# Report of the Inquiry into the prisoner riot at Spring Hill Corrections Facility on Saturday 1 June 2013


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## Foreword

The riot that occurred at Spring Hill Correctional Facility on 1 June 2013 was the largest and most destructive incident of concerted indiscipline experienced in New Zealand prisons in almost 15 years. This was a significant and traumatic incident for the Department and specifically for all who were directly involved. The inquiry team acknowledge the impact this event has had on a number of individuals.

This Inquiry was set up to establish the reasons and causes of the riot and how it was managed. It was carried out by a team led by the Chief Custodial Officer and included representatives of the Chief Custodial Officer's team, the Inspectorate, Corrections Services and the New South Wales Department of Corrections. Assistance was also provided from the Policy team in Service Development and we received advice from an external expert in health and safety for which we are very grateful.

The Inquiry team's experience has enabled us to compare the response and post-incident actions with similar incidents from other jurisdictions. Any incident of this nature, particularly one involving such extensive damage and destruction, will require a whole of Department approach and careful management and consideration in the return to business as usual. It is not unknown for the recovery of such incidents to become a protracted affair and this in turn can lead to related problems for the Department and further affect the morale of staff. The Inquiry team therefore commend the swift actions taken by the Department in regards to the recovery of Spring Hill and the support of the staff that were involved.

Finally the team would like to acknowledge the full cooperation provided by the staff and management team of Spring Hill Correctional Facility and Central Region, as well as the staff who had involvement with this incident from outside the establishment and region, including the Emergency Services.

Neil Beales

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## Executive Summary

1 This report presents findings from the Inquiry into the prisoner riot that occurred at Spring Hill Corrections Facility (SHCF) on 1 June 2013. The Inquiry examined the events immediately before, during and after the riot, including the Department's incident response and the operating context at SHCF at the time of the riot. The Inquiry was conducted by a team led by the Department's Chief Custodial Officer.

*What happened on 1 June 2013*

2 On the morning of 1 June 2013, staff in Unit 16B Section 6(c) at SHCF became aware that a small group of prisoners were intoxicated. Subsequently two containers of illicit home-made alcohol (home brew[1]) were found in one of the prisoners' cells. Shortly afterwards, staff intervened in an altercation between two prisoners that resulted in the staff being assaulted. Staff retreated to the staff base, at which point prisoners began attacking the staff base with considerable force. Due to safety concerns, staff were instructed to evacuate the unit.

3 Prisoners subsequently breached the staff base, and by midday up to 27 prisoners were uncontrolled in the Section 6(c) compound, damaging property and lighting fires, which were fuelled with property collected from their cells, the unit storeroom and the staff base, including prisoners' personal files.

4 The situation was contained throughout the afternoon by staff maintaining a perimeter outside the unit. Staff attempted to negotiate with the prisoners, however this proved ineffective due to the hostile and intoxicated state of some of the prisoners.

5 An intervention plan was developed for the Department's Advanced Control and Restraint (ACR) teams to regain control of the unit. However, before this could be implemented, the NZ Fire Service Commander on site advised that the fires in the unit had progressed to the point where the lives of prisoners who were still locked in their cells were at risk. Immediate intervention was now required and the intervention plan was revised accordingly by the ACR Commander at the scene.

6 Extraction of the prisoners commenced at approximately 1721hrs. ACR staff faced substantial violent resistance, with both ACR team members and prisoners sustaining injuries as a result. By 1824hrs the ACR teams had successfully brought the rioting prisoners under control and ensured that both pods were secured.

7 Once all prisoners were secured, both pods of Unit 16B were completely evacuated, and the rioting prisoners were transferred to Auckland Men's Prison.

*The Department's response*

8 Overall, the Department's incident response was extremely well managed. Individual staff members demonstrated courage and bravery under very difficult conditions.

[1] Home brew, in a prison context, is an illegal, rudimentary method of creating alcohol. It is made using basic ingredients, typically fruit, sugar, water and a fermenting agent such as yeast, or a product containing yeast such as bread. It may also include substances that contain alcohol, such as cleaning products or hand washes.

9 Following the [redacted] and [redacted] activations, staff responded in an appropriate manner, attempting containment, negotiations and then progressed the emergency response as events escalated. Despite the serious nature of the incident and lives being placed at risk, effective staff training and collaborative working across multiple agencies enabled the Department to contain the risk of serious harm.

10 The ACR teams' were exemplary and they were effective in regaining control of the unit in extremely difficult circumstances. However, the mