> And do you accept that more could have been done if you had been given longer? --- Absolutely.
>
> And it could have been less chaotic if you had had a greater lead time? --- Yes.
>
> And if you had the opportunity to prepare and plan the logistics of what needed to be done? --- Yes.
>
> Was it clear to you, in this fortnight before it opens, when this first group meets, that this was being done in a very, very hasty way? --- I don't think that thought had crossed my mind.
>
> You just knew you were in the middle of a chaotic planning process? ---An exhausting one at that, yes.
>
> And it was chaotic? --- Yes, yes. It was definitely chaotic.

1199 Various estimates were given as to what was a reasonable period to allow for the preparation of a youth detention centre in the circumstances of Unit 18. Mr Beck's experience was that a period of "*two months and probably three months*" was necessary.[1029] Ms Ginbey thought "*it is probably closer to six months.*"[1030]

1200 As already noted, Ms Ginbey was in charge of overseeing the preparatory work which needed to be done before Unit 18 could operate as a youth detention centre. As she described it, she was "*in charge of pulling together all of the elements*".[1031] Ms Ginbey understood the criticism that the time allowed to do everything necessary before opening Unit 18 was far too short and she accepted that was a valid criticism "*to a degree*".[1032] She also accepted the preparatory work was done at a "*frenetic*" pace.[1033]

An examination of the preparation as recorded in the action trackers

1201 As already noted, Exhibits 51.1 – 51.6 were the "action tracker" documents prepared by Ms O'Connell recording comments or decisions made in the course of meetings of the working group, or information received between meetings, in the weeks before Unit 18 opened. The latter two (Exhibits 51.5 and 51.6) are said to record information as at 22 July and 3 August 2022

[1029] Ts p.2225
[1030] Ts p.2585
[1031] Ts p.917
[1032] Ts pp.2312-2313
[1033] Ts p.2348

respectively. The earlier four Exhibits (51.1 – 51.4) are respectively dated 8, 11, 12 and 19 July 2022.

1202 The inquest received detailed evidence from Ms O'Connell as to what her notes meant in terms of what was or was not being done in the preparation of converting an accommodation wing for 128 adult male prisoners within a high security prison into a youth detention centre containing all the necessary therapeutic and trauma-informed practices and services; and doing so in the period of just nine days.

1203 The proposition in the above paragraph only needs to be stated to appreciate the impossibility of achieving what needed to be achieved in such a short period of time and in the circumstances presented.

1204 It could therefore be contended that an option available to the Department was to advise the Minister it was an impossible task for it to achieve what was being asked of it. From the evidence at the inquest, it is also open to contend that the Department portrayed a picture to the Minister and anyone with whom it communicated that was not fulsome, complete or accurate and in some cases, deliberately false.

1205 Conclusions that may be open on the evidence as to what was known or being done, or not being done, in respect of the preparation of Unit 18, based on the action trackers is described below.

Action Tracker 1 (as of 8 July 2022)

1206 Ms O'Connell was examined about this document.[1034]

1207 The evidence before the inquest leaves open the following observations as to events and knowledge as recorded by Ms O'Connell at this date:

(a) The visits regime as described elsewhere in this finding was known;[1035]

(b) The unachievably high assertion as to how many visits would occur had been made;[1036]

(c) It was known that the facility for a confidential communication with a visiting lawyer would be less than what was available at Banksia Hill;[1037]

[1034] Ts pp.1608-1630
[1035] Ts p.1620
[1036] Ts pp.1618-1619
[1037] Ts p.1622

(d) It had been expressed that the proposed staffing model had an inadequate number of staff, but the response was this was all that was available;[1038]

(e) There was a concern that the Department did not have sufficient nursing staff to service Unit 18;[1039]

(f) There will always be one prison officer based in Unit 18;[1040]

(g) It would be necessary to have in place the COPPs to set out the policies and procedures by which Unit 18 would run (but these had not been prepared before the opening of Unit 18);[1041]

(h) It was known that any detainee who moved out of Unit 18 would be restrained in handcuffs;[1042]

(i) It was known CCTV was to be installed in each cell;[1043]

(j) The scope of the work to be undertaken was at capacity.[1044]

Action Tracker 2 (as of 11 July 2022)

1208 Ms O'Connell was examined about this document.[1045]

1209 The evidence before the inquest leaves open the following observations as to events and knowledge as recorded by Ms O'Connell at this date:

(a) Eight cells would be made into study rooms in D-Wing;[1046]

(b) It had been either decided, agreed or announced that the process for ARMS in Unit 18 would mirror the process in Banksia Hill and that this would require safe cells to be provided, and that Infrastructure had listed the works that were required to do this;[1047]

(c) It was unknown when the move would occur, and the planning process will continue and get as far as it can before the time of the move;[1048]

[1038] Ts pp.1622-1623
[1039] Ts p.1623
[1040] Ts p.1623
[1041] Ts p.1625
[1042] Ts p.1625
[1043] Ts p.1625
[1044] Ts pp.1627-1629
[1045] Ts pp.1630-1641
[1046] Ts p.1632
[1047] Ts p.1633
[1048] Ts p.1635

(d) The Superintendent of Casuarina was expressing his concern about the absence of safe cells in the planned move;[1049]

(e) Ms O'Connell escalated those concerns, resulting in six cells in B-Wing having two additional modifications, namely, the fixing of stainless-steel plates over all general power outlets and removal of the bench.[1050]

Action Tracker 3 (as of 12 July 2022)

1210 Ms O'Connell was examined about this document.[1051]

1211 The evidence before the inquest leaves open the following observations as to events and knowledge as recorded by Ms O'Connell at this date:

(a) It has been announced that the necessary legal steps had been taken to create Unit 18 as a youth detention centre;[1052]

(b) Ms O'Connell was told by someone that "*safe cells*" and "*cells for classrooms/study*" were not in the initial scope of work;[1053]

(c) Ms O'Connell was told that safe cells were not going to be provided and although she may have disapproved of that decision, she noted "*CLOSED*" next to the acronyms for mental health issues. Although this proposition was not accepted by Ms O'Connell, it may be open to be made after considering the matters put to her in counsel assisting's examination.[1054]

Action Tracker 4 (as of 19 July 2022)

1212 Ms O'Connell was examined about this document.[1055]

1213 The evidence before the inquest leaves open the following observations as to events and knowledge as recorded by Ms O'Connell at this date:

(a) The person in charge of the Nursing and Health Services (Mr David Whittle) announced on 18 July 2022 (two days before the move) that he had not been able to put together a roster for

[1049] Ts p.1638
[1050] Ts pp.1638-1640; Exhibit 85
[1051] Ts pp.1641-1650
[1052] Ts p.1642
[1053] Ts pp.1642-1643
[1054] Ts pp.1646-1650
[1055] Ts pp.1660-1680

nursing staff and he was anxious about starting on the planned date, which was then known;[1056]

(b) On 19 July 2022, Mr Whittle raised additional concerns about wanting additional office space for the Health Services, an enquiry about where the medications for detainees could be kept safely and complaining of the problem being caused because Health Services still did not know the identity of the detainees to be moved and therefore could not arrange their specific medications;[1057]

(c) It was noted it would be necessary to orientate the nursing staff, but such orientation would not be done by the youth custodial estate but would be done by Casuarina;[1058]

(d) Mr Whittle had a concern as to what impact the calling of a Code Red (medical emergency) in Unit 18 would have on the Casuarina site;[1059]

(e) Mr Whittle reported he was hoping to have 24-hour nursing coverage but that had not yet been achieved, and it will be necessary for nursing support from Casuarina to be provided;[1060]

(f) It was announced that the health and nursing notes of the young detainees would not be stored in Unit 18, they would be stored in the Medical Unit at Casuarina;[1061]

(g) It was announced the aspiration was that each detainee would be given a laptop for educational purposes so that learning could occur anywhere, and it did not have to be in a classroom set up. The IT connection work would take another 2 – 4 weeks. (These aspirations had not been achieved when Unit 18 opened);[1062]

(h) It was announced that anyone, including prison officers coming into Unit 18, would need to receive a Working with Children clearance;[1063]

(i) An orientation occurred at Unit 18 for 17 staff;[1064]

[1056] Ts p.1661
[1057] Ts pp.1662-1663
[1058] Ts p.1663
[1059] Ts p.1663
[1060] Ts p.1664
[1061] Ts p.1671
[1062] Ts pp.1672-1673
[1063] Ts p.1674
[1064] Ts p.1676-1677

(j) It was announced the detainees in Unit 18 would be given particular coloured attire to distinguish them from the adult prison population;[1065]

(k) It was announced that training for those to work in the control room would occur after the move.[1066]

Action Tracker 5 (as at 22 July 2022)

1214 Ms O'Connell was examined about this document.[1067]

1215 The evidence before the inquest leaves open the following observations as to events and knowledge as recorded by Ms O'Connell at this date:

(a) On the day after Unit 18 opened, Mental Health were announcing that the space allocated to them was not satisfactory;[1068]

(b) It was noted there needed to be an instruction given to the SOG as to how to respond in a non-lethal manner if a detainee absconded from Unit 18 (an arrangement "*not even close to being necessary at Banksia Hill*");[1069]

(c) Ms O'Connell still had recorded that safe cells and cells for classroom/study remained described as not being in the initial scope, even though she has recorded "*end of scope*" on the day Unit 18 opened:[1070]

i. Ms O'Connell said this was an oversight but as I noted during her evidence at the inquest, her notes were "*extremely detailed and comprehensive*"; a description which Ms O'Connell readily accepted.[1071] It may be open to conclude that it was unlikely such a significant matter was an oversight;

ii. Ms O'Connell said the six observation cells in B-Wing were completed before the opening of Unit 18, but that Superintendent Coyne was not aware there were such cells in Unit 18. On Ms O'Connell's review, it appears as though the cells had not been used for the purpose of

[1065] Ts p.1677
[1066] Ts p.1678
[1067] Ts pp.1680-1696
[1068] Ts p.1688
[1069] Ts p.1690
[1070] Ts pp.1690-1691
[1071] Ts p.1691

observation and were used as a standard living cell. She agreed that was a serious communication breakdown;[1072]

iii. Ms O'Connell understood the Department came to the view that if all ligature points were removed and CCTV cameras installed, then all cells would serve the same purpose as an observation cell.[1073]

Action Tracker 6 (as of 3 August 2022)

1216 Ms O'Connell was examined about this document.[1074]

1217 The only matter of potential interest is that the earlier note that the safe cells and cells for classrooms/study remained recorded as not in the initial scope. Ms O'Connell repeated her earlier claim that this was an oversight.[1075] However, it may be open for a finding contrary to that conclusion.

1218 Counsel for the Department put to Ms O'Connell that the action trackers were her personal notes, that nobody checked the accuracy of those documents and that they were not an official record. Ms O'Connell agreed with all these propositions[1076] However, nothing was put to Ms O'Connell by counsel for the Department to suggest that the action trackers were inaccurate.

1219 In circumstances, it may be open to draw a conclusion that is consistent with the ordinary meanings of the words used in those documents, in the circumstances which then existed.

The Briefing Note for the Minister

1220 It was necessary for the Minister to make a decision to remove Unit 18 from the definition of part of Casuarina and to declare Unit 18 as a youth detention centre.

1221 As previously stated, the Briefing Note was prepared and provided to the Minister on 12 July 2022.[1077] It had been signed by Dr Tomison. The Minister accepted the advice in the Briefing Note and made his decision to approve the removal of Unit 18 from the adult facility known as Casuarina

[1072] Ts pp.1693-1694
[1073] Ts p.1694
[1074] Ts pp.1698-1699
[1075] Ts p.1699
[1076] Ts p.1767
[1077] Exhibit 1, Volume 6.1, Tab 1.6 (attachment 6 to Dr Tomison's statement)

Prison and approve the declaring of that unit as a youth detention centre. The Minister signed his approval on the Briefing Note on 12 July 2022.[1078]

1222 The Court had a series of the drafts of the Briefing Note. The earliest version of it was created on 5 July 2022. Ms Ginbey recalled preparing the first draft of the Briefing Note which was based on the notes Dr Tomison had prepared for the Minister to take into Cabinet on 4 July 2022 and points which had been raised at her meeting with Dr Tomison and other Department staff on 4 July 2022.[1079] Ms Ginbey and Ms O'Connell were very involved in the putting together of the Briefing Note during the next week. It should be accepted they had input from others within the Department[1080] and would have relied on the accuracy of the information provided to them e.g. the Operating Model prepared by Mr Rule.

1223 Ms Ginbey was questioned closely by counsel assisting about her understanding of the matters upon which the Minister would need to be satisfied before giving his approval for the gazettal of Unit 18 as a youth detention centre.

1224 After the 25 May 2022 meeting, Ms Ginbey requested Ms O'Connell to gather some information. On 1 June 2022, Ms O'Connell reported back to Ms Ginbey that the considerations the Minister needed to make included:[1081]

(a) Safety and security of detainees and staff.

(b) Suitability of the physical accommodation including recreational facilities, education and program delivery.

(c) Programs and supports offered at Bankia Hill are matched or greater at the new site.

1225 These factors are self-evidently important. It may be open for a finding to be made that the messaging around the consideration of Unit 18 portrayed the decision to utilise Unit 18 in a very positive manner. Ms Ginbey would not accept the proposition that if the Minister declined to approve the gazettal of Unit 18, it would reflect badly on her professionally.[1082] However, it may be open to conclude that was the reality.

[1078] Exhibit 1, Volume 6.1, Tab 1.6, p.9 (attachment 6 to Dr Tomison's statement)
[1079] Exhibit 91, p.18
[1080] Written closing submissions from Ms Ginbey dated 6 May 2025, [121]
[1081] Ts p.2370
[1082] Ts pp.2373-2374

1226 Dr Tomison said that the Briefing Note had two main purposes. The first was to persuade the Minister that the need to take the extraordinary step of using Unit 18 as a youth detention centre had arrived. The second purpose was to assure the Minister that Unit 18 was an appropriate place, and that the Department could provide all the things necessary for a youth detention centre. Dr Tomison did not see the Briefing Note as part of a rubber-stamping process, rather it was a serious decision to be considered and then made by the Minister.[1083]

1227 In his examination by counsel assisting, Dr Tomison was taken through the Briefing Note and asked about its contents. During that examination, Dr Tomison agreed some of the things in the Briefing Note to the Minister were "*blatant lies*". Dr Tomison said at the time he believed that the information in the Briefing Note was correct, and he would never have signed it if he thought otherwise. He accepted as correct, the following proposition put in his examination:[1084]

> If I knew the truth of the matter when Unit 18 opened as to what was not there and should have been there, I would never have signed this Briefing Paper that went to the Minister seeking his approval to declare Unit 18 a youth detention facility.

1228 Dr Tomison accepted:

(a) It was not accurate for the Minister to be told "*all services [at Unit 18] will be a continuation of services available at Banksia Hill*."[1085]

(b) The Minister was told that "*appointments for social and official visits can occur throughout the day*",[1086] whereas the Operating Model stipulated that visits would occur between 8.45 am and 9.45 am.[1087] (Although e-visits were available at other times during the day within Unit 18, it would appear the Briefing Note was intending to convey that the appointments it was referring to were in-person as the next sentence read: "*Having the visits away from Unit 18 will ensure other detainees' program has minimal disruptions.*"[1088])

(c) The Briefing Note gave the "*quite clear impression that those people in Unit 18 will be out of their cells more frequently and*

[1083] Ts p.1146
[1084] Ts p.1151
[1085] Ts p.1147
[1086] Exhibit 1, Volume 6.1, Tab 6, p.6
[1087] Ts pp.1147-1148
[1088] Exhibit 1, Volume 6.1, Tab 6, p.6

for longer than the present experience at Banksia Hill" and that such an assertion was also "*a blatant lie*".[1089]

(d) The Briefing Note gave the impression that those going to Unit 18 would experience an intense therapeutic environment, which was not an accurate description of Unit 18.[1090]

(e) The Minister was told "*the model of care in Unit 18 will be therapeutic and trauma-informed, not punitive or as punishment*".[1091] Yet, as already outlined earlier in this finding, Unit 18 never had a model of care. That fact only emerged during the fourth tranche of the inquest and after Dr Tomison had completed his evidence.

1229 Mr Coyne was asked to respond to the suggestion "*when Unit 18 is opened, we will be able to have in-person social visit capacity on a weekly basis of 100 individual visits*". This is the language of the Operating Model and the Briefing Note. His response was "*I think that that is not even possible*." He agreed such a claim was "*just rubbish*".[1092]

1230 The 100 visits can be calculated as 20 visits per day for five days a week. Mr Coyne said it was "*just not possible to even get close to 20 [visits] per time slot*".[1093]

1231 As already noted, the Briefing Note referred to there being 100 individual face-to-face appointments.[1094] Mr Coyne said such a forecast was not achievable.[1095]

1232 The reality of the visit regime was dramatically different. Mr Coyne said there would usually be a maximum of only 12 young people able to have a visit at Unit 18 in any given week (two per day over the six days available for visits).[1096] Mr Coyne said he understood this had been the arrangement since Unit 18 opened.[1097]

[1089] Ts p.1149
[1090] Ts pp.1122 and 1150
[1091] Ts p.1150
[1092] Ts pp.1877-1878
[1093] Ts p.1877
[1094] The Briefing Note was referring to face-to-face appointments rather than e-visits because it said they would take place away from Unit 18: Exhibit 1, Volume 6.1, Tab 1.6, p.6 (attachment 6 to Dr Tomison's statement)
[1095] Ts p.1880
[1096] Ts pp.1871-1872
[1097] Ts p.1872

1233 This arrangement is not consistent with the Operating Model. Mr Coyne, who was the Superintendent from May 2023, has never seen an operating model for Unit 18 and in fact did not know that one existed.[1098]

1234 Dr Tomison agreed that the "*rosy and false picture*" in the Briefing Note was misleading and agreed the document should not have gone to the Minister because of that.[1099]

1235 Dr Tomison agreed that what was being revealed in his examination at the inquest was an extraordinary position:[1100]

> And based on the material that went to the Minister, do you agree Unit 18 should never have been established as a youth detention facility? --- Not without presenting him with another briefing, a proper briefing that was correct.
>
> Do you agree that if the Minister had been presented with the true facts about what was and was not available at Unit 18, you would not expect him to approve it? --- Not in that form, not without proper reworking to satisfy him.
>
> No. Let me ask it again? --- Sorry.
>
> I will see if I can make it clearer. We've established that you do not think this Briefing Paper should have gone to him because of the blatant lies? --- Yes.
>
> My question is, if the truth of the matter had been told to the Minister about what was, and more importantly, what was not at Unit 18, in your opinion, do you think you would have persuaded him to declare Unit 18 a youth detention facility? --- Not without further work.
>
> And when you say not without further work, what you are saying to the Court is: "If he had been told the truth about Unit 18, I don't think he would have approved it until we improved things at Unit 18 by further work, and then, perhaps, go back to it? --- That's exactly what I would think.
>
> That's an extraordinary position we're now in, isn't it? --- Yes, it is.
>
> The former Director General of Department of Justice in a coronial inquest, when presented with facts, which he says, "That's not what I was told", is saying, "This extraordinary development of creating Unit 18 would not have occurred because I would not have signed the Briefing Note"? --- Yes.
>
> And what's more, "I would not expect the Minister to approve it on the basis of how Unit 18 was at the time?" --- At that point, Unit 18 wasn't

[1098] Ts p.1873
[1099] Ts p.1154
[1100] Ts pp.1155-1156

> open, as you would know. So, it's more that he would not approve it until satisfied with the proposed model, if I can put it that way.
>
> And if he had been given the true state of what was and was not there, he wouldn't have approved it, would he? --- Not without that work. I don't think so.

1236 Dr Tomison acknowledged that the request to the Minister in the Briefing Note was "*so unique and profound*"[1101] that it was not sufficient for him to rely on his staff, and that he should have personally verified what he was signing off on was correct.[1102] He agreed that he "*owed [this] to the children that were going to be moved into Unit 18 to do that*."[1103]

1237 Senior Counsel for Ms Ginbey examined Dr Tomison about the utility and purpose of the Briefing Note and the supporting documentation therein. The proposition being put to Dr Tomison was that "*the horse had bolted*" because "*the decision had already been made and publicly announced that there was going to be a second facility at Casuarina*".[1104] It was also put to Dr Tomison that "*the information in the Ministerial Note was so far as the Minister was concerned not particularly important … because the decision had already been made*".[1105]

1238 It was also put to Dr Tomison by Senior Counsel for Ms Ginbey that he had developed "*a view that the Minister was simply interested in the means of effecting the decision that had already been made, which was to have a facility at Casuarina*."[1106]

1239 Dr Tomison did not accept these propositions. He told the inquest: "*We still had to prepare the right paperwork and give the right analysis*."[1107] He said he did not develop the view that was put to him by Senior Counsel for Ms Ginbey. He said his recollection was: "*I was pursuing this, or doing this document, to give [the Minister] – giving the appropriate briefing that he needed for the gazettal and whilst it had been announced, my view was still we had to do that properly.*"[1108]

1240 An email sent by Dr Tomison to Mr M Reynolds on 8 July 2022 was in these terms and is consistent with the view he expressed in evidence:[1109]

[1101] Ts p.1291
[1102] Ts p.1291
[1103] Ts p.1291
[1104] Ts p.2788
[1105] Ts p.2789
[1106] Ts p.2790
[1107] Ts p.2788
[1108] Ts p.2790
[1109] Exhibit 91, attachment CG 62

> The key is the attachment which I know Christine is working on. It needs to give details of the analysis and issues the Minister needs to consider to be satisfied he's making the correct decision to gazette Unit 18. It will have to start by saying there are no other secure facilities available to us in WA apart from prisons, i.e. we can't use EMYU,[1110] or [Department of Corrections' two secure welfare residential units]. The Disability Justice Centre is not being used, it is too small and is not available. So, it has to be a prison, then we go into our analysis of sites. A key consideration is to not use a prison if at all possible. Well, we have no choice, but we need to show it.

1241 In response to questioning by counsel for the Department in respect of the Briefing Note, Dr Tomison said:[1111]

> The Minister was reliant on this Briefing Note to inform him to make the gazettal decision, if he felt or if he was – he is reliant on that decision. I think he would not have signed if he had a story which was, we can't provide any of these services, and this is not going to help.

1242 Dr Tomison agreed the Department was sensitive to the prospect that there could be a legal challenge to the decision to use Unit 18. He was aware a Supreme Court challenge had been brought in 2013 following the move of detainees from Banksia Hill to Hakea. He was aware that the concluding pages of the Briefing Note discussed the legal issues which flowed from the 2013 decision. The SSO had seen earlier drafts of the Briefing Note. It is open to conclude that the final two pages, in which there is a discussion about the 2013 decision, had been prepared by the SSO.

1243 It is open to accept that Dr Tomison is correct when he said the preparation of the Briefing Note was important, and that it was not perfunctory and had real purpose. The re-examination of Dr Tomison by counsel assisting upon his recall to the inquest concluded in these terms:[1112]

> And the reason, I suggest that the Briefing Paper had to canvass the matters that it did and include the options paper, including all of the things that it did, was to ensure that there was a documented paper trail identifying what had been given to the Minister, in order that the Minister could exercise his judgment and make a decision. That is self-evidently the purpose of what was happening? --- Yes. We had to make sure he knew of the options available, whether they were good options or incredibly bad options that would never work, before he made a decision on what he was going to gazette.

[1110] East Metropolitan Youth Unit
[1111] Ts pp.1476-1477
[1112] Ts pp.2843-2844

> Yes. So far from the task of the Briefing Note of 12 July really having no work to do, because the decision had already been made, it actually was a very important document for the reason I've just put? --- I certainly saw it as important. Yes.
>
> For the reason I've put? --- That's one of the reasons why it was important, yes.

The Department's communications regarding the opening of Unit 18

1244 In July 2022, there were some significant pieces of communication sent out by the Department relating to the opening of Unit 18.

The media release of 5 July 2022

1245 Dr Tomison was taken to the media release put out by the Department on 5 July 2022.[1113] That media release contained two quotes attributed to Dr Tomison. He said that he had not verified the information in the quotes, rather he relied on meetings with his senior staff.

1246 One of the quotes attributed to Dr Tomison was a statement that Unit 18 would operate as a separated youth detention centre within Casuarina "*and provide all services offered at [Banksia Hill]*." Dr Tomison accepted this media release was intended to provide information to the public. He accepted the public were misled by that statement.[1114]

1247 In light of that concession by Dr Tomison, a question might arise as to whether it was reasonable for the Department to publicly express the view on 5 July 2022 that Unit 18 would provide all the services offered to detainees at Banksia Hill.

The letter of 8 July 2022

1248 On 8 July 2022, the Department (via the Commissioner) wrote to a group of interested persons considered by the Department to be stakeholders in respect of the decision to use Unit 18 as a youth detention centre.

1249 It is necessary to set out the letter in full:[1115]

> Dear [blank]
>
> Movement of young people from Banksia Hill Detention Centre to Unit 18

[1113] Exhibit 71.1
[1114] Ts p.1293
[1115] Exhibit 1, Volume 6.1, Tab 1.9 (attachment 9 to Dr Tomison's statement)

On behalf of the Department of Corrective Services, I wish to provide you with an initial briefing following Minister Johnson's announcement on 5 July 2022 regarding the Gazettal of a temporary youth detention facility within Casuarina Prison.

Banksia Hill is the only youth detention facility for children and young people (on arrest, remand or sentenced to detention) aged 10 to 18 years in Western Australia.

The Centre was not designed for the purpose for which it is now utilised. When constructed, it accommodated reasonably low numbers of sentenced young people, and as such was designed as a secure campus type facility. The structural integrity of cells and units at Banksia Hill is a very different standard to cells and units within the secure adult facilities both from a construction perspective and the materials used.

Since mid-2021, Banksia Hill has been experiencing considerable challenges, particularly with a small number of detainees who continue to behave in a highly disruptive manner impacting the rest of the centre. Consequently, the site has endured an increase in critical incidences inclusive of roof and fence ascents, self-harm and attempted suicide, staff assaults and most recently extreme cell damage. These incidents have had a profound impact across the site including:

- A significant number of cells either damaged or uninhabitable.
- Damage to roofs and air-conditioning.
- Implementation of unscheduled lockdowns utilised to assure safety and security across the site during periods of limited staffing and or during critical incident management.
- Increased demand for repairs required on the site across roof and cell structures.
- Staff concerns regarding safety.

Whilst work is being carried out to repair the infrastructure, the level of damage has recently escalated across the site which is providing difficult to rectify quickly enough to keep the centre operational. Of note is the impact of COVID on the availability of materials and trades.

In the State Budget the Government announced the allocation of $25.1 million towards improving services for youth in detention which includes the redevelopment of the Intensive Support Unit, the addition of anti-climb fencing and roof structures, and the development of a new crises care unit.

Importantly to enable this work to be undertaken Banksia Hill needs to be stabilised which is not possible with the current challenges that the centre is facing. To address the immediate concerns the Minister announced his intention to Gazette a unit at Casuarina prison as a youth detention. The newly designated Youth Facility will operate as an annexe to Banksia Hill and will function separately from the adult male facility. In accordance with the Young Offender Act 1994, **young people will have access to the same services as they would within Banksia Hill Detention Centre**

> **including a full suite of therapeutic and non-therapeutic programs, recreation, enrichment programs, education, specialist services, case manager, cultural supports and visits**.
>
> Young people within the youth unit will not be part of the prison operations or visible within the complex to adult prisoners. **All services including staff that will continue to provide services to the young people will be from youth custodial services.**
>
> Whilst I acknowledge this is not ideal the Department is committed to ensuring that the young people are moved back to Banksia Hill as soon as practicable. The Department has been advised at this stage the completion date for the required reparation works is anticipated to by July 2023.
>
> As I am sure you will understand the decision to move the Young People from Banksia Hill is significant **and will require careful planning**. During this process **the Department will continue to engage with all stakeholders to keep you informed of developments**.
>
> Should you which [sic] to discuss this further, please contact Women and Young People to arrange a suitable time.
> (emphasis added)

1250 The portions of the letter that I have emphasised were examined in the inquest in detail.

1251 Ms O'Connell agreed that what occurred in the lead up to the opening of Unit 18 could not be described as "*careful planning*".[1116]

1252 Ms O'Connell said the extent of any plan to involve the stakeholders who received this letter in any part of the preparation for Unit 18 was that they would participate in a walk-through of the site and that "*there was no intention by the Directorate to involve them in any of the preparation*."[1117]

1253 Mr Collins said that to his knowledge, the Department had no engagement with the ALSWA after sending this letter and before the detainees were moved on 20 July 2022.[1118] Counsel for the Department did not challenge Mr Collins on this issue. It is open to accept this evidence from Mr Collins.

The letters of 20 July 2022

1254 On the day of the move, the Department wrote to the individual young people being moved and to their parents or responsible adults.

[1116] Ts p.1702
[1117] Ts p.1702
[1118] Ts p.698

1255 The full text of the letter to the young people read:[1119]

> Hello.
>
> This is a letter to tell you that you will moving to a different place of custody or detention.
>
> For a short time, you will be living in another safer building for young people.
>
> Youth custodial officers and other staff from Banksia Hill will be there too.
>
> You are being moved because it will be a safer place for you.
>
> At the new place, **you will still have everything you need**. There are phones to talk to friends and family and **you will have access to visits**.
>
> Aboriginal welfare officers and other support people will come there to help you.
>
> There will be Banksia Hill teachers for school, and you will be able to play sport and have time outside.
>
> You will need to look after your living area and equipment and show you can follow rules. This will help you to return to Banksia Hill.
>
> Talk to staff if you have any questions about the move.
>
> Thank you.
> (emphasis added)

1256 The full text of the letter dated 20 July 2022 from the Superintendent of Banksia Hill to their parents or responsible adults read:[1120]

> Dear [name of Caregiver/Responsible Adult],
>
> [Name of the child] has been selected for relocation to an offsite unit of Banksia Hill Detention Centre.
>
> BHDC Unit 18 is a facility **that has been specially prepared in recent weeks to receive young people with complex needs**.
>
> **Your child was selected because we believe he will benefit from being in a more specialised environment**.
>
> This move **will allow him to receive the focused intervention and supports that he currently needs**.
>
> While in BHDC Unit 18 **he will have access to the same educational, vocational, medical and mental health services as Banksia Hill and all the other supports, including Aboriginal welfare officers and mentors**.

[1119] Exhibit 1, Volume 6.1, Tab 1.10 (attachment 10 to Dr Tomison's statement)
[1120] Exhibit 1, Volume 6.1, Tab 1.10 (attachment 10 to Dr Tomison's statement)

> He will be able to have social **visits from family and official visits** from legal and other professionals. To arrange a visit, either in person or as an e-visit, call [telephone number provided].
>
> Further information on booking visits and attending Unit 18 is attached for your information.
>
> BHDC Unit 18 is located separately on the grounds of Casuarina Prison and the young people will have no contact at all with adult prisoners.
>
> They will **only be managed by Banksia Hill staff**.
>
> Your child will work with the supports to return to Banksia Hill.
>
> You can contact staff at Banksia Hill if you have any questions. You can also provide feedback or if you wish to make a complaint, this can be done through the Department of Justice website.
> (emphasis added)

1257 The letter to the family and/or the letter to the young persons[1121] enclosed two single sheets of paper, both on Department letterhead.

1258 The first sheet was headed: 'In Unit 18 you will still have everything you need'. Beneath that heading it listed:[1122]

> Doctors, nurses and psychologists
>
> Family visits and phone calls
>
> Teachers and school
>
> Sports and activities
>
> Aboriginal welfare officers and other support people.

1259 Ms O'Connell agreed that when Unit 18 opened there were no doctors on site.[1123] Ms Ginbey agreed there was never a plan to have doctors on site at Unit 18.[1124]

1260 Leaving aside any dispute as to what was or was contemplated to be provided at Unit 18, there was never a plan to have doctors on the site of Unit 18. Although no one from the Department was able to explain to the Court how such inaccurate messaging was permitted to go out, Ms Ginbey

[1121] Given how the material was attached when it came to the Court, it is not possible to determine to which correspondence the sheets were enclosed. It may not be significant; what is important is that the two separate sheets of paper were prepared by the Department to provide information.
[1122] Exhibit 1, Volume 6.1, Tab 1.10 (attachment 10 to Dr Tomison's statement)
[1123] Ts p.1703
[1124] Ts p.2389

speculated that: "*I can think that it was due to the rush with which the material was prepared.*"[1125]

1261 The second sheet provided information about visits. Some of that information was not correct; for example, that in-person visits would be available Monday to Friday, whereas such visits were not provided on Wednesdays because of staff training.

1262 The reader was not informed that when any detainee was taken for such a visit, the balance of Unit 18 would be locked down and those detainees not having a visit would be locked in their cells.

1263 Nor was the reader told that such a lockdown would be necessary because of insufficient staff in Unit 18. The planned regime was that a lockdown would always occur, it was not the case that it may occur if there was a staff shortage.

1264 Ms O'Connell agreed "*the visiting process at Unit 18 was going to look very different to the visiting process at Banksia Hill*".[1126]

1265 Ms O'Connell also agreed "*a better and fuller description of how it [the visiting process] could occur should have been done*".[1127]

1266 Ms O'Connell said she did not realise that "*the plan for visits in Unit 18 meant that it was inevitable that half of Unit 18 was locked down while visits occurred*".[1128]

1267 It should be noted that from the examination of the various versions of the Operating Model,[1129] the procedure for locking down half of Unit 18 to accommodate in-person visits was not included until the fifth version which was updated on 21 July 2022.[1130] That would explain why this detail was not included in the Briefing Note. However, it is not clear whether or not those responsible for the drafting of the letter dated 20 July 2022 was aware of this procedure.

1268 Nevertheless, it may be open to find that had the reader been told this further information, i.e. if the messaging had been more fulsome, the reader

[1125] Ts p.2389
[1126] Ts p.1704
[1127] Ts p.1704
[1128] Ts p.1704
[1129] The six versions of the Operating Model are Exhibits 70.1-70.6:
[1130] Exhibit 70.5, p.6, p.29

would have realised that the visiting regime for Unit 18 was quite different and much more restrictive than the regime in place at Banksia Hill.

1269 ***VYZ***, the first Supreme Court proceeding involving the Department, was heard before Tottle J on 14 July 2022. Ms O'Connell agreed that having this litigation in the middle of the preparation for going into Unit 18 was "*an enormous pull on the available resources and people in the Department*".[1131]

1270 Ms O'Connell said that although the plan was for an AYSO to be permanently placed at Unit 18, that did not occur.[1132]

1271 The infrastructure at Unit 18 did not permit the provision of full-time office space for the AYSO.[1133] Ms O'Connell said that this infrastructure problem was only part of the reason they were not accommodated at Unit 18.

1272 She said the other part was the AYSOs opted that it was best for their service delivery not to be accommodated in Unit 18.[1134] Although her written statement to the inquest[1135] did not say that, Ms O'Connell said she distinctly recalled speaking with a particular AYSO, who suggested it would be better if their service delivery was not accommodated in Unit 18.[1136]

1273 There was no evidence from the inquest that Ms O'Connell did not have such a conversation. However, that leaves unexplained the connection between any such conversation and the making of a decision that the AYSOs would not have a permanent presence in Unit 18.

1274 Ms O'Connell agreed that in the letter that went to the parents/responsible adults of the detainees who were being moved, there was no reference to there being an appeal process for the detainee regarding the decision to move him to Unit 18.[1137] There was only a comment that if the receiver of the letter wished to make a complaint (which was not specified) that could be done through the Department's website.[1138]

The letter of 22 July 2022

[1131] Ts p.1709
[1132] Ts p.1745
[1133] Ts p.1747
[1134] Ts p.1746
[1135] Exhibit 44
[1136] Ts p.1746
[1137] Ts p.1756
[1138] Exhibit 1, Volume 6.1, Tab 1.10 (attachment 10 to Dr Tomison's statement)

1275 The Department wrote again to the group of stakeholders on 22 July 2022, two days after the young people had been moved into Unit 18. The text of that letter from the Commissioner read:[1139]

> Dear [blank]
>
> Banksia Hill Detention Centre Unit 18
>
> On behalf of the Department of Justice, Corrective Services, I wish to provide you with an update following my earlier correspondence on the 8 July 2022 regarding the movement of some young people to a temporary youth detention facility.
>
> The Gazettal was published on 15 July 2022 which has allowed for a stand-alone unit at Casuarina Prison to be designed as a Youth Detention Centre and operate as an extension of Banksia Hill Detention Centre (BHDC).
>
> Seventeen young people identified as highly disruptive were safely moved to BHDC Unit 18 on 20 July 2022. BHDC Unit 18 is a completely separate facility, **it is staffed by youth custodial officers and other support staff who are from Banksia Hill**.
>
> I can report the young people in BHDC Unit 18 have settled into their new accommodation, are engaging with staff and support services and have had contact with their families including phone calls and visits.
>
> The young people have commensurate services to those available at BHDC including therapeutic and non-therapeutic programs, recreation, enrichment programs, education, specialist services, case management and cultural supports.
>
> **The full suite of programs**, with **individually targeted engagement strategies and therapeutic interventions**, will enable the young people to be supported to better manage their behaviours and enable their return to BHDC.
>
> Pleasingly, the BHDC site has reported a return to normal daily schedules and the delivery of programs and services. Young people there have reengaged in education and there was a return to the football program. The operational 'temperature' of the site has reduced significantly in the short time since the relocation of the 17 young people.
>
> The works that need to be undertaken at BHDC to ensure the site is a secure and safe environment are scheduled to commence in the coming week. The Department is committed to ensuring that the young people are moved back to Banksia Hill as soon as practicable.
>
> [Concludes with contact details for an appointment with Mr Budge if the recipient wanted to discuss further]

[1139] Exhibit 1, Volume 6.1, Tab 1.11 (attachment 11 to Dr Tomison's statement)

(emphasis added)

The messaging in these four letters

1276 During the inquest, considerable attention was paid to the content of these communications, particularly the emphasised portions.

1277 The decision by the Minister, upon the advice of the Department, to use Unit 18 as a youth detention centre attracted considerable controversy and condemnation.

1278 The Department is a very large government entity, and it has a dedicated Strategic Communications team able to assist it in getting particular messaging to target groups. It may be that there is no surprise the Department was aware of the need to put its messaging around the decision to use Unit 18 out into the public domain and out to specific target groups, i.e. the stakeholders, who had a close interest in the decision. Such messaging went out in many different forms and on many different media platforms.

1279 It is open to find that the messaging put out by the Department had two principal purposes:

- To tell people why the Department has had to do what it has done by making the decision to use Unit 18; and
- To allay the community's fears and to tell it not to be concerned because the young persons who will go to Unit 18 will be in a comparable or better position than if they were in Banksia Hill.[1140]

1280 There is evidence which could support an argument that the messaging put out by the Department about Unit 18 was not fulsome, was incomplete, was misleading and in some instances, not true.

1281 It is also arguable that had a different message been provided by the Department in its communications with the general public, the young persons who were moved to Unit 18, their families, their lawyers and other professionals concerned with their wellbeing, the public controversy and condemnation surrounding the decision to use Unit 18 would not have been abated; it may have escalated.

1282 The question remains as to what the Minister would have done had he received more accurate information at the time he was considering his

[1140] Ts p.2470 (Ms Ginbey)

decision and whether he would have given his approval. However, a reasonable inference could be drawn that the contents of the Briefing Note that was prepared would have influenced the Minister's decision to approve Unit 18 as a youth detention centre. Balanced against that is the fact a second detention facility was urgently needed, and Mr M Reynolds' evidence that he understood that when Unit 18 became operational, the Minister was aware that not all the works had been completed but still wanted it opened because of the conditions at Banksia Hill.[1141]

1283 Ms Ginbey acknowledged that if the Minister had received more accurate information about the inability of the Department to have a safe nursing arrangement in place when Unit 18 received the first young detainees, the Minister may have authorised the creation of Unit 18 as a young detention centre but delayed any authority to commence operations until preparations were further advanced.[1142]

1284 Ms Ginbey further acknowledged that if the complete information had been provided in relation to the regime in which visits would occur; namely the consequence that it would be necessary to lockdown that half of Unit 18 not being transported to the visits hall at Casuarina because there would be insufficient custodial staff in Unit 18, it was very likely there would have been significant concerns with the public, the detainees in Unit 18 and their families.[1143]

1285 While it is uncertain how things may have unfolded had the information from the Department to all recipients been more accurate, it may be open to contend it was not acceptable that the messaging and formal communications put out by the Department around this issue were so lacking with accurate and complete information on so many critical topics.

1286 The evidence that could support an argument that the Department's communications around the opening of Unit 18 were not fulsome, not complete, misleading and in some instances simply not true is examined below. After being taken through numerous examples of the Department's messaging, Ms Ginbey could think of no reason why such an argument could not be made:[1144]

> And this inquest has hundreds and hundreds of pages of the Department setting out its aspirations and its hopes and subcommittees with working

[1141] Ts p.4104
[1142] Ts p.2499
[1143] Ts p.2547
[1144] Ts p.2494

> parties and think tanks and whiteboard meetings. It's one thing to have aspirations, it's another to accurately state the facts, isn't it? --- Yes.
>
> So, can you think of any reason why the inquest should not conclude that the Department in the lead up to Unit 18 was sending out messages that were misleading, not correct, untrue? Can you think of any reason why the Court should not reach that conclusion?[1145] --- No.
>
> And it's not just one set of messages, it's message after message that this inquest has uncovered today, isn't it? --- Yes.

1287 Dr Tomison gave evidence about the letter sent to the stakeholders on 8 July 2022.

1288 Dr Tomison said he would have seen a draft and probably the final version of this letter before it was sent. If there was material in the letter that he did not know of his own knowledge, Dr Tomison said he would have proceeded on the basis that if it was in the draft, even though he did not have personal knowledge of it, he accepted it must be true.[1146]

1289 He identified the two principal people who had been giving him advice about what was or was not going to happen, as the Commissioner and the Deputy Commissioner.[1147]

1290 As noted above, the second page of that letter contains the following:

> Young people will have access to the same services as they would within Banksia Hill Detention Centre, including a full suite of therapeutic and non-therapeutic programs, recreation, enrichment programs, education, specialist services, case manager, cultural supports and visits.

1291 Given what he now knows, Dr Tomison accepted the following propositions in respect of the assertions extracted from that letter:[1148]

(a) It is not correct to say that the people going into Unit 18 would have access to the same services that they would have within Banksia Hill;

(b) It is not correct to describe what the detainees would have access to as being a full suite of all the things that are described in the letter;

(c) That what was communicated by the letter in this regard was not correct;

[1145] As I have already outlined, I have determined that these conclusions cannot be made by the Court.
[1146] Ts p.1106
[1147] Ts p.1106
[1148] Ts p.1107

(d) If he knew this material was not correct, he would never have let the letter go out with this content;

(e) He permitted the letter to go out because he was being told that the passage set out in the above paragraph was in fact true; and

(f) The passage set out above is in fact not true.

1292 Dr Tomison made similar concessions in respect of the second letter to the same stakeholders on 22 July 2022. In this letter, the claim about commensurate services was repeated.[1149]

1293 In the letter of 8 July 2022, the recipients were told: "*During this process [of careful planning] the Department will continue to engage with all stakeholders to keep you informed of developments*".[1150] Mr Collins gave evidence that the ALSWA was not involved in any part of the planning process, although it was part of a walk-through of Unit 18 on 12 July 2022. Dr Tomison acknowledged that the Department, having failed to engage with the stakeholders during the planning process, as it said it would, was "*a most unsatisfactory state of affairs, to put it mildly*".[1151]

1294 Dr Tomison agreed with the proposition that what was said in these two letters becomes much more egregious if the case was that when the letters were written it was known that what was promised could not be provided.[1152]

1295 Dr Tomison agreed that the letter dated 20 July 2022, sent to the young people, was not accurate. He agreed the young person was not told there were going to be prison officers at Unit 18. He agreed that the absence of observation cells in Unit 18 with a full viewing panel in the door meant it was "*simply a lie to say that going to Unit 18 is going to a safer place* " and that going to Unit 18 in such circumstances was actually "*going to a more dangerous place because if we have to observe you, we don't have any observation cells*".[1153]

1296 Dr Tomison agreed that it was not true for the letter to assert "*at the new place, you will still have everything you need*".[1154]

[1149] Ts p.1109
[1150] Exhibit 1, Volume 6.1, Tab 1.9, p.2 (attachment 9 to Dr Tomison's statement)
[1151] Ts p.1110
[1152] Ts p.1112
[1153] Ts p.1117
[1154] Ts p.1118

1297 At the same time as the Department was writing to the young people on 20 July 2022, it was also writing to their families and caregivers. They were told Unit 18 was:[1155]

> a new facility that has been specially prepared in recent weeks to receive young people with complex needs. Your child was selected because we believe he will benefit from being in a more specialised environment.

1298 Dr Tomison agreed that such a description was "*not quite accurate*".[1156]

1299 The letter also told the families that while their child was in Unit 18:[1157]

> … he will have access to the same educational, vocational, medical and mental health services as Banksia Hill and all the other supports including Aboriginal Welfare Officers and mentors.

1300 Dr Tomison agreed this statement was "*not a true statement of the situation*".[1158]

1301 Dr Tomison also agreed that the letter sent to the families read as though their child had been fortunate to be chosen. Dr Tomison agreed that such a representation was not an accurate picture.[1159]

1302 In addition, Dr Tomison agreed the letter read as if the child was "*going to be transferred through to a therapeutic, trauma-informed environment which is focusing on rehabilitation*", and accepted Unit 18 could not be described in that way.[1160]

The promotional video prepared by the Department

1303 The transcript of the interview of Ms Ginbey in the promotional video prepared by the Department (the video) was exhibit 68.2. Like the other communications engaged in by the Department, the contents of the video, both what was shown and what was said, was the subject of close attention during the inquest. Its transcript is therefore set out in full.[1161]

Q.1 Christine, tell me where are we and why are we here today?

A.1 We are standing in the middle of our newly gazetted youth custodial facility. So, it's within the grounds of Casuarina Prison, however it is completely

[1155] Exhibit 1, Volume 6.1, Tab 1.10 (attachment 10 to Dr Tomison's statement)
[1156] Ts p.1120
[1157] Exhibit 1, Volume 6.1, Tab 1.10 (attachment 10 to Dr Tomison's statement)
[1158] Ts p.1120
[1159] Ts p.1121
[1160] Ts p.1122
[1161] Exhibit 68.2

separate. The young people who will be housed here won't have any contact with the adult prisoners who are on this site. This is a completely separate facility, **and it will be staffed by youth custodial staff and other support staff,** who are used to working with our youth in custody.

Q.2 Can you tell me why the young people are being moved here from the existing Banksia Hill Detention Centre?

A.2 So, it is actually only a very small number, so it's about 20 young men who are going to be moved from Banksia Hill. The amount of destruction that these detainees have been undertaking on that site means that I just can't, I can't look after them safely on that site anymore. They have been pulling bricks out of walls, breaking doors down, climbing on roofs, pulling live electrical wires out of walls. I need to be able to maintain their safety, the safety of other detainees and also the safety of the staff who work there and at the moment with these young people who are being housed there, that's not possible. So, to be able **to bring them here into a more secure environment, I mean as you can see, it's light, it's bright, it's airy, it's spacious, it's clean, as I said completely separate from the adults**. That will enable us to **manage these young people in a much more interactive way than we are able to maintain at Banksia Hill** at the moment. So, **it's going to be a really intensive support that they receive here**, and they will be able to held somewhere that's secure, so that I can maintain their safety as well as that of other detainees and the community.

Q.3 There have been some concerns raised about moving the detainees into this Unit, how would you respond to those?

A.3 I think that for the detainees who have been moved, this is a much better environment for them. It's a much safer environment for them, it's secure, it enables them to get the care and attention that they need in a much more intensive manner than I am able to provide in the current environment that they are in Banksia Hill. So, it's very separate from the adult detainees, **it is going to be staffed fully by youth custodial staff and other people who will support them and that's mental health support, that's education, that's therapeutic programs. At least the same level of services than they're getting at Banksia Hill**, but able to be opened up more because we don't have the secure infrastructure for this very small problematic group of detainees, I've got that in this environment here and so staff are going to be able work with them much more closely.

Q.4 While they are here, what services and programs will they have access to?

A.4 The cohort of detainees who are moved here will have at least as good services as they experience at Banksia Hill, so we've got intensive education, therapeutic programs, mental health support, psychological support, official visits, social visits. We want to maintain their contact with their family, with the cultural supports that they have, I have Aboriginal Support Officers coming over to also work with the young people who are moved. They will have great supports while they are here, and we are actually able to deliver it because it's within a secure environment.

Q.5 And have any of the staff raised concerns about coming into this facility to help these young people?

A.5 I think the staff are looking forward to coming into a much better, a more fit for purpose environment. We've had staff volunteer to come. I think they are all looking forward to working here and I am sure that they will enjoy working with the young people in this environment, but at the same time as that's happening it also means that the staff who are left at Banksia Hill are going to be able have a more normalised routine, better interactions with those young people who remain at Banksia Hill, who are not the ones who are causing the extensive damage that this cohort of young people are.

Q.6 And for the young people who are staying at Banksia Hill, how will this benefit them?

A.6 By having this cohort of detainees moved, this cohort of detainees at the moment are causing so many critical incidents at Banksia Hill and the damage that they're causing impacts the ability to have a normalised routine for everybody else. So, it means that the other detainees don't get access to education and programs and being able to play footy on the oval and all of those things that Banksia Hill was designed for, so by removing this cohort of detainees into this secure environment, will mean that they're able to then get all of those therapeutic interventions that they should get while they are in custody with us.

Q.7 And when do we anticipate that the young people that will come to this Unit will be moved back into the main Banksia Hill Detention Centre?

A.7 So, we have suggested that this is going to be a temporary gazettal, so we are thinking that it's probably going to take us about 12 months to undertake the extensive works that need to happen at Banksia Hill to repair the damage, and to provide a more secure environment. However, for individual detainees, they will be assessed on a weekly basis on an ongoing basis, and when they're able to move back to Banksia Hill they will individually be moved back.

Q.8 Were there any other options that were taken into consideration before moving the young people into an adult facility?

A.8 This is not something that anyone did lightly. This an extraordinary action and was necessary because the young people are not safe or secure at Banksia Hill, neither are the other young people who are housed there or the staff. We needed something that was available, we needed something that was secure, we needed somewhere that we would be able to provide all of the therapeutic supports for the young people who are transferred here. There just is no other option that meets those criteria.
(emphasis added)

1304 Ms Ginbey did not accept the messaging from the Department at the time of the establishment of Unit 18 was comparing Unit 18 to Banksia Hill. Rather, she said, it was comparing Unit 18 to the ISU at Banksia Hill. Ms

Ginbey stated that in her mind, the messaging around Unit 18 was comparing it with the ISU.

1305 Ms Ginbey explained this on the basis that she knew the majority of the young people being moved to Unit 18 would otherwise be in the ISU. However, she did accept the proposition that a recipient of such communications, who did not have this additional and esoteric knowledge as to where the young people would normally be, would understand the communications to be a comparison between Banksia Hill as a whole and Unit 18.[1162]

1306 Similarly, Ms Ginbey told the inquest that in her mind when the video was made, she was making the comparison between the ISU and Unit 18. When asked whether she accepted there was validity in the criticism that the messaging in the video was inaccurate, Ms Ginbey did not accept that proposition: "*I don't agree that it's a valid criticism. I understand it's a criticism.*"[1163]

1307 Further, Ms Ginbey did not accept that anyone listening to the video would be misinformed about the correct situation. Nor did she accept the criticisms acknowledged by Dr Tomison in respect of the video.[1164] Although Dr Tomison was critical of the video's contents at the inquest, it must be noted that at the time of its creation he complimented Ms Ginbey in an email which said: "*The interview is outstanding.*"[1165]

1308 After remaining on its website for two years, the video was taken down by the Department on the evening of the inquest day during which Dr Tomison gave evidence to the effect that if he knew then what he knew now, he would never have given his approval for the video to have been put up.[1166] Ms Ginbey said she had no role in deciding that the video should be taken down.

1309 For much of the inquest, it was unknown how, why and at whose direction the video had been taken down. In due course, on 15 August 2024, I sought an explanation on these issues.[1167]

1310 In response to that request, on 23 August 2024, the SSO wrote to the Court to say that on 25 July 2024, it provided advice to the Department in relation

[1162] Ts p.2307
[1163] Ts p.2308
[1164] Ts p.2308
[1165] Exhibit 134, attachment 34; Mr M Reynolds and Mr Budge expressed similar views: Exhibit 134, attachments 36-37
[1166] Ts p.1092
[1167] Ts p.2739

to the video and that subsequent to receiving that advice, the video was taken down. The SSO told the Court that the advice provided by it:[1168]

> is a confidential communication between a legal advisor and a client, relating to proceedings currently on foot. We do not waive privilege. Consequently, we have not provided a copy of the email communication requested by the Court on 15 August 2024.

1311 Despite Ms Ginbey's refusal to accept the proposition, there is evidence that could support a conclusion the video was less than fulsome or not accurate; namely, that the ISU was never mentioned by Ms Ginbey and that she only referred to Banksia Hill.

The broader communications strategy

1312 Ms Short is the Director of Strategic Communications within the Department and has been in that position since 2019. For eight years prior, she was the Western Australian Police Commissioner's media advisor and for the two decades before then she was a practising journalist.

1313 Ms Short's written statement to the inquest comprised of 38 pages and 70 attachments.[1169] It is a detailed account of the assistance she and her communications team provided to the Department in respect of the matters being examined at the inquest.

1314 Her statement described the role played by Strategic Communications within the Department. She told the Court that Strategic Communications is regularly tasked by business areas within the Department to assist with the preparation of materials such as media statements, project communications, planning, and correspondence.

1315 It is necessary to set out in some detail what Ms Short told the Court in her statement because it is important that the role of Strategic Communications in the messaging that went out be properly understood:[1170]

> Review and preparation of materials
>
> 24. When a business area asks the Strategic Communications team to assist with the preparation of communications materials, it is usually the case that the business area will provide either: (a) background/contextual information (such as project documents or briefing notes, or email

[1168] The relevant portion of this letter to the Court was read onto the transcript: Ts p.3816
[1169] Exhibit 134
[1170] Exhibit 134, pp.6-9

summaries of information) to rely on to prepare materials; and/or (b) draft materials to review.

25. In either case, the substantive content of what needs to be communicated is provided by the relevant business area.

26. Strategic Communications will then develop, review and/or edit the relevant materials. Upon doing so, any draft materials are referred back to the business area for review and checking prior to approval through the chain of command.

Approval of release of communications

27. The Strategic Communications team is not responsible for approving any content that is released to staff, stakeholders or the public.

28. Whilst Strategic Communications is involved in reviewing and developing content, the contents are ultimately approved by others, such as those within the relevant business area. That is to say, whilst Strategic Communications assists with developing content and progressing approvals, it does not have authority to approve the release or publication of any information itself.

29. Given the Department's broad and complex range of and functions, the Strategic Communications team members are not (and could not be) subject-matter experts. The team specialises in advising on, and assisting with, the communication of information, but the subject matter expertise concerning the relevant content is held by the relevant business area.

…

31. A critical part of the process is that after Strategic Communications undertakes a review or prepares draft materials (etc.), the materials are referred back to the business area for review. This part of the process is vital to ensure that the business area can identify whether any additions or changes made by Strategic Communications have affected the accuracy of the content.

32. Depending on the nature and complexity of the proposed materials, the process may result in draft materials going back and forth between Strategic Communications and the relevant business area several times.

33. Once the business area determines that it no longer requires any further input from Strategic Communications, the business area may then deal with the approval of the release of the relevant information through its own approval channels, such as correspondence or staff messaging.

34. Where materials are intended to be published or released externally by Strategic Communications, the established approval process follows the chain of command and involves endorsement of the content from the business area, the head of the division and the Director General.

35. Depending on the nature of the material, this approval process may also require endorsement from the relevant Minister's Office. Strategic

> Communications does not publish or release externally any material without the appropriate approvals.

1316 In her statement, Ms Short's described the involvement of Strategic Communications in the preparation of the various letters which have been examined in the inquest, namely, the letters of 8 and 22 July 2022 to the stakeholders and the letters to the detainees and their families which went out on the day of the move to Unit 18 on 20 July 2022.

1317 Ms Short also outlined the involvement of Strategic Communications in the video which has been examined in the inquest, including the following:[1171]

> 96. I do not recall whose idea it was to produce a video, but I agreed it would be a useful asset and sought approval from Dr Tomison and agreement to participate in the filming from Ms Ginbey.
>
> 97. It is standard practice, not just for the Department, to include digital assets such as images and videos as part of contemporary communications plans and for publishing on websites and social media platforms.
>
> 98. The decision to include images and other vision of Unit 18, the Deputy Commissioner and BHDC to cover parts of the commentary referencing that site is also standard practice in video production, particularly where there is a single person speaking. The images of BHDC cell damage were already in the public domain having been provided to media by the Department on 5 July 2022.

1318 Ms Short's statement made it very clear that it is the client who has the final say in what is sent out. This position was encapsulated in the following:[1172]

> Because that's the theme throughout your whole statement, isn't it? That comms[1173] people, whether they're dealing with internal clients or external clients, if you were working as a private consultant, can prepare, can draft, can ask for information but, ultimately, it's the client, either the internal client or the external client, that signs off and says, that's the truth of the matter, that's what goes out? --- Correct.

1319 The statement from Ms Short, its description of the chronology of certain events and the documents, particularly the internal emails, attached to the statement provide a clear and detailed account of the drafting and subsequent approval of various communications sent out by the Department.

[1171] Exhibit 134, pp.25-26
[1172] Ts p.4196
[1173] Abbreviation for communications

1320 Prior to Ms Short providing her statement and then giving oral evidence, the Court was unaware that as well as the video going up on the Department's website, the Department also put up on various social media platforms an extract of the video. The link to that extract also came down from the social media platforms at the same time as the video was removed from the Department's website.[1174]

1321 The Court also learnt for the first time that when the social media content was posted, the Department made arrangements that the usual facility of a reader of such content being able to comment on it would be removed. The message put up by the Department on its social media platforms was in these terms:[1175]

> We understand and respect that there are some concerns surrounding this decision [to open Unit 18]. We have published this interview to give the public an honest account of why this is happening and to show that the facility is safe and secure for the young males that are being moved here. We are, however, turning off the comments on this post to ensure that concerns and complaints can be appropriately addressed and moderated. If you would like to provide feedback, please refer to the official process on our website. (a link was provided to the Department's website)

1322 The video was not an isolated incident, it was part of a communication strategy by the Department to disseminate as broadly as possible, information to justify its decision to recommend that Unit 18 be used as a youth detention centre. Part of that strategy was the plan to remove the ability of there being any public dissent about what the Department was doing; any dissent or comment would need to be made privately to the Department. It could be contended that this was another example of the Department's secretive approach to matters concerning Unit 18, an approach that was only exposed by the inquest.

1323 There is evidence that may support a finding that the communications examined above contained less than fulsome or accurate messaging. There is also evidence to contend that this less than fulsome or accurate messaging was a constant theme whenever the Department wrote or said something about Unit 18.

1324 Dr Tomison agreed that "COPP 14.1: Unit 18 Placement" (COPP 14.1),[1176] which was signed on 29 November 2022 (four months after Unit 18 had been operating), was not an accurate description of how Unit 18 was

[1174] Ts pp.4199-4200
[1175] Exhibit 134, attachment 36
[1176] Exhibit 1, Volume 6.2, Tab 1.17

operating. As I have already noted, the language used by those who worked at Unit 18 included the descriptions "*chaotic*" and "*like a war zone*". Yet COPP 14.1 stated:[1177]

> Through identification, referral, assessment and increased supervision, Unit 18 aims to provide a trauma-informed, positive and calm environment with Individual Engagement Plans (IEP) to support young people with unique and complex needs.
>
> Providing a unique, calm, positive environment, which delivers trauma-informed practices, encourages young people with complex needs to rebuild a sense of control and trust which reinforces healthy boundaries and promotes help-seeking behaviour.
>
> …
>
> Young people placed at Unit 18, shall have access to the same services as they would within BHDC including a full suite of therapeutic and non-therapeutic programs, recreation, programs, education, specialist services, case management, health, cultural supports, and visits

1325 Dr Tomison said that if he was aware COPP 14.1 was to be signed in such terms, he would have said that cannot occur because what is put into COPPs must be truthful.[1178]

1326 When I asked Dr Tomison why such a description would be in a COPP, he said it was "*aspirational"* but framing it in such a way as: " '*This is what's going on now*', *obviously at that time, is incorrect.*"[1179]

1327 Dr Tomison agreed anyone reading this part of COPP 14.1 would be under the impression Unit 18 was operating very positively at the time, when in fact that was not an accurate description.[1180]

What was known when these communications were made?

1328 Ms Ginbey did not entirely accept the criticism that the Department's communications and messaging prior to the utilisation of Unit 18 were not accurate. She said that such communications were based on the then available information and "*that everything in them was true – based on the information that we had*".[1181]

[1177] Exhibit 1, Volume 6.2, Tab 1.17, p.4
[1178] Ts p.1184
[1179] Ts p.1184
[1180] Ts pp.1184-1185
[1181] Ts p.2305

1329 The evidence as to what the action trackers reveal, as outlined above, may demonstrate what was known about the difficulties in providing services and facilities into Unit 18 before it opened.

1330 It could be contended that the evidence of what was in the various versions of the Operating Model have assertions about some issues, upon which the Department had complete control, that were demonstrably wrong and should never have been asserted. One example is the assertion about visits.

1331 How, where and when visits to detainees in Unit 18 would occur was a matter entirely within the control of the Department. It operated Casuarina and it operated Unit 18. It knew how it would go about facilitating such visits. It did not require any cooperation from third parties providing the services required.

1332 The information given to the Minister was that there would be available 20 face-to-face visits each day during the week (Monday to Friday) for a total of 100 such visits per week. It would seem this was never achievable. Ms Ginbey agreed that to make such a claim was "*absolute rubbish*", although she contended that "*it was based on information available to us at the time*".[1182]

1333 The examination of Dr Tomison by Senior Counsel for Nadene Dodd concluded with this exchange:[1183]

> Would you agree that Cleveland hung [sic – hanged] himself in a place that would not have been gazetted as a youth detention facility had you and the Minister known the true facts? --- I think that's highly likely.
>
> The answer is yes? --- Yes.
>
> Do you accept that the gazetting of Unit 18 was procured by deception on the part of the Department of Justice? I am not saying you personally, I am saying …? --- No, I don't think it was deliberate, but you could argue that's what the outcome was. I don't think it was deliberate deception, but you could argue that was the outcome.
>
> Well I am going to put to you that somewhere, someone was told – has painted a picture about Unit 18 that was just false. [Counsel assisting] has taken you through it? --- Yes, and I agree. I agree with that.

[1182] Ts p.2508
[1183] Ts p.1341

1334 Ms Maj told the inquest she was aware of the criticisms made concerning the messaging that went out from the Department. She was concerned about what had been uncovered in the evidence. Ms Maj stated:[1184]

> There has been a number of things brought to my attention that have resulted in immediate action.
>
> Yes. And it must cause you enormous concern to learn what the inquest has uncovered about the lack of fulsome information, the misleading information, and in some instances lies that were told to people, including the Minister? --- That concerns me. Yes.
>
> Right. So, has anything happened within the Department, by you, to ensure that that doesn't happen again? --- Yes.
>
> What's that? What have you done? --- Well, a couple of things. One is our people, Culture and Standards area, who have also been monitoring the inquest closely, are reviewing any individual, I guess, matters that have been raised that require review.
>
> Well, you've got a couple already, haven't you? --- Yes. And separately to that, I've been making changes in the Department around governance processes, so that I'm meeting more regularly with different groups of people, so that I can hear first-hand some of the information that's provided.

1335 It was put to Dr Tomison that the reality was by the time it was decided a second youth detention centre was needed, the Department had run out of time to prepare that site properly and had to persuade the government to go with that as the option. Dr Tomison was asked by counsel assisting:[1185]

> It had to do everything in its means to make sure that people were persuaded there is a need to do this, there is no other option, and what we are going to do is not going to see the young people worse off. Because if you didn't sell that message, there was a real risk that this would unravel, and you would have no second option?

1336 Dr Tomison did not accept that proposition. He accepted the Department was in a crisis and he should have made the decision for a second site earlier. He did not think there was any attempt by the Department to "*obfuscate or to hide*".[1186] Dr Tomison believed that "*the people working on this, were trying to do their very best to put the right message through, the appropriate message through*" [1187] and did not believe the individuals involved "*would deliberately mislead*".[1188] He also said that in all the time

[1184] Ts pp.2705-2706
[1185] Ts p.2764
[1186] Ts p.2764
[1187] Ts p.2765
[1188] Ts p.1159

he had worked with Mr M Reynolds and Ms Ginbey he was "*not familiar with them providing me with deliberately false material at any point*".[1189]

1337 Similar to Ms Ginbey's evidence, Dr Tomison said that the comparator in his head was between Unit 18 and the ISU at Banksia Hill. However, in contrast to the evidence from Ms Ginbey, he accepted the proposition that if the messaging in July 2022 did not mention the ISU but spoke of Banksia Hill, then such messaging was misleading because it was comparing Unit 18 with Banksia Hill.[1190]

What was or was not at Unit 18 when it opened

1338 At one level, this is a compare and contrast exercise between what was at Banksia Hill but was not at Unit 18, and there are many observations that can be made after that comparison.

1339 The other level is an examination of what should have been present at both sites but was not present at either.

Model of care[1191]

1340 The evidence has revealed that there was no model of care at either site when Unit 18 opened. Indeed, as at the time of the inquest's fourth tranche in December 2024 (nearly 2½ years after Unit 18 was opened), it still did not have a model of care.

1341 Dr Tomison told the inquest that the two attempts at creating a model of care prior to the Nous engagement were poor attempts. He agreed that in the Department's response to the Show Cause Notice in early 2022,[1192] Mr Ryan was told the Department is working on a further model of care and the features of the design of that model of care were itemised in the document sent by the Department to Mr Ryan:[1193]

(a) Treating young people differently to adults.

(b) Recognising the trauma and underlying reasons for their offending and behaviour.

(c) A multidisciplinary approach in delivery of end-to-end individualised case management.

[1189] Ts p.1113
[1190] Ts p.2842
[1191] When I refer to a model of care in this section, I am referring to a document which sets out the "*high-level principles for the care and management of young people in detention*": Exhibit 27, [6]
[1192] Exhibit 30.4
[1193] Exhibit 30.4, pp.6-7

(d) Detailed assessments designed to map critical issues and causal factors which lead to the individual's incarceration and make appropriate treatment and service referrals.

(e) A full suite of voluntary and mandated programs specifically designed to tackle the issues highlighted via assessment.

(f) A restorative justice approach which supports and underpins the behaviour management process and the facility culture.

(g) Educational, vocational, and recreational programs, targeted at different age groups, abilities and needs to assist young people to be capable, stable and/or employable.

(h) A holistic approach to Detainee, Health provision which addresses both physical and mental health.

(i) An effective through care model designed to ensure links to community, public services and support networks are well established in preparation for release.

(j) Post release support to assist young people to remain engaged with identified services and supports.

1342 Dr Tomison agreed those features were critical parts of any appropriate model of care. He agreed that none of those features were in place when Unit 18 opened. Dr Tomison accepted that when Unit 18 opened, there was no model of care in place.[1194]

1343 Considerable evidence has been received as to what facilities and services were or were not in place when Unit 18 opened. As to this, Ms Ginbey's evidence was: [1195]

> Do you accept that when Unit 18 opened, it did not have everything in place that needed to be in place? --- It had everything that needed to be in place. It didn't have everything necessarily that we would have liked to have been in place.
>
> So, when Unit 18 opened on the morning of 20 July, you thought that everything we need to have in place is in place? --- That was crucial, given the circumstances that we had at the time of Banksia Hill, where the expectation was that at any time, there could be a significant incident at Banksia Hill.
>
> And when it opened on the morning of the 20th, did you think everything we have told people will be at Unit 18 is in fact at Unit 18 as we open it, did you believe that? --- Not on the morning of the 20th. No.

[1194] Ts pp.1188-1189
[1195] Ts p.2313

> What had you told people would be there but was not? --- That we would have education, therapeutic services.

1344 Before Unit 18 opened, Dr Tomison was told that it was going to be difficult to provide the same level of services as expected at Banksia Hill and that the Department was working on ways to meet that need.[1196] At the inquest, counsel assisting asked Dr Tomison:[1197]

> Were you ever told by the Commissioner or the Deputy Commissioner that, "There are deficits in what we can provide at Unit 18"? --- Yes.
>
> And when were you first told that? Before it opened? --- Before it opened, the conversations were, "It's going to be difficult to provide the same level of - of service as - as expected at Banksia Hill. We are working on ways to - to - to meet that need, and it may be --- "
>
> Who was telling you that? --- From memory, it would have been DC Ginbey and her – and her team, and the Commissioner.
>
> So let me just be clear. Before Unit 18 opened, Christine Ginbey was telling you, "Director General, it is going to be difficult for us to provide what we've got at Banksia in Unit 18, but we're going to do the best we can." Is that a fair summary? --- Essentially. And, following up with that, they were exploring the strategies to do that, but yes.
>
> Yes. But, in your mind, you have no doubt that before Unit 18 opened, that was the message you were getting from Deputy Commissioner Ginbey? --- Certainly, that it was going to be difficult, yes. That was the message I - I was getting.
>
> Yes, that, "We were not going to be able to put into Unit 18 what we had at Banksia"? --- They were going to struggle to make it all work, but they were - they - that's what they were looking at.
>
> Trying to make it work is one issue. The fact of the matter is you were told, "We're not going to be able to put into Unit 18 what we've got at Banksia"? --- I think that's correct.
>
> Right. And the source of that was Christine Ginbey? --- Well, I think and the Commissioner too.

1345 Ms Maj agreed that the model of care was designed for Banksia Hill, and it has not been "*designed for a youth detention centre being run out a maximum-security adult prison*".[1198] She confirmed there was no model of care being applied to Unit 18, rather the approach in Unit 18 was "*an individually tailored response to young people*".[1199]

[1196] Ts p.1082
[1197] Ts pp.1082-1083
[1198] Ts p.2729
[1199] Ts p.2730

1346 Ms Ginbey's account of her conversations with Ms Butt regarding the implementation of a model of care for just Banksia Hill was that she told Ms Butt to concentrate on Banksia Hill as the model of care prepared by Nous was only for Banksia Hill. She also recalled that at the time of these conversations (after Ms Butt commenced in October 2023), it was still envisaged Unit 18 would be a temporary facility and she thought a model of care for Unit 18 would not be finished before Unit 18 was closed.[1200]

1347 Ms Ginbey was asked: "*What was your understanding, in July 2022 about the model [of care] that was to apply to U18 upon it opening/? What was the model and who developed it?*".[1201] Ms Ginbey responded that as of July 2022 no model of care had been implemented at Banksia Hill and her understanding was that:[1202]

> … the care provided was contained in the [Banksia Hill Detention Centre Unit 18] Operating Model which was prepared by Deputy Superintendent (Operations) Chris Rule. I understand that Mr Rule prepared the Operating Model based on how services were delivered to the ISU at Banksia Hill.

1348 It may be open to question Ms Ginbey's explanation as the Operating Model and its various subsequent versions[1203] do not come close to replicating what a properly understood therapeutic model of care should look like. It largely sets out the day-to-day management of Unit 18 with an emphasis on security.

Staffing numbers

1349 It quickly became apparent when Unit 18 opened that its staffing numbers were inadequate.[1204]

1350 Mr Rule was also responsible for preparing the staffing model for Unit 18 before it opened. Ms O'Connell saw this model and told him that it did not have sufficient staff. His response effectively was: "*That's all I've got. That's what we will have to go with*".[1205]

1351 It is open to conclude that the nub of the problem was that for a very long time an insufficient pool of resources had been provided to run Banksia Hill

[1200] Exhibit 145.3, [22.4]
[1201] Exhibit 144.3, [25]
[1202] Exhibit 145.3, [25.1]
[1203] See Exhibits 70.1-70.6
[1204] Ts p.2316
[1205] Ts p.1623

and that was only exacerbated when this inadequate pool of resources was required to stretch across two sites after the opening of Unit 18.

1352 Incentives were provided to staff to come to Unit 18. The glowing comment by Ms Ginbey in the video that staff were wanting to come to Unit 18 did not mention this incentivisation.

Lack of training or induction

1353 During the first tranche of evidence, the Department's employees who worked on the floor of Unit 18 gave evidence of being deployed into Unit 18 on very short notice, to undertake work for which they had received no induction or training. That evidence was not challenged.

1354 It was Ms Ginbey's expectation that there would be some induction or training process before staff were rostered to work at Unit 18. She understands from the evidence given at the first tranche, that such induction and training did not occur. She accepted that was a very significant shortfall in how Unit 18 was operating.[1206]

Presence of prison officers

1355 Ms O'Connell agreed that by 8 July 2022, the working group was "*being told that when we open Unit 18, there will be one prison officer always there in Unit 18, and the authority to put that person there comes from Section 11E of the Young Offenders Act"*.[1207]

1356 The fact that this was known to those involved in the planning of Unit 18 by 8 July 2022 is important when considering the content of the messaging in the various letters sent by the Department and the content of what Ms Ginbey said in the video.

Nursing model and nursing staff

1357 A potential finding that may be open against the Department concerned the significant differences of the nursing model for Unit 18 compared to Banksia Hill.

1358 From the very first meeting of the working group on 6 July 2022, Mr Whittle, from the Directorate, Offender Services, which was responsible for the provision of nursing coverage, was enquiring which of two possible models would be used in Unit 18.

[1206] Ts p.2320
[1207] Ts p.1623

1359 One model was that of a clinic where nurses come to a site at a prearranged time, run a clinic and see people and then go away to return at a preordained time in the future.

1360 Another model was a stable model where the nursing service would be on site and is available 24/7.

1361 Banksia Hill provided nursing services using the 24/7 model. When Mr Whittle raised this concern at the first meeting on 6 July 2022, he was told that it was yet to be determined what model was to be used.[1208]

1362 In the following fortnight before Unit 18 was opened, the arrangements as to the provision of nursing services in Unit 18 remained very problematic. Ms Ginbey told the inquest that Mr Whittle said to her: "*That nursing coverage would be available from Health Services from 7.00 am until 7.00 pm and that after that, emergency services would have to be provided from elsewhere*".[1209] Ms Ginbey understood the effect of this was Mr Whittle was indicating that was all he could provide. Ms Ginbey told the Court she then had to accept if that was all that could be provided "*we will have to go with that and treat that as adequate*".[1210]

1363 Ms Ginbey did not think that what was being offered by way of a nursing model when Unit 18 opened was safe.[1211]

1364 Ms Ginbey thought the safest nursing model for Unit 18 when it opened should have been the provision of nursing 24/7, as was the case at Banksia Hill.[1212]

1365 Ms O'Connell agreed that her notes in the action trackers refreshed her memory that there was an issue about the provision of nursing staff.[1213] That is consistent with other information available to the Court, including the letter from the SSO to the Court dated 17 September 2024 regarding nursing services at Unit 18.[1214]

1366 Ms O'Connell believed that by 18 July 2022, she was aware the move was likely to occur on 20 July 2022.[1215]

[1208] Ts p.2417
[1209] Ts p.2419
[1210] Ts p.2420
[1211] Ts p.2420
[1212] Ts p.2420
[1213] Ts p.1623
[1214] Ts 2474
[1215] Ts p.1661

1367 As I have previously noted, on 18 July 2022, Mr Whittle was expressing a number of concerns to Ms O'Connell about starting on the planned date before Health Services were ready. One of those concerns was that he had not been able to put together a roster for nursing staff.[1216]

1368 On the following day, Ms O'Connell recorded a detailed entry documenting a variety of concerns raised by Mr Whittle on behalf of the Health Services. Those concerns included that he wanted additional office space identified for his Health Services. The response to that concern was not the identification of a particular space, rather he was told those plans, "*are being developed*".

1369 Ms Ginbey acknowledged that when Unit 18 opened, it did not have in place "*the nursing arrangements that we would have liked*".[1217] She accepted that the effect of the messaging about the nursing was that the nursing to be provided at Unit 18 was what was at Banksia Hill. In response to a question as to whether she was happy that the nursing arrangements at Unit 18 were appropriate, she answered: "*I don't know if I would use the word 'happy'. I was satisfied it was what was needed at that time*".[1218]

1370 From 20 July to 1 November 2022, the arrangement for nursing services at Unit 18 had a nurse present from 7.00 am to 7.00 pm. During this period, nursing services were provided in accordance with those hours 78% of the time, with nurses at Casuarina available, as required, for the remaining balance (22%). For four days during this period (1, 3, 6 and 9 October), there was no nurse present at Unit 18.[1219]

1371 Otherwise, outside the hours from 7.00 am to 7.00 pm, nursing services were provided, as required, by nurses at Casuarina.[1220]

Mental Health Services

1372 As noted above, the action tracker of 22 July 2022 recorded that Mental Health Services was telling Ms O'Connell on the day after Unit 18 opened that the space allocated to them was not satisfactory.

1373 Ms O'Connell's evidence below may support a finding against the Department in respect of the inaccurate messaging it was sending. The fact that this messaging involved the provision of mental health care to

[1216] Ts p.1661
[1217] Ts p.2314
[1218] Ts p.2314
[1219] Exhibit 116
[1220] Exhibit 116

detainees with severe neurodevelopmental disorders increases the gravity of such a finding should it be made:[1221]

> So, notwithstanding whatever you might have thought, do you accept that the day after Unit 18 is opened, Mental Health are saying to you, whatever you have given us is wholly unsatisfactory. It doesn't meet our needs. This is what we need. You need to go away and be able to provide it. That was essentially the message? --- Yes.
>
> And do you now accept that in terms of the Mental Health Services that were available when Unit 18 opened, they were not equal to or better than what was available at Banksia? --- Correct.
>
> And do you agree that is contrary to the messaging that was being sent out by the Department that I listed earlier this morning? --- Correct.
>
> And do you agree that what was in the messaging about Mental Health Services was untrue? --- Correct.

Visits

1374 By 8 July 2022, Mr Rule, who had been tasked with putting together the Operating Model, was telling the working group there would be 254 hours of visits available to the young people in Unit 18.[1222] Ms O'Connell said that the working group was told how visits would occur at Unit 18.[1223] Ms O'Connell agreed that the facilities for a lawyer to speak in a confidential manner with their client at Banksia Hill were much better than what existed for detainees at Unit 18.[1224]

1375 Ms O'Connell agreed that from the time of the first meeting of the working group on 6 July 2022, it was understood that any time a young person was moved out of Unit 18 they would be restrained by handcuffs.[1225]

1376 In relation to the arrangements for visits at Unit 18, Ms Ginbey initially gave evidence that the practice of restraining detainees in transit from Unit 18 to the Casuarina visits hall was a practice which developed only after there had been an attempted escape.[1226] However, after reflecting on what was in the action trackers, Ms Ginbey corrected her evidence. The evidence leaves open a finding that it had always been the intention during the planning of Unit 18, and it had been the practice since the

[1221] Ts p.1689
[1222] Ts p.1618
[1223] Ts p.1620
[1224] Ts p.1622
[1225] Ts p.1625
[1226] Ts p.2306

commencement of Unit 18, that young people would be restrained during the journey to the visits hall at Casuarina.[1227]

1377 Dr Tomison agreed that the Operating Model was never given to the Minister as part of the briefing process for the gazettal of Unit 18.[1228]

1378 The Operating Model asserted: "*The total combined in person social visit capacity on a weekly basis is 180 individual visits* ".[1229] Dr Tomison agreed that "*given the staffing levels at Unit 18, it would be impossible to have 180 individual visits, each of them for one hour*".[1230]

1379 At the inquest, Mr Collins accepted there was "*a very stark difference*" between the visiting regimes at Banksia Hill and Unit 18.[1231]

1380 The evidence from the inquest leaves open a finding that the visiting regime at Unit 18 was considerably inferior to that at Banksia Hill.

Educational facilities

1381 When Unit 18 opened, the plan was that the D-Wing would be the teaching area. That area was subsequently converted to office space for the SMT.[1232]

1382 At Banksia Hill, teaching was delivered in a dedicated building.[1233] That could not be the plan for education in Unit 18 because there was no available building which could be so dedicated.

1383 Ms O'Connell acknowledged that education facilities were not in place when Unit 18 opened:[1234]

> That might have been the aspiration. That wasn't in place when it opened? --- No, no.
>
> So, my question again is, are you telling the Court that the cells for classrooms study had been constructed by the 19th [July 2022]? --- No.
>
> So, do you agree with the proposition that education facilities were not in place in Unit 18 when it opened? --- Not to the level that was planned, no.
>
> Not to the level? --- That we had planned for.

[1227] Ts p.2429
[1228] Ts p.1131
[1229] Exhibit 61, attachment CG 18, p.17
[1230] Ts p.1138
[1231] Ts p.702
[1232] Ts p.1604
[1233] Ts p.1603
[1234] Ts p.1679

> No, but my question is, do you agree that education facilities were not in place? --- Yes.

1384 Ms O'Connell then qualified this answer:[1235]

> Because the minimum was able to be achieved, which was informed by the school principal as to what she wanted. The add-on was for the cells to be repurposed for IT. An education program could still be delivered in that Unit at that time with the facilities and of what the school principal had informed she required, which was bare minimum. This was an add-on.

1385 However, the subsequent evidence from Ms O'Connell leaves open a finding that the Department's messaging of the availability of education services when Unit 18 opened was misleading:[1236]

> So, you accept, don't you, that whatever the bare minimum was, it was not up to what was being provided at Banksia. Do you agree? --- Correct.
>
> And you know that the Department was messaging all of those people I identified earlier saying, amongst other things, that the education services to be provided would be equal to or better than what was at Banksia? --- Correct.
>
> And that messaging you accept is not true. Do you agree? --- Agreed.

Observation/safe cells

1386 Ms O'Connell indicated in her statement that it was her view that mandating the use of CCTV in each cell was not a trauma-informed practice.[1237] However, she said that at the first meeting of the working group on 6 July 2022, Ms Ginbey gave the direction that the installing of CCTV to every cell "*was essential and critical given the complexities of the cohort*".[1238]

1387 Ms O'Connell made notes in the action trackers in relation to the topic of "*safe cells*". Those notes included recording that on 8 July 2022, the Superintendent at Casuarina was expressing his concerns about the absence of safe cells in the planned move to Unit 18.[1239]

1388 On 12 July 2022, Ms O'Connell recorded that "*safe cells*" and "c*ells for classrooms/study*" were not in the initial scope.[1240] She considered this was

[1235] Ts p.1680
[1236] Ts p.1680
[1237] Exhibit 44, [95]
[1238] Ts p.1626
[1239] Ts pp.1636-1638
[1240] Exhibit 51.3, p. 4; Ts p.1642

not good enough and she said as much to Mr Budge and Ms Ginbey. They told her they were going to manage it, and the matter was taken out of her hands.[1241]

1389 Ms O'Connell said the works proposed for the observational safe cells was different to what was happening in the other cells which included the addition of cell CCTV cameras.[1242] Ms O'Connell made a note in the action tracker on 12 July 2022, "*CLOSED*" next to a series of acronyms in respect of mental health issues.[1243]

1390 Ms O'Connell had previously agreed that if there was an entry with the word "*CLOSED*" at the end of it in an action tracker, it meant nothing further needed to be done on that topic.[1244] However, she was reluctant to accept the proposition that this note was her recording that even though she may not have liked the decision, nothing further was to be done on the topic of safe cells. Her interpretation of the note was someone was telling her that they have the paperwork to explain the ARMS process but there are no safe cells.

1391 In the end, Ms O'Connell accepted that it was possible that when she raised this matter with Ms Ginbey and Mr Budge, she was told that was the end of the discussion and recorded that with the word "*CLOSED*".[1245]

1392 A possible alternative interpretation of Ms O'Connell's notes on this topic is what had been put to her during her examination by counsel assisting. On that interpretation, it means by 12 July 2022 nothing further was being done about the provision of safe cells in Unit 18. It is an undisputed fact that nothing similar to the clear covered front section of observation cells at Banksia Hill was in Unit 18 prior to Cleveland's incident. However, it is also not disputed that on 8 July 2022, it was planned that B-Wing was to be used as the "*observation cell wing*" with six cells having all fixtures and potential ligature points removed. The modifications to these cells were completed by 19 July 2022.[1246]

1393 Mr O'Siochain acknowledged that the ISU at Banksia Hill had four dedicated observation cells, and that Unit 18 has never had any such cell.[1247]The four observation cells at the ISU not only have Perspex doors

[1241] Ts pp.1644-1645
[1242] Ts p.1646
[1243] Exhibit 51.3, p.5
[1244] Ts pp.1641,1646
[1245] Ts p.1650
[1246] Exhibits 77 and 85
[1247] Ts p.2989

but they are located opposite the ISU control room so custodial officers can see directly into each cell.[1248]

1394 The Operating Model asserted young people would be managed in accordance with the ARMS Youth Manual. Dr Tomison agreed he understood that if a person was on level 1 ARMS, they required actual constant supervision in an observation cell like those in Banksia Hill. Dr Tomison agreed it was simply untrue that young people could be managed in Unit 18 in accordance with the ARMS Youth Manual when it opened.[1249]

1395 Dr Tomison agreed that "*anyone reading this document [the Operating Manual] would think that when Unit 18 receives it first young people there will be six observation cells, like the ones in Banksia Hill, sitting in B-Wing ready to be used*".[1250] In addition, he agreed that never occurred and that "*Unit 18 should never have been opened until they [the six observation cells] were there*".[1251]

1396 Dr Tomison said that CCTV cameras in cells housing detainees was not "*a fully adequate substitute*" for having safe cells.[1252]

1397 Mr Coyne agreed that during his time as Superintendent at Unit 18, there were no dedicated observation cells like the observation cells at Banksia Hill.[1253]

1398 Included in an email sent to Mr Reid, Ms O'Connell and Mr Budge on 8 July 2022, Ms Ginbey said:[1254]

> I'm still not convinced we have resolved the at-risk issue. We won't have obs as such – we can have 24/7 observation. Do we keep a young person in Unit 18 we have serious concerns re self-harm or do we transfer them back – see above, we also don't want to send a message that if you don't like it in Unit 18 [then] self-harm and you will be sent back to BH.

1399 Ms Ginbey provided a series of sworn answers to questions put by counsel for Nadene Dodd and included questions regarding the above email. Ms Ginbey explained that "*obs*" meant observation cells and that because of the location of the control room at Unit 18 and because of the absence of

[1248] Exhibit 145.2, p.14
[1249] Ts p.1139
[1250] Ts p.1128; the Operating Manual stated that there was "*allocated for observation cells (six) strategically located in B-Wing*": Exhibit 61, attachment CG 18, p.4
[1251] Ts p.1129
[1252] Ts p.1167
[1253] Ts p.1901
[1254] Exhibit 144.2, attachment M

Perspex fronted cells, the only way observations could be done to satisfy the requirements of a detainee on level 1 ARMS was for it to be done by cell CCTV cameras.[1255] As at the date of the email, it was not clear that a CCTV camera would be installed in each cell.[1256]

1400 By 19 July 2022, Ms Ginbey believed the "*at risk issue*" had been resolved because the "*young people on ARMS level 1 could be continuously monitored by the CCTV cameras in the control room*".[1257]

1401 However, it may be open to contend that the issue was unresolved if there could not be continuous monitoring by the cell CCTV cameras, as Unit 18 would not be able to provide the necessary continuous observations for those detainees on level 1 ARMS.

1402 The above extract from Ms Ginbey's email may also shed light on the Department's reluctance to return detainees to Banksia Hill who might engage in self-harm when in Unit 18 in order to have that occur. This raises the question of what was to happen to high-risk detainees at Unit 18 once cell CCTV cameras began to be continuously covered and no longer provided the "24/7 observation".

1403 There is evidence that leaves open a finding that the decision to use Unit 18 was made without any consideration as to whether the continuous observation requirements of those young persons on level 1 ARMS could be met. The confirmation that cameras could be installed in each cell was not received until 19 July 2022. And, of course, the use of cell CCTV cameras to monitor detainees in their cells soon became ineffectual.

Access to Total Offender Management System (TOMS)

1404 Another difference between Banksia Hill and Unit 18 was that Casuarina staff would have access to TOMS[1258] in respect of Unit 18 detainees.[1259] This is entirely contrary to the legislative regime governing custodial services. The youth estate is to be managed differently to the adult estate. The sharing of information in this manner is not the regime.

[1255] Exhibit 145.2, pp.13-14
[1256] Exhibit 145.2, p.14
[1257] Exhibit 145.2, p.14
[1258] The Department's computer programme that is used, relevant to this inquest, to record all information relating to young people detained in youth detention centres.
[1259] Ts p.1144

1405 It could be contended that the correct regime was altered because of the fact that part of the youth custodial estate was put into a building which was part of the adult custodial estate.

Were correct procedures followed for detainees transferred to Unit 18 on 20 July 2022?

1406 As I have previously noted, the Department established an MDT to undertake an assessment of each individual detainee being considered for transfer from Banksia Hill to Unit 18. The initial membership of the MDT comprised of 11 people and included Mr Rule and Dr Cooney.[1260]

1407 The MDT process was set out in the "Unit 18 Multi-Disciplinary Team Committee: Terms of Reference".[1261]

1408 At 1.00 pm on 13 July 2022, the MDT held its first meeting to consider those detainees to be initially transferred to Unit 18 when it opened. Ten of its 11 members attended.[1262] A document titled "Unit 18 Multi-disciplinary Meeting Initial Referral Review" (IRR) had been prepared for each detainee which was to be used by the MDT when undertaking its assessment.[1263]

1409 On the morning of 15 July 2022, Mr Rule sent an email to Ms Ginbey (and copied Mr Reid, Dr Cooney and Ms O'Connell) that contained a table of the outcomes of the assessments performed by the MDT on 13 July 2022. The email also attached the IRRs for each of the detainees assessed for a transfer to Unit 18 (the original IRRs) and the IRRs for the detainees who were not.[1264] Later that morning, Ms Ginbey emailed Ms O'Connell and said: "*We need the criteria from the YOA included please, Mel.*"[1265] Ms Ginbey advised the Court that she was referring to section 7 of the *Young Offenders Act 1994* (WA).[1266] Section 7 is headed: "*General principles of juvenile justice*".

1410 On the evening of Friday, 15 July 2022, Ms Ginbey forwarded an email to Ms O'Connell which said:[1267]

> The assessments performed by the MDT are missing the criteria we developed - this isn't optional - can you please work with

[1260] Exhibit 144.2, attachment I
[1261] Exhibit 41
[1262] Exhibit 144.2, attachment I (Colin Muijs was an apology)
[1263] Exhibit 144.2, attachment I
[1264] Exhibit 144.2, attachment I
[1265] Exhibit 144.2, attachment H
[1266] Exhibit 145.2, p.11
[1267] Exhibit 144.2, attachment J

> Chris/Angela/Colin[1268] **to retrofit it into the template they seem to have gone with**. I'll send them to you.
> (emphasis added).

1411 Ms O'Connell responded that she will do that, noting: "*They can NOT overlook the process as it is or the criteria.*" This email was sent late in the afternoon of Sunday, 17 July 2022. Ms Ginbey responded: "*Not optional and has to be fixed asap*".[1269]

1412 At 6.16 pm[1270] on 18 July 2022, Ms O'Connell sent an email to three members of the MDT[1271] and copied Ms Ginbey and Mr Reid (the Superintendent of Banksia Hill). The email attached the first "*reworked*" IRR for one of the detainees to be transferred to Unit 18 "*to align*" with the *Young Offenders Act 1994* (WA) and asked that it be reviewed.[1272]

1413 In the email, Ms O'Connell described the reworking of the IRR as a "*lengthy process, however does aid defensive decision making for Wade [Reid]*". She said the information in the reworked IRR had been "*adapted from the minutes*[1273] *sent through and updated following information from TOMS.*" Ms O'Connell also advised Mr Reid: "*I have added into your recommendation so please review. These will need to be all signed by you and scanned into Content Manager (when we get to it)*".[1274]

1414 At 8.25 am on 19 July 2022, Mr Reid emailed Ms O'Connell: "*That's a good level of detail. Acknowledged.*"[1275]

1415 In June 2025, Ms O'Connell apparently recalled listening to an audio recording of the MDT meeting when reworking this IRR and added details from that into the reworked IRR. She also confirmed adding information from TOMS and, in addition, information from the Incident and Occurrences report for the detainee. In addition, Ms O'Connell could not recall reworking any other IRR for the other detainees transferred to Unit 18.[1276]

[1268] Christopher Rule, Dr Angela Cooney and Colin Muijs
[1269] Exhibit 144.2, attachment J
[1270] Although this email has a time stamp of 10:16:09, the Court was advised by the SSO that a number of emails have the Greenwich Mean Time which was, at the relevant time, eight hours behind WAST.
[1271] Ms Carson, Mr Rule and Dr Cooney
[1272] Exhibit 144.2, attachment K
[1273] Ms Ginbey and Ms O'Connell referred to the IRRs as "*minutes*" in their correspondence: Exhibit 145.2a, p.1
[1274] Exhibit 144.2, attachment K
[1275] Exhibit 145.2, attachment CG 173, p.40
[1276] Supplementary written submissions filed on behalf of Ms Ginbey on 27 June 2025

1416 The reworked IRRs for another 15 detainees initially transferred to Unit 18 were completed during the course of the afternoon and evening of 19 July 2022 (the day before the transfers to Unit 18 took place).[1277] The 17th detainee transferred on 20 July 2022 (TW) did not have an IRR prepared for the MDT meeting on 13 July 2022.[1278]

1417 From the information available to the Court, it is open to conclude that these 15 reworked IRRs were completed by Dr Cooney, Ms Carson and/or Ms Sarah Malcolm.[1279] Of these three, only Dr Cooney and Ms Carson (Manager, Case Planning and Programs Unit, Banksia Hill) were members of the MDT.

1418 Given the above timeline, the 16 reworked IRRs could not have been considered by any member of the MDT before the evening of 18 July 2022. The Court was not provided with any information from the Department or a witness from the Department to indicate that the MDT met after the IRRs had been reworked or that every member of the MDT received copies of the reworked IRRs before 20 July 2022.

1419 Yet the final sentence in the box titled "Superintendent Recommendation" on each of the reworked IRRs states:[1280]

> As the Superintendent, I have considered the information outlined in the referral and MDT discussion and based my assessment on such, and in deliberation of the principles of the *Young Offenders Act 1994.*
> (underlining added)

1420 A signature block was below this concluding sentence and read:

> Wade Reid
> Superintendent BHDC
> **15th July 2022**
> (emphasis added)

1421 It is open to conclude Mr Reid signed each of these IRRs in accordance with Ms O'Connell's instructions in her email dated 18 July 2022. The Court only has a copy of one of these IRRS where a signature appears alongside Mr Reid's signature block with the date of 15 July 2022.[1281]

1422 It is open to find that non-members of the MDT were involved in one or more of the reworkings of the original IRRs. It is also open to find that the

[1277] Exhibit 145.2a
[1278] Exhibit 145.2a, p.2 (affidavit of Ms Ginbey dated 27 May 2025)
[1279] Exhibit 145.2a, p.3 (affidavit of Ms Ginbey dated 27 May 2025)
[1280] Exhibit 145.2a, attached IRRs, pp.9-157
[1281] Exhibit 145.2a, attached IRRs, p.151

reworked IRRs never went back to the MDT for its consideration at a group meeting.

1423 The Court was not able to ascertain precisely when Mr Reid made his recommendations based on the reworked IRRs. However, it could not have been on the date specified in his signature block (15 July 2022).

1424 It could be contended that the reworked IRRs appear on their face to be a record of the MDT meeting at 1.00 pm on 13 July 2022 (as detailed on the first page of each of them) and do not disclose that they were reworked or identify the information that was added when they were reworked.

1425 It is understandable why Ms O'Connell said that the reworking of the IRRs was a "*lengthy process*". A comparison between the material contained in the some of the original IRRs[1282] and their reworked IRRs[1283] corroborate that account. Significantly, it would appear the contents of the original IRRs indicated that the 10 MDT members who attended the meeting on 13 July 2022 did not consider the criteria from section 7 of the *Young Offenders Act 1994* (WA) and therefore did not comply with what was set out in the "Unit 18 Multi-Disciplinary Team Committee: Terms of Reference".

1426 It is also open to argue that the reworked IRRs may have contained information which was not available at the time of the MDT meeting on 13 July 2022, and could therefore not have been part of the decision-making process on that day. Yet such information is recorded in the reworked IRRs as purporting to document that decision-making process.

1427 As outlined above, Ms Ginbey was very much aware that the IRRs had been reworked after the MDT meeting on 13 July 2022 as she was the person who told Ms O'Connell of the need to "*retrofit*" the template of the original IRRs.[1284]

1428 On 21 July 2022, Ms Ginbey sent an email to Dr Tomson which stated: "*As discussed, please see attached the Unit 18 assessment process and a completed example.*"[1285] What was attached was the first reworked IRR that was completed on 18 July 2022. As noted above, it was signed by Mr Reid with the date, 15 July 2022. The email did not disclose the circumstances

[1282] Exhibit 144.2, attachment I, attached IRRs
[1283] Exhibit 145.2a, attached IRRs at pp.9-157
[1284] Exhibit 144.2, attachment J
[1285] Exhibit 144.2, attachment L

surrounding either this reworked IRR or any of the subsequent 15 IRRs that were reworked after 18 July 2022.

1429 By affidavit, Ms Ginbey denied she intended to have Dr Tomison believe the attached IRR, "*was a document issued or approved by the Unit 18 multi-disciplinary team, was a true record of what the meeting considered on 13 July 2022 and that it was an 'example' of what existed with respect to other 'initial referral reviews' carried out that day.*"[1286] It may be open to contend a reading of Ms Ginbey's email may suggest otherwise when regard is had to the following.

1430 Prior to the above material coming to the Court's attention, Dr Tomison was asked by the Court to "*particularise the method and criteria by which children were assessed as being within the 'cohort of high-risk detainees' that required transfer out of BHDC [on 20 July 2022]*". Dr Tomison responded:[1287]

> The first detainees to be transferred were selected following a multi-disciplinary team (MDT) meeting on 13 July 2022. The MDT considered a total of 25 detainees who has been identified, and referred by BHDC security, as high-risk due to their ongoing involvement in incidents which posed a threat to the safety and security of the site, staff and other detainees. In attendance was:
>
> [Dr Tomison then identifies the titles of the 10 MDT members in attendance]
>
> Each young person referred to the MDT was considered on their individual risks and needs, and information was provided by the respective multi-disciplinary areas to the Superintendent.
>
> The Superintendent considered each of the referrals and the recommendations made by the MDT and decided which detainees would be transferred to Unit 18.

1431 This outline from Dr Tomison provides no details regarding the reworked IRRs. This may indicate he was not aware of them.

1432 It is also open to contend that a briefing note to the Minister that Ms Ginbey amended and approved on 20 July 2022 may not have been entirely fulsome.[1288] The purpose of this briefing note was to advise the Minister of: "*The first transfer of detainees from Banksia Hill Detention Centre to the*

[1286] Exhibit 145.2, p.13
[1287] Exhibit 1, Volume 6.1, Tab 6.1, pp.32-33
[1288] This briefing note is not to be confused with the Briefing Note to the Minister dated 12 July 2022.

temporary Youth Detention Centre (Unit 18) at Casuarina."[1289] Under the heading of "Assessment of suitability", the briefing note stated:[1290]

> An assessment process was developed in line with the objectives and principles of the *Young Offenders Act 1994* and applied to a number of high-risk young people at Banksia Hill.
>
> The assessment of each young person was undertaken by a multi-disciplinary team including; two assistant superintendents, two deputy superintendents, health services, mental health services, psychological services, Aboriginal welfare officer, case planning and security. A recommendation was made to the Superintendent for each young person for his decision.

1433 It could be contended that Ms Ginbey knew the "assessment process" was not developed in line with the *Young Offenders Act 1994* (WA) by the people identified in the briefing note. That is because she had identified on 15 July 2022 that the assessment process undertaken by the MDT on 13 July 2022, which relied on the material in the original IRRs, had failed to address the objectives and principles in section 7 of that Act (necessitating the urgent preparation of the reworked IRRs).

1434 Support for this contention may be found when analysing one of Ms Ginbey's sworn answers in her affidavit to the Court dated 27 May 2025 (the second affidavit).[1291] For context, one answer in Ms Ginbey's affidavit to the Court dated 7 February 2025 (the first affidavit)[1292] must also be considered.

1435 When answering questions from counsel for Nadene Dodd regarding her email to Dr Tomison on 21 July 2022, Ms Ginbey asserted in her first affidavit that the attached reworked IRR to that email, "*was a 'completed example' as all the MDT assessments considered by the MDT had been varied by the MDT and approved by Superintendent Reid by 21 July 2022*." (underlining added)[1293]

1436 This would appear to be consistent with the contents of the briefing note cited above if that was Ms Ginbey's state of mind at the relevant time. However, leave was granted to counsel for Nadene Dodd to further question Ms Ginbey and her answers to these questions were in the second affidavit.

[1289] Exhibit 91, CG 85, p.422
[1290] Exhibit 91, CG 85, p.422
[1291] Exhibit 145.2a
[1292] Exhibit 145.2
[1293] Exhibit 145.2, p.13

1437 Noting that Ms O'Connell's email dated 18 July 2022[1294] was only addressed to three of the 10 MDT members who attended the meeting on 13 July 2022, counsel for Nadene Dodd asked Ms Ginbey: "*On what basis do you say that 'all the MDT assessments considered by the MDT had been varied by the MDT'?*".[1295] The relevant part of Ms Ginbey's response was:[1296]

> It was my understanding that the assessments had been considered by the MDT and varied by it because at the time, I understood that Dr Cooney was the Chair of the MDT and I knew (from the matters set out above) that Dr Cooney was working on the revised IRRs and I was told by Ms O'Connell that Superintendent Reid signed the IRRs. To the best of my recollection, Ms O'Connell told me this on or before 20 July 2022.
> …
> I do not have any knowledge of which of the other members of the MDT (if any) were consulted or considered the revised IRRs.
> (underlining added)

1438 The information before the Court is that aside from Dr Cooney, Mr Rule and Ms Carson, no other MDT members were (i) aware of, (ii) involved in the reworking of the original IRRs, or (iii) received the reworked IRRs. The Court has not been provided with any information that the MDT met to consider the reworked IRRs after 13 July 2022.

1439 It could therefore be contended it is not surprising Ms Ginbey has no knowledge that other members of the MDT "*were consulted or considered the revised IRRs*". Which may give rise to the question why she asserted the involvement of all the MDT members she identified in the briefing note and why she said the reworked IRRs had been varied by the MDT in her first affidavit. It may be open to consider that Ms Ginbey would appreciate that a body (comprising of 11 members) performing a task is not the same as three members of that body performing the same task.

1440 The Department accepted that on the basis of Ms Ginbey's affidavit evidence and the documents, it was open to make the following findings:[1297]

a. the "minutes" or the "initial referral review" document, of the MDT meeting were added to after the initial meeting of the MDT on 15 [sic-13] July 2022;

[1294] Exhibit 144.2, attachment K
[1295] Exhibit 145.2a, p.4
[1296] Exhibit 145.2a, pp.4-5
[1297] Written closing submissions from the Department dated 16 June 2025, [193]

b. the reworked IRRs objectively give the impression that they are the meeting of the MDT that it refers to;

c. the reworked IRRs include some information that the MDT Committee could not have considered at the MDT meeting, as it postdates the meeting;

d. the reworked IRRs do not disclose that they were reworked and that some of the information was compiled after the MDT meeting;

e. the final versions of the reworked IRRs signed by Mr Reid are identical to those attached to the various emails of Dr Cooney, Ms O'Connell, Ms Malcolm and Ms Carson;

f. seven of the reworked IRRs were prepared by Ms O'Connell and Ms Malcolm who were not members of the MDT;

g. Ms O'Connell did not send the reworked IRRs of [two detainees are named] to Dr Cooney by email for her review; and

h. the final versions of the reworked IRRs signed by Mr Reid bear the date of 15 July 2022, but must have been signed at a later date, no later than 20 or 21 July 2022.

The transfer of detainees to Unit 18 on 20 July 2022 did not change their behaviour

1441 Dr Tomison agreed with this proposition:

> So, what's happening is Banksia is identifying a group of people that it wants offsite because of their behaviour and this group is being told: "You go to Unit 18, and you can't contemplate coming back to Banksia until your behaviour changes".[1298]

1442 Ms Ginbey accepted, in hindsight, that it was "*somewhat misguided*" to have an expectation that the behaviour of the young people would change simply by being moved from Banksia Hill to Unit 18.[1299] She also acknowledged these detainees were given no preparation for this move.[1300]

My recommendation

1443 I confirm that I am satisfied it was appropriate and within the Court's power to investigate the matters as outlined above in this section in order to determine how Unit 18 came to be in the state it was in during Cleveland's last period of detention there. It also fell within the reasons stated by the State Coroner for the inquest's priority listing.

[1298] Ts p.1260
[1299] Ts p.2332
[1300] Ts p.2332

1444 The manner in which Unit 18 was operating during his last period of detention was clearly connected to Cleveland's death.

1445 Consequently, I am also satisfied that the manner in which Unit 18 was established was a matter connected to Cleveland's death and therefore fell within section 25(2) of the Act. My reasoning is as follows.

1446 Despite what it had submitted during the inquest, by the completion of the inquest, the Department accepted that information received about matters after the death an inquest is investigating "*can inform whether or not to make a recommendation*", adding that the Court "*simply can't make an adverse finding or a finding about it*".[1301] This submission aligned with the written closing submissions from the Department.[1302]

1447 A logical extension of the Department's submission with respect to information received regarding matters after the death, is that matters before the death can also be investigated so as to inform the Court whether or not to make a recommendation; provided those matters are "*connected with the death.*"[1303] Given that section 25(2) of the Act states that "*a coroner may comment on any matter*" (underlining added) connected with the death, I am satisfied that a broad interpretation can apply to these matters. This is consistent with the broad construction that Buss JA applied to the provisions of section 25(1) of the Act that I have cited earlier in this finding.[1304]

1448 That interpretation is consistent with the recommendations made by the Court, without challenge, since the introduction of the Act nearly 30 years ago. Many of those recommendations made in inquests and numbering in their hundreds demonstrate a very broad interpretation by the Court of its powers to make comments and recommendations pursuant to section 25(2) of the Act.

1449 Accordingly, I am satisfied that it was appropriate and within the Court's power to examine how and why Unit 18 came to be established in order to not only (i) determine why it was operating in the manner it was during Cleveland's last period of detention and (ii) to assist in my findings as to the standard of Cleveland's supervision, treatment and care, but also to

[1301] Ts p.4439
[1302] Written closing submissions from the Department dated 6 May 2025, [9]
[1303] *Coroners Act 1996* (WA) s 25(2)
[1304] ***Re State Coroner; Ex parte Minister for Health*** (2009) 38 WAR 553, 565-566; [2009] WASCA 165 [42]-[47]

determine the utility in making any recommendations in discharging my functions under section 25(2) of the Act.

1450 It may be open to find that there was a lack of resolve from the Department to implement in a timely manner, a contingency plan for a second youth detention centre (referred to as "Plan B" in the inquest and this finding). No witness from the Department's executive took issue with the proposition that when it was eventually realised a second youth detention centre was necessary, the Department was bereft of viable and suitable ready-made options. Nor was any issue taken that Unit 18 was the best of a very impractical list of options. Because of the low bar the other options presented, it may be open to conclude that describing Unit 18 as "the best" is disingenuous and that it ought to be described as "*the least-worst option*".[1305]

1451 An argument could be made that it was never going to be possible to transition a unit within an adult male prison into a rehabilitative, trauma-informed and culturally appropriate youth detention centre; no matter how much time was devoted to implement that transition. Of course, as the inquest heard, the Department's Women and Young People's Directorate effectively had nine days.

1452 A strong contention can also be made that Mr Torrijos was correct when he said Unit 18 was "*set up to fail*". In that regard, I note that later in the inquest, Mr M Reynolds reached exactly the same conclusion when he said that he thought, "*Unit 18 was destined to fail.*"[1306] The hasty manner in which Unit 18 was set up as a youth detention centre, the inadequate infrastructure of the unit to function as a stand-alone youth detention centre and the insufficient number of custodial and non-custodial staff working at Unit 18 may provide plausible explanations for these comments.

1453 It is arguable to contend that the Department was prepared to paper over the figurative cracks that began to emerge as it prepared to open Unit 18. It may be open to find that this approach to tolerate Unit 18's obvious shortfalls was taken as it was only meant to be a temporary youth detention centre for approximately 12 months.

1454 It is also open to find that the shortcomings of Unit 18 were evident from the very first day it opened and that those shortcomings were never

[1305] Exhibit 20, p.21
[1306] Ts p.1812

rectified, and had gotten worse by the time of Cleveland's final period of detention.

1455 I have reached the view that the manner in which Unit 18 came to be the State's second youth detention centre is worthy of a further inquiry. I have determined that the documents the Court received and the oral evidence it heard at the inquest regarding what I have outlined above in this section, warrants an investigation by a body with the power to make findings. There is a basis to contend that not only were there shortcomings and mistakes made in the establishment of Unit 18 as a second youth detention centre in 2022, but that those shortcomings were not disclosed to the Minister and the community, and that the mistakes were as profound as they were avoidable.

1456 I stress that my view of the need for this further inquiry was not motivated by the concessions made by Dr Tomison (including his agreement that the Briefing Note contained "*blatant lies*" and that Unit 18 was established "*based on a series of grievous lies*"[1307]). I accept it is open to contend that some of these concessions were made with the benefit of hindsight. However, I am firmly of the view that there remains a basis for a further inquiry, even in the absence of deliberate lies, if inadequate consideration was given by the Department to (i) the planning of Unit 18, (ii) the accuracy of information disseminated about Unit 18, and (iii) ensuring Unit 18 could safely care and provide treatment for detainees before it opened.

1457 I am not satisfied that a Royal Commission is the appropriate body to hold such an inquiry. Instead, my firm view is that the matter can be dealt with appropriately under the provisions of the *Public Sector Management Act 1994* (WA). This Act provides three means by which the operations of a public sector body (which the Department is) can be reviewed or investigated.

1458 The first is that the Public Sector Commissioner may, either on their own initiative or by written notice from the Minister for Public Sector Management, "*conduct a review in respect of part or all of the functions, management or operations of one or more public sector bodies.*"[1308] However, I am of the view that the magnitude and importance of the investigation I am proposing warrants the use of the second means i.e. a special inquiry.

[1307] Ts p.1155
[1308] *Public Sector Management Act 1994* (WA) s 24B (1)(2)

1459 Section 24H of the *Public Sector Management Act 1994* (WA) provides:

> (1) The Commissioner may on his or her own initiative -
>
> (a) arrange for the holding of a special inquiry into a matter related to the Public Sector;[1309] and
>
> (b) appoint a person or persons to carry out the special inquiry.
>
> (2) The Minister may direct the Commissioner to arrange for the holding of a special inquiry into a matter related to the Public Sector.
>
> (3) A direction given under subsection (2) must specify the matter to be the subject of the special inquiry.

1460 A special inquirer has broad powers. These include entering the premises of a public sector body, requiring a person to produce any document in their possession or under their control, inspecting any document produced and retaining it for a reasonable period and making copies of it, and summonsing witnesses to attend the special inquiry.[1310]

1461 Notwithstanding these broad powers, in this instance a special inquirer would have the benefit of the Court having already collected a vast amount of material that would be relevant to the special inquiry as well as access to the transcript of the examinations of relevant witnesses.

1462 For completeness, the final means by which an investigation may occur is through section 24(1) of the *Public Sector Management Act 1994* (WA) which confers all the powers of a special inquirer on the Public Sector Commissioner (or a person authorised by the Public Sector Commissioner) to "*investigate the activities of any public sector body*" for the purpose of performing the Public Sector Commissioner's functions. Again, for the reasons I stated above, the scope of the investigation would most likely preclude the Public Sector Commissioner from undertaking such an investigation given the many other functions the Public Secor Commission performs.

1463 There is a very recent precedent for a special inquiry under section 24H of the *Public Sector Management Act 1994* (WA). On 2 April 2025, it was announced by the State Government that a special inquiry would be conducted into concerns raised by voters, candidates and politicians about the staffing and management of polling booths for the State Election held on 8 March 2025. The Hon. Malcolm McCusker AC CVO KC was

[1309] The Public Sector is defined as including the Department: *Public Sector Management Act 1994* (WA) s 3(1)
[1310] *Public Sector Management Act 1994* (WA) s 24I, Schedule 3

appointed to carry out the special inquiry, and its report was tabled in the Western Australian Parliament on 12 August 2025.[1311]

1464 Also, in November 2011, the Hon. Peter Blaxell, a former Supreme Court judge, was appointed to conduct a special inquiry under section 24H of the *Public Sector Management Act 1994* (WA). That involved the response of government agencies and officials to allegations of sexual abuse. The subsequent report, "St Andrew's Hostel Katanning: How the System and Society failed our Children" was tabled in the Western Australian Parliament on 19 September 2012. As that report stated:[1312]

> The role of any Inquiry under s.24H(2) of the PSM Act[1313] is to promote the efficiency and/or effectiveness of the Public Sector by identifying any failure by public officials to meet proper standards, and recommending any improvements to the way in which they conduct official business in the future.

1465 The Department accepted the general proposition that subject to the recommendation being related to the death the Court is investigating, "*it is possible for a Coroner to recommend that consideration be given to the appointment of a special inquirer under s 24H of the [Public Sector Management Act 1994 (WA)]*."[1314] However, it is clear the Department does not accept that the manner in which Unit 18 came to be a youth detention centre was a "*matter connected with*" Cleveland's death. It therefore submitted that with respect to how Unit 18 came to be a youth detention centre, the Court was precluded from making a recommendation under section 25(2) of the Act.

1466 For the reasons I have already outlined above, I do not accept the narrow interpretation to section 25(2) of the Act that the Department has submitted I should apply.

[1311] https://www.gov.au/organisation/public-sector-commission/special-inquiry-the-planning-and-delivery-of-the-2025-wa-state-election
[1312] "St Andrew's Hostel Katanning: How the System and Society failed our Children", p.3
[1313] *Public Sector Management Act 1994* (WA)
[1314] Ts pp.4464-4465; email from the SSO to the Court dated 1 July 2025

1467 Accordingly, I make the following recommendation:

> ***Recommendation No.16***
>
> **Pursuant to section 24H of the *Public Sector Management Act 1994* (WA), a special inquiry be held to investigate the manner in which Unit 18 came to be Western Australia's second youth detention centre.**

1468 Areas that I would anticipate a special inquirer could investigate and make findings include:

(a) The response by the Department to concerns about youth justice expressed by the OICS in the years before the opening of Unit 18;

(b) The Department's response to the OICS's Show Cause Notice issued in December 2021 with respect to Banksia Hill;

(c) The issues experienced in Banksia Hill in 2022 prior to the establishment of Unit 18;

(d) The accuracy of the messaging from the Department about the opening of Unit 18; and

(e) Whether Unit 18 was opened as a youth detention centre before it was safe to do so.

1469 If there was one particular matter that should concern government the most, it is this: there was information before the Court which left open a potential finding that the Minister may have been misled by the Department as to how Unit 18 would operate and, if so, whether it was done to ensure the Minister gazetted Unit 18 to become a youth detention centre as a matter of urgency. That should be of considerable concern to government as it expects the public sector to always provide it with fearless, accurate and fulsome advice.

1470 It should also be very concerning for government that not only stakeholders and detainees who were initially sent to Unit 18 and their families, but the Western Australian community at large, may have also been misled by the Department as to how Unit 18 would operate.

1471 Whether or not he agreed with the benefit of hindsight, alarm bells may well be ringing when the Director General at the relevant time agreed with

the proposition, "*that Unit 18 was established in July 2022 based on a series of grievous lies.*"[1315]

1472 I would invite the Minister for Public Sector Management to use his powers under section 24H(2) of the *Public Sector Management Act 1994* (WA) to direct the Public Sector Commissioner to hold this special inquiry. The current Minister for Public Sector Management is the Premier of Western Australia, the Hon. Roger Cook MLA.[1316]

RECOMMENDATIONS REGARDING THE FUTURE OF UNIT 18

Introduction

1473 The future of Unit 18 involves the consideration of many issues, including:

(a) Is Unit 18 currently fit for purpose?

(b) How is it being operated?

(c) If it is not fit for purpose, what should be done about it?

(d) Are the inherent physical limitations of Unit 18 insurmountable?

(e) When should Unit 18 be closed?

1474 In response to that last question, Ms Ginbey noted at the inquest that this was a decision for government. However, she accepted it was "*very undesirable that Unit 18 is in existence*"[1317] and that: "*No one wants Unit 18 in operation. We don't want Unit 18 in operation*".[1318]

1475 Mr Idowu, the Assistant Superintendent, Security at Unit 18, has some tertiary qualifications in Justice Studies and has been taught about trauma-informed care. He said he had not felt personally good about the use of Unit 18.[1319] And when I asked him how he felt about Unit 18 remaining as a youth detention centre for possibly another five years,[1320] part of Mr Idowu's response was: [1321]

> Unfortunately, Unit 18 is not a perfect place; I do agree with that. I do agree with that. I do agree there should be a place where we have access to resources needed to support those young people. But at this stage, it sounds personally to me like a necessary evil, if you want to put that way,

[1315] Ts p.1155
[1316] https://www.wa.gov.au/government/premier-and-cabinet-ministers/roger-cook
[1317] Ts p.2323
[1318] Ts p.2324
[1319] Ts p.3363
[1320] As at 8 October 2024.
[1321] Ts p.3364

> in terms of, yes, it's not the best place but it is where we have at this point in time to support Banksia to function as a facility.

1476 Mr O'Siochain, who was the Acting Superintendent at Unit 18 when he gave evidence, considered Unit 18 should remain open until "*an adequate facility is available*".[1322] He maintained that view even if there were no detainees in Unit 18.[1323]

Conflicting evidence from the Department regarding the closure of Unit 18

1477 When she gave evidence at the inquest on 9 August 2024, Ms Ginbey said that one of the main issues around the closing of Unit 18 was getting the Jasper Unit at Banksia Hill open again, and she understood every effort was being made to accelerate completion of the works being undertaken at that unit.[1324] When asked to identify a date when she thought Unit 18 could close, Ms Ginbey told the inquest she thought it could be by the end of 2024.[1325]

1478 One week earlier, on 2 August 2024, Mr Coyne told the inquest that working out how Unit 18 could be closed as quickly as possible was the most important job on his desk.[1326] Like Ms Ginbey, he said the closing of Unit 18 depended on the infrastructure repairs being completed at Banksia Hill.[1327]

1479 Mr Coyne also thought the reopening of Jasper Unit would be critical to the closure of Unit 18. Towards the conclusion of his evidence, Mr Coyne was asked to gather some information for the Court about the current situation in respect of Jasper Unit. Although he was unable to return to Court to give that evidence, Mr Coyne prepared a very useful report that provided information as to how Banksia Hill could be used to house detainees from Unit 18 once the repairs had been completed at Banksia Hill.[1328]

1480 I was reassured when I heard this evidence from Ms Ginbey and Mr Coyne. The Court was being told by two members of the Department's senior executive that a potential date for the closure of Unit 18 was only a matter of months away as at August 2024. However, my optimism was short-lived

[1322] Ts p.2994
[1323] Ts p.2997
[1324] Ts p.2327
[1325] Ts p.2329
[1326] Ts p.1890
[1327] Ts pp.1883-1884
[1328] Exhibit 97

by the subsequent evidence of two witnesses at the inquest who hold higher positions within the Department's senior echelons.

1481 Contrary to what Ms Ginbey and Mr Coyne had told the inquest, when Mr Royce was asked by counsel assisting on 14 August 2024 what has to happen at Banksia Hill so that all detainees could be safely managed there, he answered: "*I need a second facility*", and agreed that it had to be "*brand spanking new*".[1329] In answering questions from me, Mr Royce confirmed that his advice to the State Government was that Unit 18 must remain available for detainees until such time as the new youth detention centre was built and opened.[1330]

1482 Ms Maj agreed with Mr Royce that until the new youth detention centre was "*up and running*", Unit 18 had to stay open.[1331]

1483 As to this contradictory evidence, either there was (i) a major communication breakdown between Ms Ginbey and Mr Coyne on one hand, and Ms Maj and Mr Royce on the other or (ii) the Department completely altered its position regarding the future of Unit 18 from when Ms Ginbey gave her account on 9 August 2024 and five days later when Mr Royce testified. Either explanation is a cause for some disquiet.

The purpose of the yet-to-be built youth detention centre

1484 Mr Royce told the inquest that Unit 18 was presently being used by the Department:[1332]

> To manage individual detainees that I can't manage at Banksia Hill safely and securely, which then allows me to run Banksia Hill the way it has been running, with significant programs, out of hours. We are getting the works done, all the things that don't happen when I go into security modes at Banksia Hill regularly.

1485 Like the current use of Unit 18, Mr Royce said the detainees who would be housed in the new youth detention centre would be those who required "*a higher security facility*", with "*more treatment options*" than what was presently available.[1333] He also said his expectation of the new facility was that it is not going to look anything like Unit 18.[1334]

[1329] Ts p.2638
[1330] Ts p.2660
[1331] Ts p,2696
[1332] Ts p.2638
[1333] Ts p.2639
[1334] Ts p.2678

1486 Acknowledging that the new youth detention centre will not look anything like Unit 18 rather underscores the extent of the shortcomings with the current arrangement at Unit 18.

1487 Mr Royce said the new facility would be more therapeutic than Unit 18, describing what it would seek to achieve:[1335]

> When I do a new facility, my aim is to make it more internalised [than Unit 18] so that it can operate itself. So, I would like more opportunities for treatment on site, things like that. Because we know - we know that the critical issues with these young people, over a 24-hour period, go from everything from, you know, self-harm through to medical needs. We're on and off site. These things all increase the risk for everybody – the safety of everybody. So, if we have an opportunity to build something for the State of Western Australian that is going to see us into the future, that we won't end up losing a facility again, it needs to be highly secured. It needs to be purpose-built. It needs to embrace technology – best designs from other people. We need to put some effort into it.

1488 Mr Royce was not telling me things about Unit 18 that I did not already know; namely, it was not a building that could operate by itself, it did not have all the necessary treatments and services on site, and the fact that some services and treatments were off-site increased the risk of harm to both staff and detainees.

1489 Whether or not it is necessary to have a new second detention centre built before Unit 18 ceases operation is a matter of contention. However, one matter appears certain: Mr Royce's description of his vision of the new youth detention centre and what it should be and contain, only highlights the inadequacies of what was provided by the Department for Cleveland and his fellow detainees during his last period of detention.

1490 Mr Royce was reluctant to estimate how long it would take before the new facility was operational, but he hoped it would not take anywhere near five years, but he knew it would take more than two years.[1336]

Improvements to Unit 18 since Cleveland's death

1491 The inquest heard that additional resources had been put into Unit 18 since Cleveland's death. As Dr Tomison stated: "*There was clearly a lot of focus on improving things given that Cleveland's death was so tragic*".[1337]

[1335] Ts pp.2639-2640
[1336] Ts pp.2644-2645
[1337] Ts p.1269

1492 Although that evidence was very positive, it was regrettable Dr Tomison agreed that one of the major reasons for this additional resourcing was because of the critical scrutiny being applied to Unit 18 and the Department by the media and members of the public in the aftermath of Cleveland's death.[1338]

Approach to cell CCTV cameras being covered

1493 As already outlined above, the problem with the covering of cell CCTV cameras was largely resolved within a relatively short space of time after Cleveland's incident.

1494 This is yet another example of the Department being reactive, rather than proactive, in changing practices that should not be dependent on a catastrophic event taking place. Sadly, coroners are only too familiar with organisations being reactive to major events before implementing meaningful and effective change. Sometimes, those events may not be predicted or predictable and a plausible explanation for not making those changes before the event can be made. The Department cannot avail itself of such an explanation for the changes it introduced following Cleveland's incident regarding the problem with cell CCTV cameras being covered.

The commencement of Aboriginal Service Officers visiting Unit 18

1495 Mr Coyne accepted that Aboriginal Services Officers (ASO) did not attend Unit 18 before Cleveland's death. This evidence was supported by Dr Cooney who said that although ASOs commenced at Unit 18 on 9 October 2023, they did not start attending Unit 18 until 20 October 2023.[1339]

1496 Mr Coyne accepted that the reason they commenced the day after Cleveland's death was because of the death.[1340] He agreed it was no coincidence, and that bringing them in so quickly after Cleveland's death was "*an acknowledgment that the absence of ASOs in Unit 18 to that date was entirely unacceptable*."[1341]

The preparation of handbooks for Unit Managers, Senior Officers and Control Officers

[1338] Ts p.1269
[1339] Dr Cooney's report stated that rotational visits commenced on 20 October 2023: Exhibit 23, p.25
[1340] Ts p.2011
[1341] Ts p.2012

1497 Mr Coyne agreed that the creation of handbooks specific to Unit 18 for the positions of Senior Officer, Unit Manger and Control Officer did not commence until after Cleveland's death. They were only made available to staff for the first time on the last day of the first tranche of evidence in April 2024. That was nearly two years after Unit 18 opened.[1342]

1498 The Department is document heavy; it has many policies, procedures and prescriptive directions as to how its facilities are to operate.

1499 The fact that Unit 18 was operational for such a lengthy period without written instructions for these key positions may be seen as an example of whether the Department's approach to the proper management of Unit 18 was appropriate. Similarly, there was information before the Court that indicated the Department's written training materials at the Corrective Services Academy largely ignored the existence of Unit 18.

1500 Given it was always known Unit 18 would house some of the State's most vulnerable detainees, it is arguable that this was a most unsatisfactory state of affairs

The placement of larger viewing windows in the doors of a cell in C-Wing

1501 By July 2024, one of the cells in C-Wing had a much larger viewing window in its door measuring approximately 50 cm x 50 cm.[1343] The impetus for this change was because Mr Coyne had sat through the first tranche of the inquest and had heard the evidence and my comments about how unsatisfactory the arrangement was regarding the reliance on cell CCTV cameras and personal checks for continuous observations of detainees deemed at high-risk.[1344] As at July 2024, there was also a new hatch design for cell doors being trialled.

1502 In January 2025, further improvements were made to cell doors at Unit 18, with eight doors being installed (four in B-Wing, and two each in A-Wing and C-Wing) with two large viewing panels for each door.[1345]

Increase in custodial staffing numbers

[1342] Ts pp.2007-2008
[1343] Exhibit 57, attachment 2
[1344] Ts pp.3354-3355
[1345] Exhibit 146 with attached photograph

1503 The Court was told that staffing shortages have been addressed since Cleveland's death. As recently as November 2024, the Department's response to the OCIS Report dated November 2024[1346] stated:[1347]

> The Department is recruiting, training and retaining staff at higher levels than previously, with more than 100 additional Youth Custodial Officers (YCOs) to be appointed in the 2024 calendar year and attrition rates have declined to less than 2% in recent months.

1504 The inquest also heard oral evidence of the attempts to improve the staffing situation.

1505 The safe operation of Unit 18 requires a significant number of custodial staff that far outweighs the ratio of custodial staff to detainees at Banksia Hill.

1506 Mr Idowu described the usual staffing arrangement for a day shift at Unit 18 in early October 2024, which was the time Mr Idowu was giving his evidence. He described the following persons would be on such a day shift:

- Superintendent
- Deputy Superintendent
- Assistant Superintendent, Operations
- Assistant Superintendent, Security
- Principal Officer
- Senior Manager
- Unit Manager
- Facility Manager
- 14 YCOs, of whom two would be in the control room and the remaining 12 on the floor
- Four Tango Officers (these are prison officers in prison uniform)

1507 On a usual day shift there would be 27 custodial staff, namely, nine SMT members, 14 YCOs and four Tango Officers.[1348]

[1346] Exhibit 20.1: OCIS Review of Youth Custody: Follow-up to 2023 Inspection (Part 2)
[1347] Exhibit 20.2, p.2
[1348] Ts p.3329

1508 Mr Coyne did a similar exercise of calculating how many staff would be needed to run Unit 18 safely and efficiently. He said a cohort of eight young detainees would require 20 YCOs, plus a SMT, plus a Facilities Manager, plus prison officers and a Principal Officer. He identified eight detainees would require 34 adults to work the day shift and nine adults (including five YCOs) to work the night shift; a total of 43 adults over a 24-hour period to safely manage eight young people.[1349]

1509 One measure to examine the extent to which staffing shortages have been addressed is to examine the recent use of confinement orders. This is examined in detail below.

Dedicated education space

1510 When Mr Coyne became the Superintendent of Unit 18 in May 2023, there was no dedicated education space. It was not until 25 March 2024, shortly before the commencement of the first tranche of the inquest, that such a space existed. This was done by installing sea containers at the rear of Unit 18.[1350]

The process for providing water

1511 In his written statement to the inquest, Mr Coyne outlined that since April 2024, there is now a standard process to open a cell and provide water to the detainee if the cell has no running water. This change occurred after the inquest's first tranche.[1351]

The Department's written closing submissions regarding improvements since Cleveland's death

1512 I have carefully considered the submissions made by the Department regarding the other improvements made to Unit 18 since its inception and also in the period after Cleveland's death.[1352] As to the latter period, the Department cited improvements that included:[1353]

- The provision of psychological appointments.
- Greater access to psychiatric services.
- Greater access to in-person GP appointments.

[1349] Ts pp.1862-1865
[1350] Ts p.2073
[1351] Exhibit 57, p.41
[1352] Written closing submissions from the Department dated 6 May 2025, pp.104-106
[1353] Written closing submissions from the Department dated 6 May 2025, p.105

- Additional programs being made available.
- Improvements with educational engagement.

Issues that remain in Unit 18 since Cleveland's death

Current visiting regime

1513 Mr Idowu said that for each young detainee having a visit, four staff from Unit 18 are lost. Mr Idowu said that when such a visit occurs, the "*A-Wing, the privileged boys stay out, and B and C get locked down until the staff come back*."[1354] This occurs in circumstances where there is no confinement order in place. Mr Idowu said that there is usually one trip to the visits hall at Casuarina each day. That exercise reduces the number of YCOs from 12 to nine and the number of Tangos from four to three. He said the remaining staff numbers were sufficient to operate Unit 18 without having to lock anyone down, so long as there were no incidents. If there were insufficient staff during the visit, the lockdown described above would occur.[1355]

1514 Mr Idowu agreed this problem could be overcome if Unit 18 had its own dedicated visiting area, but that will never be possible given the location of Unit 18 inside the adult prison. At the inquest, Mr Idowu agreed with my observation that if Unit 18 remains open until the new facility is built, this arrangement about lockdowns occurring when visits occur will be in place for all the time Unit 18 is open.[1356]

Detainees at Unit 18 spend less time out of their cells than those at Banksia Hill

1515 Banksia Hill and Unit 18 have been said to be the one youth detention service being operated over two sites, i.e. Unit 18 is an annex to Banksia Hill. That however is not borne out on the evidence.

1516 Dr Cooney told the inquest that if everything went well during a day at Banksia Hill, a detainee could expect to spend about 10 hours out of their cell during that day.[1357] But if that same detainee was in Unit 18 and everything went well during the day, he could expect to spend only eight hours and 10 minutes out of their cell during that day.[1358]

[1354] Ts p.3357
[1355] Ts pp.3358-3359
[1356] Ts pp.3359-3360
[1357] Ts p.3480
[1358] Ts p.3481

Use of confinement orders

1517 As already outlined above, the evidence is that before Cleveland's death, confinement orders were being used frequently in Unit 18, almost daily, as a management tool, principally because there were insufficient staff available to operate it otherwise. These confinement orders followed a usual "copy and paste" request for an order, and the decision that made the order followed a similar process.

1518 These confinement orders were made pursuant to Regulation 74(2) and applied across the whole of Unit 18, as opposed to being directed to an individual detainee.

1519 The practice in respect of issuing confinement orders in Unit 18 on a daily basis continued up until the end of July 2024. Mr Idowu agreed that the reason daily confinement orders were made during 2024 until that date as it provided the comfort that if it was necessary to lockdown a particular detainee, there was in place a legal mechanism which authorised it.[1359]

1520 On 8 August 2024, Mr O'Siochain, the acting Superintendent of Unit 18, issued a Superintendent's Notice to Staff on the subject of non-routine confinements. The Notice specified that a confinement order pursuant to Regulation 74(2) could not be made for multiple detainees.[1360] It also specified that the more routine such a confinement order is made, "*the more likely that a Court will find it to be invalid*."[1361]

1521 An identical Notice dated 6 August 2024 had been issued to staff at Banksia Hill.[1362]

1522 This is a striking change in the management practices in Unit 18.

1523 On 13 September 2024, the Court requested the Department to provide a copy of all confinement orders made at Unit 18 during 2024. That material was provided to the Court on 3 October 2024 for the period 1 January to 2 October 2024.[1363]

1524 An analysis of this material reveals:

(a) Between 1 January and 17 July 2024, a confinement order applying to all detainees in Unit 18 was made every day.

[1359] Ts pp.3354-3355
[1360] Exhibit 127.7, p.3
[1361] Exhibit 127.7, p.3
[1362] Exhibit 127.6
[1363] Exhibit 124.2

(b) Confinement orders applying to detainees on B and C-Wings were made on 18, 19, 20 – 25, 31 July 2024.

(c) Confinement orders in respect of only B-Wing were made on 26, 27, 28 and 29 July 2024.

(d) This means there was a confinement order of one sort or another for everyday from 1 January to 31 July 2024.

(e) In August 2024, a confinement order was made on 2 August for B and C-Wings only and on 7 August (for B-Wing only and for just under four hours).

(f) These were the only two confinement orders made in August 2024.

(g) In September 2024, there were only three confinement orders. Each was in respect of an individual detainee for periods of just over three hours and two periods of one hour. These orders were made on 13 and 16 September (when two were made).

1525 The way confinement orders have been issued in Unit 18 has altered dramatically since the end of July 2024. That change can be seen in the confinement orders for August and September 2024.[1364]

1526 To determine whether the changes in August and September 2024 in respect of confinement orders was continuing, the Court directed the Department to provide a copy of all confinement orders made in Unit 18 after 2 October 2024, up until the hearing of oral submissions at the end of June 2025.

1527 The table below summarises what is revealed in those confinement orders:

[1364] Exhibit 124.2, pp.427-436

Month	Number of Days Upon Which Confinement Orders Are Made	Total Number of Confinement Orders Made	Number of Orders Made that Included Staffing Issues	Number of Detainees Subject to an Order
October 2024[1365]	1	1	Nil	1
November 2024[1366]	6	14	12	5
December 2024[1367]	7	20	14	9
January 2025	Nil	Nil	Nil	Nil
February 2025	Nil	Nil	Nil	Nil
March 2025[1368]	5	14	12	5
April 2025[1369]	3	16	15	13
May 2025[1370]	9	37	22	13
1-25 June 2025[1371]	1	1	Nil	1

1528 The Court was told in correspondence from the SSO that no confinement orders pursuant to Regulation 74(2) were issued in January or February 2025.

1529 The above table identifies a column titled "Number of Orders Made Included Staffing Issues". Twelve of the 14 confinement orders made in November 2024 included the following reasons for the making of the order:[1372]

(a) "*have spoken to [Banksia Hill] regarding staff replacements. None available due to staff shortage at Banksia Hill*";

(b) "*staff shortages due to injuries*";

[1365] Exhibit 138.1
[1366] Exhibit 138.1
[1367] Exhibit 138.2
[1368] Exhibit 138.5
[1369] Exhibit 138.6
[1370] Exhibit 138.7
[1371] Exhibit 138.8
[1372] Exhibit 138.1

(c) "*[contacted Banksia Hill] to request further staffing, however they are unable to redeploy without confining their own detainees*";

(d) "*staff shortages*";

(e) "*due to staffing levels today we cannot safely unlock*";

(f) "*staff are required to take a late lunch to sit at their cell doors and provide constant supervision. This impacts the staff ability after the scheduled lockdown as those staff are required to take their breaks*"; and

(g) "*due to staff needing lunch breaks due to being required to remain on cell doors to conduct constant observations on level 1 ARMS YP during the allocated lunch break*".

1530 During December 2024, the confinement orders which reflected staffing issues included reasons of:[1373]

(a) "*short staffing by five officers*";

(b) "*staff required to supervise level 1 ARMS detainees during lunch break*";

(c) "*staff shortages due to the assault*"; and

(d) "*due to low staffing levels*".

1531 Mr Idowu agreed that an examination of some of the confinement orders he made in 2024 before the end of July[1374] revealed reasons for making such orders to be events which one would expect to occur daily if Unit 18 was running well. These included detainees on level 1 ARMS requiring additional support, multiple alerts existing between detainees, visits, and video court links.[1375]

1532 As is apparent from the above analysis of the confinement orders made in November and December 2024, such reasons were still being proffered as the basis for making such orders.

1533 The confinement orders for December 2024 also contained two other matters of note.

1534 First, on 6 December 2024, there were nine detainees in Unit 18. On that day, a confinement order was made in respect of eight detainees for a period

[1373] Exhibit 138.2
[1374] Exhibit 124.2
[1375] Ts pp.3365-3366

from 12:40 hours until 14:00 hours. This was a period which would otherwise be a time for cell unlocks. The reasons for the eight confinement orders are identical:[1376]

> Short staffing by five officers. One detainee requiring two staff to recreate alone due to having multiple alerts with other detainees in Unit 18. Staff required to supervise level 1 ARMS detainees during lunch break. Multiple escorts for official visits, education and psychology calls during this time.

1535 The request for these eight confinement orders indicates that shortly after the commencement of the morning shift, Unit 18 sought additional staff from Banksia Hill. After several attempts to get a response from Banksia Hill, Unit 18 was advised shortly before 10.00 am that the request had been declined "*due to BHDC staffing issues*".[1377]

1536 Secondly, on 27 December 2024, there were only eight detainees in Unit 18. However, there were insufficient experienced YCO staff to manage them and a request was made for a confinement order for the next day in respect of four individual detainees. The request included: "*I am requesting a confinement order for 28 December 2024, due to low staffing levels and ongoing safety concerns caused by detainees' unsettled behaviours and significant threats to staff*."[1378]

1537 The key factors impacting staffing levels included one staff who left the site feeling unwell, another who did not attend for work, another who left the site "*stating they did not want to work with a detainee or be at Unit 18*" and another who left the site due to a family member being unwell.[1379]

1538 The request then noted "*there are 11 YCOs on the floor including 10 new staff members and only one experienced YCO*".[1380] It noted there had been an attempt to request additional staff from Banksia Hill. It would appear this attempt was unsuccessful because the reasons for granting the confinement orders noted the attempts to have additional staff redeployed from Banksia Hill.[1381]

1539 Notwithstanding the Department's positive statements regarding recruitment, the confinement orders discussed above indicate that staffing problems remained late into 2024, causing detainees to be locked down.

[1376] Exhibit 138.2, pp.5-20
[1377] Exhibit 138.2, pp.7-19
[1378] Exhibit 138.2, pp.33-39
[1379] Exhibit 138.2, p.33
[1380] Exhibit 138.2, pp.33-39
[1381] Exhibit 138.2, p.33-39

The overwhelming majority of confinement orders were still being made because there are insufficient staff to manage the detainees during the time when they should be unlocked. There are also examples of confinement orders being directed to an individual detainee in response to that young person's behaviour. That is unremarkable because that is the purpose of confinement orders being available.

1540 Furthermore, the evidence the Court has obtained regarding the use of confinement orders in Unit 18 up to 25 June 2025 demonstrates that the use of lockdowns through confinement orders is still predominately occasioned by the fact there are insufficient staff available to manage Unit 18 without such measures.[1382]

1541 The information also indicated that Banksia Hill had no surplus staff to spare when Unit 18 asked for such help. This suggests the cohort of available staff to work across both youth detention centres is still insufficient. The events of 6 December 2024 exemplify the problem when eight detainees were locked down so the ninth detainee could recreate.[1383]

1542 However, if the reduction in the number of confinement orders in 2025 suggests that staffing problems at Unit 18 is no longer the major issue that it was during 2023, then there must be a sizeable pool of custodial staff available at Unit 18 who are capable of being deployed at Banksia Hill. As a matter of logic, deploying such youth custodial resources back to Banksia Hill would increase the capacity of that site to safely manage the small number of detainees who are now being housed in Unit 18 at any one time.

Population numbers at Unit 18 from December 2024 to 25 June 2025

1543 In addition to seeking information about the most recent use of confinement orders, at the completion of the oral evidence at the inquest, the Court requested information from the Department as to the daily population of Unit 18.[1384] That information was obtained up to 25 June 2025 and is summarised in the table below.

1544 The daily population fell dramatically after 11 December 2024. On that date the Court announced that it was requiring the Department to provide ongoing information about Unit 18 for the following six months, until all

[1382] Exhibits 138.1-138.8
[1383] Exhibit 138.2, pp.5-19
[1384] Exhibits 139.1-139.8

written submissions were completed.[1385] The intensity of the use of Unit 18 has fluctuated since that direction.

- For the first 11 days of December 2024, the daily population ranged between 8-10, with a daily average of just above nine detainees.
- For the remaining 20 days of December 2024, the range fell to 7-8 detainees, and the daily average fell to 7.65.
- To the end of January 2025, a period of 51 days since the Court's direction to the Department to supply the daily population details, the daily range had fallen to 3-8 detainees, with a further reduction in the daily average of just above six detainees.
- For the month of February 2025, the average daily population was 4.64 detainees.
- To the end of February 2025, a period of 79 days since the Court's direction to the Department to supply the daily population details, the daily range was 2-8 detainees, with a daily average of 5½ detainees.
- This was close to a 50% reduction in the daily population of Unit 18 over a period of 79 days.
- Despite an increase thereafter, the average daily number per month has only been over 10 once (in April 2025).

1545 Just as the data in respect of confinement orders has revealed a significant change in management practices, so too has the data in respect of daily populations revealed a significant change in the Department's use of Unit 18.

1546 It is evident that Unit 18 is no longer been used to "*provide a safe environment for the 20 young men while [the Department] restores Banksia Hill to a safe working environment for staff and detainees and completes the necessary infrastructure works*", as described in the Department's media release on 5 July 2022.[1386] The initial justification for the use of Unit 18 as a youth detention centre is no longer the reason for its continued existence.

1547 Over a five-day period during February 2025, Unit 18 was being used to detain just two children. Unit 18 is a 128-bed accommodation unit

[1385] Ts p.4340
[1386] Exhibit 71.1

originally built for the adult custodial estate. The Court has been told of the staffing numbers necessary to operate Unit 18 safely. Just the SMT at Unit 18 comprises of four or five persons. There is a need for a greater number of YCOs.

1548 As previously noted, Mr Coyne said that a cohort of eight detainees would require a staff of 43 adults over a 24-hour period to manage them safely.[1387] Ms Ginbey agreed that this ratio sound about right.[1388]

1549 Unit 18 appears to be operating in 2025 differently from the chaotic, dangerous and unliveable place it was in the time before and at Cleveland's death. However, that does not mean it is a suitable place to be a youth detention centre. It remains an accommodation unit in a high security adult prison. Its infrastructure remains limited.

1550 In an environment where resources are scarce, there must be a need to consider whether the resources presently being poured into such a small group of detainees at Unit 18 could not better be utilised at Banksia Hill to look after that group, and thereby returning to the adult prison estate a valuable resource.

Month	Range of the number of detainees in Unit 18	Average number of detainees for this month
October 2024	4 - 11	7.32
November 2024	8 - 11	9.47
December 2024	7 - 10	8.16
January 2025	3 - 7	5
February 2025	2 - 8	4.64
March 2025	7 - 11	8.55
April 2025	11 - 14	12.1
May 2025	7 - 11	9.55
1 - 25 June 2025	7 - 13	9.48

[1387] Ts p.1865
[1388] Ts p.2323

The identity of Unit 18's population

1551 The relevant data regarding this subject matter encompasses the time before Cleveland's death and the time since the inquest commenced.

1552 Professor Morgan and Mr D Reynolds prepared a joint report[1389] expressing their opinion as to what the data received by the Court reveals about the population of Unit 18 during its existence as a youth detention facility and any changes therein. To understand this report and the material upon which it has been based, it is necessary to set out the data received by the Court.

1553 The first data provided to the Court on the composition of the detainees in Unit 18 was provided by the Department via the SSO at my request when I asked, "*how many of the young people who go into detention end up spending some time at Unit 18*".[1390]

1554 With respect to my question and in response to questioning from counsel for the Department, Professor Morgan stated:[1391]

> My estimate, with respect, is that probably 20% of the children in detention are going to spend time at Unit 18. Because if you look at the figures, it is probably 10% or more at any given time, and then – because they will roll in and roll out. My estimate – and because the Department refuses to release figures, please do not question me on that; I am doing my best with the lack of information that we are being provided with – my estimate is that 15 to 20% of the young people will spend time at Unit 18.

1555 After Professor Morgan expressed this opinion, the Department tendered a document (exhibit 63). When tendering the document, counsel for the Department referred to the above opinion expressed by Professor Morgan and continued:[1392]

> We've asked for an official review of that [opinion]. You will see on the second page, at point four, there is the answer for the time since Unit 18 opened on 20 July 2022, up to 30 June 2024. And you will see that there were 71 young people who went through Unit 18 out of a total of 1,223 distinct young people who had been detained in that period. So, that is about 5.8% of the total who had gone through Unit 18.
> (underlining added)

1556 The Court provided this document to Professor Morgan. His comments formed the basis of a request by the Court to the Department for more

[1389] Exhibit 105.2
[1390] Ts p.746
[1391] Ts p.767
[1392] Ts p.853

information on the topic it had raised and upon which it had tendered evidence. This further request[1393] was sent to the SSO on 12 August 2024.

1557 Exhibit 63 was not the only data the Court received in respect of the population of Unit 18. After Professor Morgan and Mr D Reynolds had concluded their respective evidence, the Court requested and received from the OCIS information for the then current financial year (2024/25). When received, this data was for the period 1 July – 12 August 2024 and became exhibits 98.1, 98.2 and 98.3.

1558 This data from the OCIS was provided to Professor Morgan and Mr D Reynolds for their comment. On 22 August 2024, they produced a brief report explaining what they considered was revealed and what was not revealed by exhibits 98.1, 98.2 and 98.3.

1559 That brief report became exhibit 105.1 and expressed the following opinions as to what was revealed:

(a) The total number of young people in detention remains low in historical terms;

(b) Numbers fluctuate rapidly because of short stays (mainly remandees);

(c) The number of boys in Unit 18 has dropped, especially since the second tranche of the inquest began;

(d) Unit 18 almost exclusively holds Aboriginal boys;

(e) A large proportion of the Aboriginal youth custodial population spends time at Unit 18; and

(f) On 12 August 2024, there were only 4 boys at Unit 18.

1560 Professor Morgan and Mr D Reynolds noted that data in respect of several matters had been requested by the Court[1394] but was not yet available. This included data in respect of:

- The use of Unit 18 since its commencement in July 2022.
- How many of the detainees at Banksia Hill on any given day have also spent time in Unit 18.
- The number of young people whose stay is seven days or less.
- The profile and backgrounds of the young people at Unit 18:

[1393] Exhibit 92
[1394] Exhibit 92

- Sentenced/remand status
- Age
- Where they are from.

1561 Professor Morgan and Mr D Reynolds noted that the requested, but still outstanding, data will "*give a much better sense of the use of Unit 18 now, and since it opened*".[1395] They concluded:[1396]

> The data provided by the Inspector of Custodial Services for 1 July to 12 August [2024] raises many concerns. It certainly presents a very different picture of the use of Unit 18 from the data provided by the Department to the Coroner on 23 July 2024. This said that 5.8% of the discrete persons received into custody spent time at Unit 18. Measured on a daily population basis the figures are much higher, especially for Aboriginal youth.

1562 The requested data was provided by the Department on 30 August 2024 and became exhibit 111. This exhibit was provided to Professor Morgan and Mr D Reynolds. Their analysis of this data became exhibit 105.2 on 2 October 2024.

1563 The analysis by Professor Morgan and Mr D Reynolds (the joint report) produced 12 key findings:[1397]

1. The number of children in detention has fallen to historical lows;
2. Numbers fluctuate rapidly because of short stays. Only one third of the boys discharged from youth detention has been there for over seven days. Two thirds are there for seven days or less;
3. Unit 18 is only used for boys serving more than seven days;
4. Unit 18 was most heavily used in the run up to Cleveland's death;
5. Use of Unit 18 dropped markedly from the start of the inquest's second tranche of evidence (22 July 2024);
6. When Unit 18 was opened, the government and the Department said it was a short-term circuit breaker for a specific small "cohort". It has been nothing of the sort. On average, it has held 17% of the Aboriginal boys in detention on any given day, and 11% of the non-Aboriginal boys;

[1395] Exhibit 105.1, p.4
[1396] Exhibit 105.1, p.3
[1397] Exhibit 105.2, pp.3-4

7. If the short stay population is removed, the proportion of boys being held at Unit 18 increases to at least 25% of Aboriginal boys and 17% of non-Aboriginal boys;
8. Unit 18 is a prison for Aboriginal children:
    a. The daily population is predominantly Aboriginal.
    b. Per head of the detention population, Aboriginal children are far more likely to be at Unit 18 than non-Aboriginal children.
9. For a brief period after Cleveland died in October 2023, the Department sent fewer Aboriginal children to Unit 18. Within six months, numbers had gone back up;
10. Before Cleveland's death, Unit 18 held similar numbers of remand and sentenced boys. Since Cleveland's death, 75% of the population has been sentenced;
11. Most of the Unit 18 boys are 15 to 17 years of age. But it regularly holds 14-year-olds. At least one 13-year-old has spent time there; and
12. Generally, boys from the metropolitan area are more likely to be at Unit 18. But:
    a. When Cleveland died, it held a large number of regional boys;
    b. On the latest available figures, it now mainly holds regional boys.

1564 The joint report contained a detailed statistical analysis[1398] of the data provided by the Department to support the 12 key findings it made. Those findings examined how the Department had been using Unit 18 before and at the time of Cleveland's death and how it has been using Unit 18 since Cleveland's death, particularly at times of intense scrutiny.

1565 From this analysis, the joint report reached the following conclusions:[1399]

1. The number of children in detention is at an all-time low;
2. Unit 18 has a discriminatory impact on Aboriginal children and children with disabilities;
3. Unit 18 compromises community safety;

[1398] Exhibit 105.2, pp.10-18
[1399] Exhibit 105.2, 4-8.

4. The Department cannot properly manage sentenced children;
5. In deciding whether to move a child to Unit 18, the Department seems to respond to external pressure;
6. It is important to monitor the use of the ISU at Banksia Hill;
7. The data strongly suggest questionable management of Unit 18 and of transfers to Unit 18; and
8. The Department should be required to continue to provide information.

1566 The joint report was highly critical of the Department and how it had been using and continued to use Unit 18. It suggested the Department was manipulating its management of Unit 18 to prevent external scrutiny of it by the Children's Court and to put itself in the best possible light. It said the data revealed that the heaviest and most intensive use of Unit 18 occurred in the two months before Cleveland's death.

1567 The joint report noted three significant changes in the population of Unit 18:

1. The dramatic drop in numbers at Unit 18 after the second tranche of the inquest commenced on 22 July 2024;
2. The cessation of sending Aboriginal children to Unit 18 for months after Cleveland's death; and
3. The reduction in remandees being sent to Unit 18.

1568 This last change has the consequence that the Children's Court does not have jurisdiction "to keep an eye on" sentenced detainees, it can only do so for those on remand. The Children's Court has for many years now been requiring information from the Department about OOCH and exposure to Unit 18 in respect of those children coming before it. However, these detainees are remandees, not sentenced young people.

1569 The authors of the joint report found that the Department's data revealed that from 1 August 2022 to the time of Cleveland's death, the split of remandees/sentenced detainees was about 50/50. This changed in the period 1 November 2023 to 22 July 2024 (which was the date the inquest's second tranche commenced) when the split was about 75% sentenced (and thus beyond the scrutiny of the Children's Court) and only 25% on remand. Between 29 July and 12 August 2024, when the numbers at Unit 18

markedly dropped, the split returned to about 50/50. The conclusion reached by the authors was:[1400]

> We believe the Department changed its policies in relation to placing remand children at Unit 18 after Cleveland's death because of a series of cases in which the Children's Court castigated the treatment of remand children at Unit 18.

1570 After noting these changes, the joint report stated:[1401]

> These changes are so sudden and dramatic [sic] marked that the Department should be asked to explain them. It is inconceivable that the objective needs and risks of the population shifted so suddenly and so dramatically. The findings also raise uncomfortable questions about the transfer processes and the use of Unit 18.

1571 The changes which occurred during the second tranche of the inquest were noted:[1402]

> At the start of July 2024, Unit 18 held 10-12 children. By August 2024, numbers had fallen to between 4 and 7.38 We have no doubt that the resumption of hearings in the Coroner's Court on 22 July 2024, and the nature and content of the evidence, was a key factor in in this remarkable and otherwise unexplained drop.

1572 The analysis challenged the assertion by the Department that only 5.8% of the population had been in Unit 18. The authors of the joint report submitted that the inclusion of females and short-stay detainees in the calculation by the Department painted a less than fulsome picture, with the correct picture being:[1403]

> From 20 July 2022 to 30 June 2024, there were 929 discharges of boys who had spent more than seven days in detention. Over the whole period, one in six or 16.25% (149 cases) had been at Unit 18 during their stay. In some months it was more than one in five.

1573 I note that when the Department provided the document that became exhibit 63, it presumably instructed its counsel to state to the Court that only 5.8% of detainees have been placed in Unit 18.[1404] This, of course, refuted the estimate of 15% to 20% provided by Professor Morgan in his evidence. However, if a more nuanced approach is considered then Professor Morgan's estimate was accurate. This estimate challenges the

[1400] Exhibit 105.2, p.16
[1401] Exhibit 105.2, p.6
[1402] Exhibit 105.2, p.12
[1403] Exhibit 105.2, p.12
[1404] Ts p.853

basis for the existence of Unit 18 i.e. it is necessary to manage a small cohort of detainees who cannot be managed safely in Banksia Hill.

1574 Further data was sought by the Court from the Department and the OCIS. This additional data was also examined by Professor Morgan and Mr D Reynolds in the joint report.

1575 The Department chose not to place any further evidence before the Court responding to the joint report. The Court raised this issue several times with the Department's legal representatives and was told that no further evidence would be provided.

1576 It is apparent the Department adopted that stance as it has formed the view that the Court's examination of this issue is beyond jurisdiction. In the written closing submissions from the Department, it was contended that the opinions expressed in the joint report that were cited by counsel assisting in his written closing submissions:[1405]

> … do not concern the immediate circumstances of Cleveland's death, nor are they connected with his death in anything other than a remote fashion. In respect of the demographic of Unit 18 after Cleveland's death, these cannot have any logical causal connection to Cleveland's death, as they postdate it.
>
> Instead, the findings and comments are directed at the overall management of the youth justice estate by the Department. …
>
> They are findings and comments that are beyond the jurisdiction of this Court to make.

1577 I accept that much of this evidence does not fall within section 22(3) of the Act and the Court is not permitted to make findings with respect to it. However, I am satisfied it is evidence gathered for the purpose of informing the Court of the recommendations it ought to make. And, as I have already cited above, the Department accepted that information received about matters occurring after Cleveland's death that are connected to it, "*can inform whether or not to make a recommendation*", adding that the Court "*simply can't make an adverse finding or a finding about it*".[1406]

1578 As I am satisfied the manner in which Unit 18 was operating was connected to Cleveland's death, I am able to compare how it was operating at the time of Cleveland's last detention to how it has operated since October 2023 for the purpose of any recommendation I make.

[1405] Written closing submissions from the Department dated 6 May 2025, p.91
[1406] Ts p.4439

1579 The Department made submissions that if the joint report was "*within jurisdiction*" then the opinions expressed in the joint report should not be accepted.[1407] It noted that "*much of the report is comprised of opinions expressed without reference to any data*", including that Unit 18 has a discriminatory impact on Aboriginal detainees and detainees with disability, that it comprises community safety, and that the Department cannot properly manage sentenced children.[1408] I accept that submission and have therefore taken into consideration the limited weight I am able to give to those parts of the joint report which contained opinions that do not refer to supporting data.

1580 As to the contention in the joint report that the Department had undertaken a decision to send less remand detainees to Unit 18 in order to avoid scrutiny by the Children's Court, the Department cited Dr Cooney's evidence that it is misleading to look at statistics in isolation from contextual factors, and that any trend towards accommodating less remand detainees at Unit 18 "*happened by chance*", rather than because of an intentional decision by the Department.[1409] That submission carries some weight and I have ignored that part of the joint report when determining what recommendations I make.

1581 The Department also asserted that Professor Morgan and Mr D Reynolds were "*advocates, rather than independent experts.*" Therefore: "*little, if any, weight can be attached to the evidence of such an expert.*"[1410] I do not accept that submission.

1582 After carefully considering these submissions by the Department and its other contentions regarding the joint report, I am satisfied that parts of the joint report from these two highly eminent and respected persons with considerable knowledge of youth justice and the youth custodial estate provided credible information that supported a recommendation for the immediate closure of Unit 18.

My recommendation

1583 Notwithstanding the additional resources and improvements which have occurred in the management of Unit 18 since Cleveland's death, I am satisfied it is still not fit for purpose as a youth detention facility.

[1407] Written closing submissions from the Department dated 6 May 2025, pp.91-93
[1408] Written closing submissions from the Department dated 6 May 2025, p.91
[1409] Written closing submissions from the Department dated 6 May 2025, p.92
[1410] Written closing submissions from the Department dated 6 May 2025, p.91: citing ***R v Doogan, Re: Ex parte Lucas-Smith*** [2005] ACTSC 74 [117]

1584 Unit 18 has been and continues to be treated differently in respect of a model of care. The evidence in relation to this has already been addressed in this finding.[1411]

1585 The physical impediments at Unit 18 remain (and will always remain). It is an accommodation block for adult prisoners who would otherwise have access to the services provided in other parts of the adult prison. The regime for visits at Unit 18 has been described and the physical impediments which require this regime remain and will always be present.

1586 As outlined above, the inquest heard evidence as to the number of custodial and non-custodial staff engaged over a 24-hour period to care for the one or two handfuls of detainees in Unit 18.

1587 The cost of keeping a young person in detention is approximately $3,000 per day, i.e. about $1.1 million per annum. Given the higher ratio of staff to detainees in Unit 18, it is inevitable that the cost of keeping a detainee in Unit 18 is considerably greater. The cost of the Department caring for that young person in the community is about $150 per day, or approximately $55,000 per annum. The daily cost of incarcerating an adult is about $380, just under $140,000 per annum.[1412]

1588 I am satisfied of the following:

(a) Unit 18 was not fit for purpose as a youth detention centre during Cleveland's last period of detention.

(b) Unit 18 remains not fit for purpose to house detainees who have severe neurocognitive disorders and who comprise some of the State's most vulnerable children.

(c) When Unit 18 commenced in July 2022, it was only intended to be a temporary arrangement to detain a small percentage of young persons and to operate for a period of about 12 months.

(d) That intention was thwarted with the serious disturbances in Banksia Hill in May 2023.

(e) As at 9 August 2024, the inquest was told that Unit 18 would close once the infrastructure repairs at Banksia Hill (and specifically those to Jasper Unit) were completed.

[1411] See: **ADVERSE FINDINGS, *The Department,*** *14. The failure to implement a model of care at Unit 18*
[1412] Ts p.2653

(f) All the academic, medical and scientific evidence is that the continued operation of Unit 18 is detrimental to the detainees who are kept there.

1589 Whether Unit 18 remains a youth detention centre until the proposed second site is operational is ultimately a political decision for the government of the day. During the inquest, in support of its application that the Court was exceeding its jurisdiction in making a recommendation that Unit 18 be closed as a matter of urgency, the Department submitted:[1413]

> Questions concerning matters of public policy are the prerogative of an elected government rather than a coroner. It is not for a coroner to examine the wisdom or otherwise of policy decisions by any government.
> …
> Importantly, to the extent that the cause of a death might entail matters of public policy, those matters are "properly the prerogative of an elected government rather than the coroner or, indeed, any other judicial officer." (citations omitted)

1590 Those propositions may well be apposite in certain circumstances. However, in the present circumstances, it is appropriate and necessary that the Court comment about these matters because they involve issues regarding the health and safety of those members of the public who are detained by the State from time to time, and who are some of the most vulnerable children in the State. The Court has the power to comment and make recommendations in those circumstances provided they are connected to the death it is investigating.[1414]

1591 Professor Stanley agreed that this inquest was a seminal moment in youth justice in Western Australia.[1415] There is much to endorse her view that these issues are so much bigger than something only for the Department; these issues demand a whole of government response, that involves Health, Education, Child Protection, Housing and Police to name just a few government entities.[1416]

1592 Professor Stanley advocated for reinvestment by government and for listening by government, particularly to Aboriginal people. She was not the only witness to underscore the importance of such investment.

[1413] Written submissions from the Department dated 11 October 2024, [144] and [51]
[1414] *Coroners Act 1996* (WA) s 25(2)
[1415] Ts p.2873
[1416] Ts p.2874

1593 As already noted, Mr Beck has a wealth of considerable practical experience and training in youth justice in Western Australia, in other Australian jurisdictions and overseas. Ms Maj acknowledged that because of his experience and his work, the opinions of Mr Beck are to be seriously considered.[1417]

1594 When Mr Beck was discussing the level of support young detainees with severe neurocognitive disorders required, by reference to the ratio of staff to detainees, he said:[1418]

> … for young people who were clearly extremely troubled, that ratio should be one to two. And even in some instances, to get the best out of some of these young people, you need almost one to one. It is almost like a daily support person to actually help them through the day. That is the level of resource you need for these young people. You know, there are 600,000 young people in Western Australia. We have got 100 of them in detention. If you can't invest in those 100 young people, who are our most challenged young people, then who can you invest in?

1595 Dr Watson, when asked for possible recommendations that could be considered by the Court, said: "*The first thing is I think that children should not be in an adult detention facility, and they should be taken out of that facility*."[1419]

1596 Although Ms Butt thought there was a need for a new youth detention centre to be built, she agreed the optics and infrastructure of Unit 18 were not the best.[1420]

1597 When Professor Stanley was advised the current position of the Department was that Unit 18 was to remain operational until the new facility was built (which may have taken up to five years as at August 2024), she responded:[1421]

> I am horrified because I would like to know the evidence on which they base this kind of decision. Where is the evidence that keeping these children in an adult prison and obviously not providing the kinds of therapeutic assessments and – and – nurturing that I've talked about is going to make a difference, is going to improve the outcomes for these children, is going to be good for society?

[1417] Ts p.2705
[1418] Ts p.2252
[1419] Ts p.3645
[1420] Ts pp.4178-4179
[1421] Ts p.2870

1598 Not surprisingly, the Department did not support counsel assisting's proposed recommendation that Unit 18 should be closed as a youth detention centre as a matter of urgency.[1422]

1599 Given the significance of such a recommendation, I will cite in full the Department's submission:[1423]

> The Department does not concede that this recommendation arises from, or responds to, the proper scope of the investigation into the cause and circumstances of Cleveland's death, as articulated in Part 1 above. In any event, while noting that this decision is the responsibility of the Minister, and not the Department, the Department does not endorse this proposed recommendation, as it considers that a second youth detention facility is needed in Western Australia and that Unit 18 remains the only option for that second facility at this time. It currently provides a safe and therapeutic response that meets the needs of young people. It is not unusual for young people to request placement at Unit 18 for a variety of reasons including safety and wellbeing. Unit 18 currently offers unique support and case management opportunities along with a lower overall occupancy ratio. Decisions to place a young person at Unit 18 are made by a multi-disciplinary team who take into account the views expressed by the young person, and young people have avenues to appeal decisions made. (underlining in the original)

1600 I note that this submission mirrors what Ms Ginbey said about the decision whether to close Unit 18 being a matter for the Minister. Strictly speaking, that is true. However, like any government agency, the Department plays a critical role in the government's decision-making. This was explored by counsel assisting when asking Ms Maj these questions at the inquest:[1424]

> Regarding anything to do with Unit 18. That is how it works. Departments give Ministers advice. Ministers seek advice? --- Yes. And they also give instruction.
>
> Yes. But they give instructions after they have had proper, balanced advice. They make a decision and give an instruction? --- Yes.
>
> Right. So, the Minister - when the government sends the Minister off, the Minister is going to come down and knock on your door and say to the Department, "I want some advice"? --- Likely, yes.
>
> Right. Ultimately, it will be the Minister and the government's decision. That they will be acting on advice? --- Yes.
>
> And you are telling his Honour that the advice you give, when asked, will be Unit 18 had to stay open until the brand spanking new facility is

[1422] Written closing submissions from counsel assisting dated 25 March 2025, p.307
[1423] Written closing submissions from the Department dated 6 May 2025, p.107
[1424] Ts pp.2697-2698

> operational? --- I believe government has already given that instruction and is not asking for my advice on that matter.
>
> Now, that is very important. So, you believe the Department has been told by the Minister that the decision to close Unit 18 will be made after the operation of the new site. It is not that it is going to fall to you to give advice. Is that what you are saying? --- I believe that was publicly announced following the youth infrastructure review, that there would - there was a need to always have a second facility and that a new facility would be built. So, my understanding is that its government's view that there must always be a second site.
>
> …
>
> **So, the universal position is we need two sites? --- Across government and the agency. Yes.**
>
> **Right. The two-site solution does not of itself mean that Unit 18 must remain open until the second site is operational. You agree that as a matter of logic --- ? --- Correct.**
>
> **--- and philosophy? --- Correct.**
> (bold type added)

1601 In my view, there is nothing preventing the Department from reassessing its position and adopting the stance that it had taken at some stage in 2024 as outlined at the inquest by Ms Gibney and Mr Coyne i.e. that Unit 18 was to be closed once the infrastructure repairs and modifications had been completed at Banksia Hill.

1602 Notwithstanding the recent incident involving six detainees climbing onto a roof at Banksia Hill on 24 November 2025, there has been no significant disruptive incident at either Unit 18 or Banksia Hill since May 2023[1425] that must mandate the continued operation of Unit 18 until the new youth detention centre is built – whenever that might be.

1603 Accordingly, I make the following recommendation:

Recommendation No.17

In order to provide an appropriate level of therapeutic care to detainees who require that care the most, Unit 18 should be closed as a youth detention centre as a matter of urgency.

1604 I sincerely hope that the Department, like the changes it has already made from evidence it heard at the inquest, will reflect upon the evidence from

[1425] In May 2023, about 50 detainees were involved in a major disturbance at Banksia Hill that caused a significant amount of damage to infrastructure.

the inquest relevant to the closure of Unit 18 and provide advice to the State Government that Unit 18 should as of now no longer function as a youth detention centre.

1605 And, of course, if Unit 18 was not a youth detention centre, 128 beds would become available to hold adult male high security prisoners for which Unit 18 was built. The current crisis of insufficient number of cells to house adult prisoners is well-documented. Recently, Mr Ryan provided these sobering facts regarding adult prisoner numbers in Western Australia as at 3 November 2025:[1426]

- Total number: 8,510 comprising of 7,635 male prisoners;
- This number represents a 35% increase since January 2023;
- Six prisons have over 100% capacity; and
- 120 male prisoners sleeping on trundle beds or mattresses on the floors of already double-bunked cells initially built as single person cells.[1427]

1606 If the Department does not accept the evidence from the inquest and outlined in this finding, it need only pay heed to its own information it provided to another governmental agency.

1607 Infrastructure WA[1428] provided a report dated July 2024 titled: "*Major Infrastructure Proposal Assessment, Department of Justice, New Youth Detention Facility, Summary Assessment Report*".[1429] With respect to the business case prepared by the Department for the proposed new youth detention centre, this report stated:[1430]

> There is sufficient evidence within the business case that the current use of Unit 18 within the Casuarina Prison to hold the disruptive youth is inadequate, with there being an urgent need to provide alternatives. A number of studies and reports are adequately outlined in the business case to support the need to discontinue Unit 18 and establish an alternative facility.
>
> …
>
> In addition, the business case notes that there is increasing pressure on the capacity of the adult prison estate and that returning Unit 18 to adult use will reduce this pressure.

[1426] Presentation by Mr Ryan, the Magistrates of Western Australia Annual Conference, 12 November 2025.
[1427] Mr Ryan reported that this number got as high as 350 in June 2025.
[1428] An independent statutory body that provides advice to the State Government on infrastructure needs.
[1429] Exhibit 149
[1430] Exhibit 149, p.3

(underlining added)

1608 I also note that the Department has made this acknowledgement:[1431]

> The Department acknowledges that the Inspector of Custodial Services reported in 2023 that Unit 18 is not fit for purpose, and that it is cold and bleak without any purposeful attempt to include youth-focused design elements to mitigate and soften its construction as a maximum-security prison and accommodation block.

1609 If the Department fails to provide advice to the Minister that Unit 18 can and should be closed now, I would invite the current Minister to consider that his predecessor, when signing the gazettal authorising Unit 18 to operate as a temporary youth detention centre, did so on the advice of the Department that it was necessary to enable repairs to be carried out at Banksia Hill.[1432]

1610 The completion of those repairs (and those required following the critical incident in May 2023) should already be completed. Meanwhile even the ceremonial turning over of the soil by dignitaries for the construction of the new youth detention centre is some time away. I have no doubt that when the Minister approved the use of Unit 18 as a youth detention centre in July 2022, he never envisaged that the "temporary" youth detention centre that Unit 18 became would remain in operation for at least six years.[1433]

1611 It would be a catastrophic tragedy if another young person was to take their life inside Unit 18 whilst we wait for the funding, planning and construction of the new youth detention centre to take place.[1434]

My alternative recommendation

1612 There is no reason why the "*alternative facility*" referred to in the report from Infrastructure WA could not be the extensively modified, reinforced and strengthened Banksia Hill.

1613 In support of this proposition, I rely on the document prepared by Mr Coyne in August 2024 which became exhibit 97 (Mr Coyne's report). It was detailed and comprehensive and provided cogent evidence supporting the

[1431] Written closing submissions from the Department dated 6 May 2025, p.52
[1432] Exhibit 1, Volume 6.1, Tab 1.6, p.7
[1433] The report from Infrastructure WA stated the new youth detention centre "*is not expected to be operational until mid-2028*." This timeline would appear to be extremely optimistic.
[1434] Shortly before this finding was handed down the State Government issued a press release that said it had "*committed $147 million to fully fund construction of a new youth detention facility in Perth.*": https://www.wa.gov.au/government/media-statements/Cook%20Labor%20Government/New-youth-detention-facility-fully-funded-with-$147-million-boost--20251121

suspension of the operation of Unit 18 as a youth detention centre for a fixed period to determine whether the detainees then in Unit 18 can be safely cared for in the now refurbished Banksia Hill.

1614 I will quote extensively from Mr Coyne's report so I can make it clear that my recommendation at the end of this section is based not on my analysis, but on the analysis of the then Department's Assistant Commissioner, Young People who had previously been the Superintendent at Banksia Hill and Unit 18. Mr Coyne has spent nearly 40 years in Corrections[1435] and is therefore eminently qualified to provide this analysis.

1615 Mr Coyne explained the works undertaken at Banksia Hill since 2022 as follows:[1436]

> A range of work was approved and has been progressed since 2022 with the specific focus on developing the ISU and Jasper Units into a more secure residential unit to house young people who are considered to be at high risk to the safety and good order of the centre.
>
> The ISU and Jasper works intended it to be a dedicated management opportunity for young people who present with the most high-risk behaviour in relation to their risk to staff, other detainees or good order of the centre. The units provide more secure infrastructure, greater resources, and high intensity of supervision to manage the risks posed by the young people.

1616 The reader of this part of Mr Coyne's report will immediately recognise that he is describing detainees who have been transferred to Unit 18 since July 2022.

1617 Nevertheless, Mr Coyne cautioned:[1437]

> The movement of the cohort of detainees back to Banksia Hill has the potential to disrupt the current stabilised operations of Banksia Hill including the model of care and accommodation options. In the event of incidents, the whole site will be secured in cell for the management of the incident to reduce the contagion of behaviours and to ensure their safety.
>
> In the event the infrastructure in Jasper is proven not to be safe or secure, the only strengthened cells at Banksia Hill are in ISU (total of 8+12+8+8 cells). Placement of the cohort in the ISU will reduce the ability to accommodate those detainees who require psychological, medical or mental health observations, short term stays, overnight arrests etc.

[1435] Ts p.1855
[1436] Exhibit 97, p.1
[1437] Exhibit 97, p.1

1618 Mr Coyne stated that a total of 168 cells would be available at Banksia Hill by mid-2025.[1438] The usual total number of detainees in the youth custodial estate hovers at around 80 in recent times.

1619 Mr Coyne's report detailed the extensive works at the Jasper Unit that had considerably strengthened the cells, including the use of compressed fibre cement. Advice from Infrastructure Services was that the strengthening of Jasper Unit was "*equivalent to that of Unit 18 cells.*"[1439]

1620 Mr Coyne's report identified two options that outlined how detainees at Unit 18 could be accommodated at Banksia Hill.

Option One

1621 This option was that all detainees from Unit 18 would be placed in the Jasper Unit precinct.

1622 Mr Coyne identified some issues with this option.[1440] One of those is the existence of one recreational area available which could cause a problem if detainees with known alerts against each other had to recreate together. However, Mr Coyne considered this issue could be resolved by one of two methods. First, detainees could recreate in the A and C-Wing yard at the ISU whilst detainees in the ISU were at school. Or secondly, separate recreation times could be allocated to those at risk and those with alerts to ensure their safety; although, this would impact on OOCH.[1441] I note that Unit 18 has extensively used this system which results in less OOCH for detainees housed there.

1623 Another issue identified by Mr Coyne concerned the lack of space for Jasper Unit custodial staff to write reports and complete administrative tasks. The report also noted a similar problem for the Senior Management Teams. However, Mr Coyne had a resolution for these issues. The two sea containers installed at Unit 18 could be removed and placed in the Jasper Unit and fitted out to accommodate staff.[1442]

[1438] Exhibit 97, p.1
[1439] Exhibit 97, p.5
[1440] Exhibit 97, p.5
[1441] Exhibit 97, p.5
[1442] Exhibit 97, p.5

Option Two

1624 As this option seems to be the more viable of the two, I will set out in full the relevant section from Mr Coyne's report that deals with this option:[1443]

> Detainees from Unit 18 could potentially be accommodated in ISU A and C Wings (total 16 cells) and have the option to step up into Jasper Unit as part of their transition into more normalised program subject to the detainees' individual needs and behaviour.
>
> The refurbishment of the ISU A and C Wing has included the installation of in cell CCTV which allows for ongoing monitoring of detainees.
>
> The ability to separate the Unit 18 cohort across two areas (ISU and Jasper - 5 Wings) supports the management of risk to and from alerts more effectively and will assist in the reduction in the contagion of less-than-optimal behaviour between detainees.
>
> This option allows for Banksia Hill to continuing use of the ISU B and D Wing to be used for short term management and stays of those on level 1 or 2 ARMS monitoring.
>
> It is proposed the staffing model remain as it currently stands at Unit 18, with the senior management, uniformed and non-uniformed staff working across the ISU A and C Wings and Jasper Units holistically.
>
> Education can be facilitated in EdVoc2 with access gates assessable from the ISU A and C Wing yard and from the Jasper Unit.
>
> There are no dedicated spaces for psychological intervention in the ISU A and C Wing areas; however, the facilities in the ISU B and D Wing could be utilised, or detainees could be moved to the Jasper Unit to use the repurposed sea container.
>
> E-visits can continue to be facilitated for those in the ISU A and C Wing in the Jasper Unit sea container (once IT has been completed).
>
> Recreation can be provided in the ISU rear yard, in the C Wing caged area or back in the Jasper Unit, thus three viable options.

1625 The issues raised by Mr Coyne regarding this option did not appear insurmountable to me. One of these issues concerned the lack of staff accommodation; however, Mr Coyne pointed out that two sea containers could be placed in the ISU area with IT capability to accommodate staff to write reports, and still be on site and in a position to respond to an incident.[1444]

1626 I also note that the number of cells in the A and C Wings in the ISU (a total of 16) would have been able to accommodate, at all times, the number of

[1443] Exhibit 97, p.6
[1444] Exhibit 97, p.7

detainees in Unit 18 from October 2024 to 25 June 2025. The average daily number of detainees in Unit 18 for these months ranged from 5 to 12.1. There were never more than 14 detainees in Unit 18 at any one time over this nine month period, with as little as two detainees housed there at one point.[1445]

1627 From my calculations, there would still be 20 cells in the B and D Wings of ISU that could be made available for detainees on short term management and those requiring more intensive ARMS monitoring if all 16 beds in A and C Wings held detainees from Unit 18.

1628 However, the situation regarding available beds will be greatly improved once the Crisis Care Unit (CCU) opens in Banksia Hill. This opening is scheduled for March 2026.[1446] The CCU can accommodate up to eight detainees who have an imminent risk to themselves, or who are experiencing acute mental health issues or acute psychological/emotional distress.[1447] Once the CCU becomes operational, the Court was advised that the intended use of the ISU will be to "*continue to provide short-term intensive support and supervision for young people who cannot be safely accommodated elsewhere within Banksia Hill. The ISU will function as a transition space only and is not designed for long-term accommodation.*"[1448] To me, those young people that are being placed in the ISU sound very similar to those that are being transferred to Unit 18. Which begs the question whether detainees are being sent to Unit 18 as a form of punishment.

1629 Despite the careful analysis undertaken in the preparation of Mr Coyne's report, Mr Royce said that implementing either option would jeopardise what had been achieved at Banksia Hill:[1449]

> The significant risk going back to a single operating model with one facility is that we can see a reduction in the great work we had around hours out of cell, programs, stability, staff stability.

1630 That may well be a description of the improvements at Banksia Hill since Unit 18 was established. However, the evidence at the inquest was that up until a fortnight before Mr Royce gave that evidence, the daily practice at Unit 18 was to issue a confinement order. The evidence also was that when Unit 18 is functioning as well as it can, it is inevitable that the daily hours

[1445] See table at [1550] of this finding.
[1446] Email from the SSO to the Court dated 19 November 2025
[1447] Email from the SSO to the Court dated 19 November 2025
[1448] Email from the SSO to the Court dated 19 November 2025
[1449] Ts p.2648

out of cell for any detainee in Unit 18, will be almost two hours less than a detainee at Banksia Hill.[1450]

The Court's notification to the Department of its proposed recommendation

1631 The Court invited a response from the Department with respect to a proposed recommendation that there be a suspension of the operation of Unit 18 for a fixed period to determine whether those detainees then in Unit 18 can be safely cared for at Banksia Hill.[1451]

1632 The Court received the Department's response via an email on 23 October 2025. It was disappointing, although not a complete surprise, to read that the Department did not support such a forward-thinking recommendation. The Department maintained that the yet-to-be built youth detention centre remains necessary and it did not consider the suspension of Unit 18 to be "*a current feasible option*".[1452]

1633 One of the reasons cited by the Department for not supporting this recommendation was that an unspecified number of young people at Unit 18 are there at their request and that a temporary closure of it and a relocation of these detainees would be "*disruptive and distressing to them*".[1453]

1634 I suspect these detainees were not asked if that would be their reaction to such a relocation as the Department did not say they were consulted. In any event, I do not accept this submission. It had been cited previously by the Department as a reason for keeping Unit 18 open and I would expect only a small percentage of detainees who have been transferred to Unit 18 are there by request. Although the Department did not identify the reasons why these detainees have made such a request, I suspect it is because of conflict they have with other detainees at Banksia Hill. Either of the options proposed in Mr Coyne's report would be able to deal with such an issue.

1635 Another reason cited by the Department concerned the impact the recommendation would have on the new trauma-informed model of care for Banksia Hill. However, Ms Butt struck me as a very intelligent person and I have no doubt that she would be able to make the necessary changes to the model of care at Banksia Hill to accommodate the temporary movement of detainees from Unit 18.

[1450] Ts p.3481
[1451] Email from the Court to the SSO dated 3 October 2025
[1452] Submissions from the Department received on 23 October 2025
[1453] Submissions from the Department received on 23 October 2025

1636 I am not persuaded by the Department's reasons not to support this recommendation. I have formed the view that these reasons failed to place the necessary emphasis on the following factors:

- It is desirable that the best information be available for any decision-making in relation to the future use of Unit 18.
- A fixed trial period for the suspension of Unit 18 would be a valuable source of information to inform the decision-making around the future use of Unit 18.
- Such a trial period would enable all the resources which are presently being deployed at Unit 18 to become available for use at Banksia Hill.
- Appropriate protective measures could be taken to ensure such a trial period was not an unacceptable risk to all involved.
- If, after a genuine trial period, it was decided that it could not be safely continued, the present arrangement would inevitably return.
- However, if the trial period revealed that there was potential for Banksia Hil to receive back all those young people presently in Unit 18, that would be important information for those making decisions around the future use of Unit 18.
- A realistic completion date for the new youth detention centre is still several years from now.
- No witness at the inquest (including staff from the Department) considered the use of Unit 18 to hold young people was desirable.
- Another governmental agency has concluded from a business case compiled by the Department that the use of Unit 18 to hold the most disruptive detainees is "*inadequate*".[1454]

My recommendation

1637 The future of Unit 18 to hold young people should not be simplified to whether there ought to be two sites to hold young people. There is another consideration, which before mid-August last year appeared to be the Department's position. Namely, the refurbished and reinforced Banksia Hill, combined with the improved resources now available to manage the detention of young people at that site, is capable of managing

[1454] Exhibit 149, p.3

the small group of young people who would otherwise be transferred to Unit 18.

1638 It is worthwhile having a trial period to obtain the necessary information to consider whether that is a viable option. If, after this trial period, it was decided that Unit 18 would continue to be used by the youth custodial estate, the information gained during the trial period would inform decision-making relating to whether a particular young person did actually need to go to Unit 18, or whether the refurbished and strengthened Banksia Hill could manage them.

1639 Accordingly, I make the following recommendation:

Recommendation No.18

Should my recommendation to immediately close Unit 18 not be implemented, the Department suspends the operation of Unit 18 as a youth detention centre for a fixed period to determine whether all or some of the detainees then in Unit 18 can be safely cared for at the newly refurbished Banksia Hill.

My second alternative recommendation

1640 At the inquest, Mr Ryan advocated that a closure date be announced for Unit 18:[1455]

> I think the Department needs, and the government needs, to set an ambitious plan to close Unit 18. I have mentioned that there are no obvious practical alternatives. So, they need to set an ambitious target to close Unit 18. And that needs to drive the construction of the second unit that they are planning.
>
> …
>
> Set a date. And then work to it. And that date drives the construction, the design, construction funding and so on.
>
> …
>
> Rather than we will close this place when we get around to building this other place. So, I think, you know – and I don't like setting targets. And governments don't like setting targets. But I think that is a really important thing that should happen. We have got a date. And we are going to work to it. And then, it drives people.

[1455] Ts p.826

1641 Professor Morgan also considered it was necessary that there be a closure date set for Unit 18.[1456] He expressed the concern that Unit 18 had "*become a routine part of the youth custodial estate with no end in sight*."[1457] Professor Morgan observed:[1458]

> It's now become part of the routine management of the youth justice estate. And so, for me, I think it would be, with respect, appropriate to think about a recommendation to the effect that there's a closure date.

1642 I agree with this evidence from Mr Ryan and Professor Morgan. Should it be that neither of my recommendations regarding the immediate closure of Unit 18 or its temporary suspension are adopted, then I sincerely hope that at least a recommendation that nominates a closure date for Unit 18 is implemented.

1643 Back in July 2022, the Department's Briefing Note stated why the "*temporary*" creation of Unit 18 as a second youth detention centre was necessary:[1459]

> The proposed 12-month "circuit braker" for Banksia Hill will enable repairs and infrastructure strengthening to occur. The Department will continue to review all drivers to expedite upgrades to enable the return of detainees back to Banksia Hill at the earliest opportunity.

1644 To encourage the Department "*to review all drivers to expedite*" the construction of the new youth detention centre, I make the following recommendation:

Recommendation No.19

Should Unit 18 remain as a youth detention centre until the yet-to-be built second youth detention centre becomes operational, a closure date be immediately announced for Unit 18. The purpose of such a closure date is that it will provide the necessary impetus to fund, design and construct the new youth detention centre in an expedited manner.

1645 I would urge the Department to collaborate with the State Government so that a closure date for Unit 18 can be announced.

[1456] Ts p.744
[1457] Ts p.746
[1458] Ts p.745
[1459] Exhibit 1, Volume 6.1, Tab 6, p.7

1646 However, it would be a fallacy to adopt this recommendation and then nominate a closure date many years from now. An ambitious date would be 31 January 2028, which is arguably not particularly ambitious when it is noted Unit 18 was initially supposed to close more than four years before then.

CONCLUSION

1647 When she gave evidence at the CCC, Ms Mitchell, a Unit Manager at Unit 18, stated:[1460]

> But something good has to come out of a horrible situation like his [Cleveland's] passing. Something hopefully will come out and a change of policy and a change of all of this will happen, because this cannot continue to work like this. It's - it's not sustainable. It's not sustainable for staff or for the detainees …
>
> You've got rules, but sometimes you can have all the rules in the world, [but] if you haven't got the tools to make these rules work, you might as well throw them away, because like I said … You can have a rule on a piece of paper. It means nothing.

1648 I am satisfied that the lack of "*tools*" Ms Mitchell was referring to at Unit 18 included appropriate custodial and non-custodial staffing levels, an appropriate infrastructure, appropriate means by which high-risk detainees can be continuously monitored, an appropriate trauma-informed environment, and appropriate access for detainees to mental health care, education, support services and OOCH. I am satisfied these tools were sadly lacking at Unit 18 during Cleveland's last period of detention.

1649 The actions by staff on duty during the night of Cleveland's incident in no way caused or contributed to his death. They simply did not have the resources to provide an appropriate level of care for him. The responsibility for the failings that existed in Unit 18 on that night and during Cleveland's last period of detention largely rests with the Department.

1650 On the last day of the inquest's final tranche, Cleveland's mother made a statement which included the following:[1461]

> My son didn't deserve to be treated the way that he was treated. My son didn't deserve to die. My son's death will not be in vain. In his memory, I must remain stalwart to change, to a kinder world and solid in the pursuit of justice even in the strongest winds.

[1460] Exhibit 1, Volume 2.1, Tab 11.2, p.50
[1461] Ts p.4333

> Cleveland's legacy will be to highlight the many ways in which the system failed him and to bring about real reforms to ensure that no child has to endure what he did in Unit 18. The time has come for those responsible for the administration of youth justice to be held to account. I hope that this process, which is unimaginably difficult for me and my family and indeed all those who loved Cleveland, will be the catalyst for real and lasting change. Enough is enough. My son didn't deserve to be treated that way. My son didn't deserve to die. I want justice for my Cleveland.

1651 No child in detention deserves to be treated in the way Cleveland and the other young persons in Unit 18 were treated at the time he decided to end his life. Prolonged periods in solitary confinement, isolation, intense boredom, eating all their meals by themselves, and lack of access to mental health services, education and even running water had sadly become the norm for Cleveland and his fellow detainees.

1652 Cleveland's mother is correct, the youth justice system failed Cleveland. His mother is also correct when she says there must be change.

1653 The evidence from the inquest is that some change has occurred after and because of, Cleveland's death. Much more is needed. The evidence I heard supports the recommendations I have made; recommendations that if implemented, should result in significant changes to how youth justice looks and operates in Western Australia. I hope this inquest will be a major contributor to that change. The apparent downward spiral of how youth justice was operating over the course of a decade did not abate with the opening of Unit 18 in July 2022. From the evidence gathered at the inquest, an argument could be made that it actually worsened. Whether that conclusion is ultimately reached and who was responsible for that decline will need to be a matter for an independent inquiry.[1462]

1654 Cleveland's mother is also correct when she says her son did not deserve to die. His death and the circumstances in which it occurred are harrowing and horrifying; every effort, no matter the cost, must be made to avoid such a death from happening again.

1655 It should never be forgotten that detainees are not only children but are some of the most vulnerable children in our State; many of whom have intellectual disabilities that can be directly linked to not only their offending in the community, but also to their behaviour when they are placed in detention.

[1462] See: ***Recommendation No.16***

1656 It is now time to realise that tinkering at the edges is not going to solve the long-standing problems that exist with youth justice in Western Australia. There is a compelling argument that wholesale reform and a complete reset is necessary. That will take courage as it would involve an admission that the State has got it wrong in the past. It will take a long-term commitment as it must be acknowledged that the benefits of substantial reform and readjustment will not be seen for some time. And it will be costly.

1657 But do we want the cost of more children who are detained in the care of the State taking their lives because they have given up all hope?

PJ Urquhart
Coroner
28 November 2025

Annexure A – transcript of oral findings delivered on 1 July 2025 [1463]

CORONER: Yesterday, the court heard oral submissions from counsel, the Department of Justice, and other interested parties who had been given leave to appear during the inquest. Prior to yesterday, the court had received very detailed written closing submissions from counsel assisting, and comprehensive responding submissions from counsel for the Department and various counsel on behalf of the other interested persons. As I've said at the conclusion of yesterday, I thanked counsel and their instructors for the considerable time and effort that went into the preparation of those submissions.

They have all been of considerable assistance. Of course, there was one counsel who was not able to engage the help of any instructing solicitors, and who has been, for the most part, a one-man show since the completion of the first tranche in April of last year, and that was counsel assisting. I extend my appreciation to Mr Crocker for his invaluable assistance since the beginning of last year.

On 11 December 2024, the final day of oral evidence, in response to a request by the interested parties, I provided a non-exhaustive list of topics I expected to be addressed in their written submissions.

I also outlined a list of possible recommendations. At the time, I stressed this was a list of potential recommendations I was considering, not a list of recommendations I proposed to make. I invited submissions in respect of this list and any other possible recommendations that any interested person wanted me to consider. The written submissions of counsel assisting canvassed this list and other possible recommendations. The responding written submissions from some interested persons have also canvassed this list and other possible recommendations.

The closing written submissions from counsel assisting and other counsel total well in excess of 1000 pages. There were subsequent written submissions of hundreds more pages. I have read all the submissions closely. I carefully listened yesterday to the oral submissions.

[1463] Ts pp. 4465-4476 (minor redactions have been done to surplus wording and some paragraphing changes have also been made)

The final matter I mentioned before the court adjourned on 11 December last year was that I said I may, and I put it no higher than that, be in a position after hearing oral submissions to deliver in oral form some of my findings, make some comments regarding the evidence, and outline some of my recommendations.

There are many matters upon which I must continue to reflect in light of the submissions I have received, both written and oral. However, I am in a position to address some of the matters I foreshadowed on 11 December last year. I will deliver my written finding in this inquest as soon as possible. I have reached conclusions about some of what will be in that document, and I consider it is appropriate that I announce those conclusions at this time. Before I do so, I just wish to note the following.

In recent weeks, the court had received a request from the ABC for permission to record the vision and/or the audio of yesterday's and today's proceedings. That media outlet has covered this inquest in detail and reported extensively about the proceedings. However, after careful consideration, the court declined that request. The transcript of these oral remarks of mine will be made available to counsel in the usual manner. In order to assist accurate reporting, if requested, a copy of these remarks can be provided by the court to media representatives later today. Please direct those inquiries to counsel assisting.

Some formal findings. Section 25(1) of the Coroners Act requires me to find, if possible, the deceased's identity, how the death occurred, and the cause of death. It also requires me to identify the particulars needed to register the death under the Birth, Deaths and Marriages Registration Act of 1998. My formal findings on these matters will be (1) that the identity of the deceased person was Cleveland Keith Dodd,(2) that his death occurred by way of suicide,(3) the cause of death was complications of ligature compression of the neck (hanging), and (4) the required particulars for registration are that Cleveland died on 19 October 2023, from complications of ligature compression of the neck (hanging), by suicide.

Section 25(3) of the Coroners Act requires me to comment on the quality of the supervision, treatment and care provided to Cleveland by the Department while he was in its care. My comments regarding this area are confined to the care provided by the Department during Cleveland's final period

of detention in Unit 18, that is, from 17 July 2023 to 12 October 2023.

In its written closing submissions, the Department has acknowledged many shortcomings and failings in its treatment, supervision and care of Cleveland while he was in the Department's custody, and that adverse findings and comments are open to be made against the Department.

The Department has also acknowledged that operational issues impacted on its treatment, supervision and care of Cleveland. The Department has not only acknowledged past failings, but it has acknowledged the need for change. Although it is commendable that the Department has made those acknowledgments, the weight of evidence from the inquest meant that it would have been difficult not to do so.

The inquest has also received evidence which, it has been submitted, supports the making of adverse comments in respect of other matters not acknowledged by the Department as failings. In respect of many of these matters, the Department's submissions have been twofold. First, it is said that the relevant matter is beyond the jurisdiction of the inquest. Secondly, it is said that if the matter is within jurisdiction, the proposed adverse comment is not open on the evidence. I will return to those matters in more detail a little later.

I am satisfied to the required standard that the inquest has received evidence which supports the making of adverse findings or comments on the following matters which have been acknowledged by the Department:(1) Cleveland's death should not have happened while he was in the care of the Department. (2) The Department's failure in its supervision of Cleveland on 11 and 12 October 2023. (3) The failure by staff to wear radios on the night of 11 and 12 October 2023, when Cleveland self- harmed.(4) Cleveland's access to a ligature point by way of an unfixed broken ceiling vent. (5) Cleveland being subjected to excessive in-cell hours. And finally, the supervision, treatment, and care provided to Cleveland during his final period of detention in Unit 18.

I'm now going to say something about the fact that these acknowledged failings range over many topics. However, even in the brief list I have outlined above, it is apparent that the acknowledged failings by the Department cover a range of issues and circumstances, including the non-compliance

by custodial staff with the policies and procedures set out by the Department as to the discharge of their duties whilst on shift; what supervision, treatment, and care was or was not being provided by the Department to Cleveland during the last three months of his life; the physical state of Cleveland's cell, which included the availability of a ligature point in his cell, and the lack of access to running water; and finally, the extent of what the Department has acknowledged to be an excessive number of hours that Cleveland was kept in his cell, how frequently it occurred, and why it was occurring.

Returning to what is the court to do with these acknowledged failings. To take the acknowledged failings in respect of supervision, treatment and care of Cleveland during his last period of detention as an example.

Such an acknowledgment has not been made in a vacuum. It has been made against the background of extensive evidence before the inquest of what was or was not available to Cleveland in terms of meeting his mental health needs, his therapeutic needs, his educational needs, his recreational needs, and his need for access to fresh air. There is much evidence to suggest that these needs of Cleveland were not adequately met.

It is not sufficient for the court to simply note these needs were not met. It is necessary to attempt to understand why these needs were not met, in order to have the most complete understanding and the best opportunity to prevent a recurrence of such failings.

This involved an understanding of how it came about that Cleveland was being detained in Unit 18, which, until a little over a year before his death, had been an accommodation wing for adult men in a building in a high security adult prison. In particular, it was necessary for the court to examine whether the circumstances of the establishment of Unit 18 just 15 months earlier, and its subsequent operation, contributed to the occurrence of the fact acknowledged by the Department. That fact is that during Cleveland's last three months of his life, the Department failed in its supervision, treatment and care of him. It is my view that the court was entitled to explore that connection.

To take another example, the acknowledged excessive number of hours Cleveland was confined in his cell. It is not

sufficient for the court merely to note the acknowledged inadequate out-of-cell hours provided to Cleveland. It is necessary for the court to understand how and why this occurred. Such an understanding is relevant to, amongst other things, potential recommendations to avoid the recurrence of such failings in the future.

And to take a final example, the Department has acknowledged that Cleveland's access to programs and supports offered by the Department was limited due to operational issues that impacted on out-of-cell hours. It is not sufficient for the court to receive evidence only of the existence of such a failing. It is necessary for the court to have an understanding of what were such operational issues. How did they arise? How often did they arise? And what was the nature and extent of any limitation they caused upon Cleveland's access to programs and support?

This understanding is necessary for the reasons as I have just stated. The court needs to understand how and why this situation developed. Is the situation still occurring? And what can be done to prevent a recurrence of the circumstances which gave rise to the acknowledged shortcomings?

I'm now going to make a few observations about the fact that an inquest is a fact-finding exercise. In the first tranche of evidence heard in April last year, the court was told by staff who worked on the floor of Unit 18 during Cleveland's last period in detention, of the appalling conditions in which the young people were being detained.

These staff described the chaotic operating environment they experienced working there. The court heard evidence it was like, I quote here, "a war zone". They described the soul-destroying daily confinement orders which kept detainees in their cells, sometimes for 24 hours a day. They described the lack of support and training given to them to do their jobs. They described the chronic shortage of staff. It was never suggested then, nor since, that this evidence was not a proper matter for the court to explore.

These circumstances of how Unit 18 was operating in the time before Cleveland's death did not arise out of thin air. There had to be an explanation as to why Cleveland and his fellow detainees were in Unit 18, and why their living conditions were as they had been described. To examine the circumstances, the place in which Cleveland was detained

when he self-harmed, it was necessary for the court to understand how it got to that state.

There is a story behind the establishment and operation of Unit 18. That story revealed how and why Unit 18 was operating as it was at the time of Cleveland's incident.

As the inquest proceeded during its second tranche of evidence across a four-week period in July and August last year, the court heard evidence about what the Department was doing or was not doing in the lead-up to the establishment of Unit 18. The inquest heard about how the Department operated Unit 18, and the difficulties the Department had in operating it in the circumstances which existed.

There is a considerable body of evidence gathered at the inquest that may very well warrant an investigation to make findings in the areas that were outlined in paragraph 15 of the Department's written closing submissions, dated 6 May 2025. However, the Department and other interested parties have submitted that these areas are beyond the jurisdiction of the court. Paragraph 15(a) to (g) reads as follows:

(a) Findings with respect to issues experienced in Banksia Hill in 2022 and prior to the establishment of Unit 18;

(b) Findings with respect to the Department's response to a show-cause notice issued in 2021 with respect to Banksia Hill;

(c) Findings with respect to the decision to use Unit 18 as a youth detention facility;

(d) Findings with respect to allegedly untruthful or misleading messaging about the opening of Unit 18;

(e) Findings with respect to an alleged failure to respond meaningfully to concerns about youth justice expressed by the Inspector of Custodial Services in the years before opening Unit 18;

(f) Findings with respect to allegedly commencing to use Unit 18 as a youth detention centre before it was safe to do so; and

(g) Findings with respect to a failure to provide adequate resources during the entire period during

> which Unit 18 operated, and beyond Cleveland's final period of detention there.

I will just cite three small extracts of transcript from the inquest that are examples of why an investigation into these areas may be warranted. The Deputy Commissioner of the Department's Directorate of Women and Young People was Christine Ginbey, and she oversaw the preparations to stand up Unit 18. At the inquest, she agreed that the timeframe to stand up Unit 18 was "entirely unreasonable" (transcript page 2413.

Dr Tomison announced to his executive, including Ms Ginbey, that Unit 18 was going to be the second detention centre on 1 July 2022. In excess of 100 male adult prisoners were only removed from Unit 18 on 10 July 2022. On 20 July 2022, the first intake of detainees was moved into Unit 18. The current Commissioner of Corrective Services, Bradley Royce, told the inquest this timeframe was "ridiculously short" (transcript page 2676).

When the then Commissioner of Corrective Services, Mike Reynolds, was asked at the inquest that with the benefit of hindsight, would have he conscientiously objected to Unit 18 being chosen as the site of the second detention centre, he answered as follows:

> "I think that Unit 18, as a second site, was a bad decision. I think we needed a circuit breaker for Banksia. What that was, yes, I'm not sure, but I think Unit 18 was destined to fail." (transcript page 1812)

If the court is not to consider the evidence about the manner in which Unit 18 was set up and opened, should another entity consider what this inquest has revealed?
The Department has submitted the comments concerning its management of, and I quote, "the general operation of youth justice in this State properly belongs to", and it continues, "entities other than the court". And in its written closing submissions, one suggestion was the Office of the Inspector of Custodial Services.

If there are matters of potential concern which are to be determined – and I'm quoting from the Department's written closing submissions: "at another time and in another place", how is that to occur? If the court was to accede to the Department's submission, what is to happen to such potential concerns? How would these concerns be brought to the

attention of other entities whom the Department has identified as the time and place for such an examination? Is it reasonable to expect that the Department itself would bring them to the attention of those entities?

I do not consider the Department would do so. The principal reason for that is that the Department does not consider there is any material to suggest there is any scope for an adverse comment to be made about itself or its employees on most, if not all, of those issues I have just read out, that appear in paragraph 15 of the Department's written closing submissions. The Department has submitted that, and I quote:

> "The oversight of government departments and their employees, including with respect to the accuracy and truth of communications made by those entities, rests with others."

In such circumstances, it cannot be expected that the Department would refer these matters to any other entity.

I therefore foreshadow that I am considering making a recommendation that a special inquiry under section 24H of the Public Sector Management Act 1994 be held to address the manner in which Unit 18 came to be in existence. That review would necessarily have to include an examination of the state of affairs leading up to the opening of Unit 18.

From the evidence I have heard at the inquest, an appropriate starting point for that examination would be January 2013, when the serious incident at Banksia Hill occurred. At the very least, it would involve an investigation into matters identified in the Department's written closing submissions at paragraph 15.

Given the amount of evidence that would be considered by this inquiry, I am of the view the recommendation, if made, would be that the Public Sector Commissioner should consider using the provisions of section 24H(1)(b) to appoint a person or persons to carry out the special inquiry. Such a special inquiry can be held into a matter related to the public sector. The Department of Justice is a public sector body.

Such a review can be commenced upon the Public Sector Commissioner's own initiative, or by the Minister for Public Sector Management directing the Commissioner to undertake such a review. The role of the Public Sector Commission is

to strengthen the efficiency, effectiveness and capacity of the public sector to meet existing and emerging needs and to deliver high quality service.

There is evidence that has revealed aspects of the manner in which the Department did its work which is worthy, in my view, of closer examination in a special inquiry. That evidence I've already cited from Ms Ginbey, Mr Royce, and Mr Mike Reynolds, are just three examples. As I've observed on a previous occasion, this inquest has been unique and unprecedented in many aspects. At one stage, counsel assisting described it as seminal.

That is an apt description. This inquest is of immeasurable importance in the context of youth justice in this State. It is an opportunity to ascertain the necessary facts, to enable a consideration of those facts to be undertaken, so as to identify and make changes to prevent the recurrence of the tragedy of Cleveland's death. Everything must be done to minimise the risk of another death of a child in youth detention in Western Australia.

When the current Director General, Ms Kylie Maj, gave evidence at the inquest, she said she was concerned about what had been uncovered in the evidence. She told the court she did not need to wait for recommendations at the conclusion of the inquest before acting on certain matters. Several witnesses agreed that if there had been no inquest, the evidence which had just been revealed would never have come to light. Other witnesses agreed that the material being revealed during the inquest was causing the Department to make changes to how it was operating Unit 18.

I now return to where I began. The Department has acknowledged that adverse findings can be made about failings in its supervision of Cleveland on 11 and 12 October 2023. It has acknowledged that adverse findings can be made about the supervision, treatment, and care provided to Cleveland during his final period of detention in Unit 18. It has acknowledged adverse findings can be made about Cleveland's access to a ligature point by way of an unfixed, broken ceiling vent. It has acknowledged adverse findings can be made about Cleveland being subjected to excessive in-cell hours.

Given those acknowledgments, I am able to advise, and am satisfied, that I will be making adverse findings against the Department that align with those concessions.

As I have said earlier, it remains my view that the manner in which Unit 18 came into existence was a necessary investigation for the inquest to undertake in order to understand how Unit 18 got to a stage where it was operating in the manner that it was during Cleveland's last period of detention there. A manner that was so vividly described by those witnesses who worked on the floor at Unit 18, who gave evidence at the first tranche of the inquest in April of last year.

If I'm wrong about that, then the evidence I have heard in this area was relevant to my functions under section 25 (2) of the Coroners Act, to make recommendations. For example, the potential recommendation I have outlined for a special inquiry under the Public Sector Management Act. There are other recommendations that I am considering that could well be based on this evidence. One is that the Department of Justice no longer retains control of the youth detention estate. Another is that Unit 18 should be closed.

It is my view that these three potential recommendations relate to matters that are sufficiently connected to Cleveland's death to enable me to make them; particularly in light of the Department's acknowledgment that there were failings with respect to its supervision, treatment and care provided to Cleveland during his last period of detention.

As to the court's proposed recommendations that the Department supports, I will make those recommendations that have not yet been implemented.

The utility of those three potential recommendations I outlined a moment ago, and other recommendations I am considering, is not affected by whether the court makes adverse findings, comments or conclusions on matters that the Department and other counsel for the interested parties say the court ought not consider, as they are either outside the court's jurisdiction or are irrelevant to the findings the court is to make.

After careful consideration of the submissions made by counsel assisting and counsel for the interested parties, I have determined that any adverse findings or comments I make against the Department or an individual employee of the Department will be confined to (1) actions taken or not taken during the last time Cleveland was detained in Unit 18, that are connected to his death, and (2) actions taken

or not taken that are directly related to matters relevant to Cleveland's death. I will give two examples of actions taken or not taken that I regard as being directly related to matters relevant to Cleveland's death.

They are what the Department and/or its employees did regarding (a) the covering of cell CCTV cameras, and (b) the existence of damaged ceiling vents, not just in Cleveland's cell, but also looking at the widespread nature of that damage.

I have outlined the narrowed scope of my adverse findings at this stage and before my written finding is handed down, so that counsel for the interested parties can advise their clients of what that means for them sooner rather than later. I'm now going to make some concluding remarks.

There can be no doubt the evidence from the inquest has revealed that youth justice was in a crisis at the time of Cleveland's death, and had been for some considerable time. Indeed, the reason given for opening Unit 18, the fear of losing control of Banksia Hill, was a part of that crisis. The coronial process is a unique opportunity to make recommendations about how things could be changed and improved into the future. It does not do this in a vacuum. It undertakes this exercise against a factual understanding of what did or did not occur.

It is not an exercise in blaming people. That is not to say that the behaviour of people cannot be examined in detail. It is important that it be understood that if I do make the foreshadowed recommendation that there be a special inquiry under the Public Sector Management Act, the court is not diminishing the importance of the evidence it has considered in order to make that recommendation; to the contrary.

The Department is very clear in its position to the court. It says that if there are potential concerns about the conduct of the Department, which it says is not sufficiently connected to Cleveland's death, these are matters for another time and place. There is such a place. Should I decide to make a recommendation for a special inquiry into the Department's conduct in the lead-up to the establishment of Unit 18, that will be an acknowledgment of the importance of the evidence that has been revealed during this inquest.

As I had mentioned at one point during the inquest, I sincerely hope that those responsible for implementing the

recommendations I ultimately make, will have the resolve and commitment to make them.

The death of a loved one is always a sad occasion. But when that loved one is a child who has died in such tragic circumstances as those that existed for Cleveland, it would be, without any doubt, an unbearable tragedy.

On behalf of the court, I convey to all of Cleveland's family and loved ones, particularly his mother, Nadene, my heartfelt condolences for your loss.

In its written closing submissions, the Department expressed its regret for its acknowledged failings, and apologised to Cleveland's family and the community for those failings. That apology to Cleveland's family was entirely appropriate. It was also appropriate that the apology be extended to the wider community. As Nelson Mandela once said: "There can be no keener revelation of a society's soul than the way in which it treats its children."
I certify that the preceding paragraph(s) comprise the reasons for decision of the Coroner's Court of Western Australia.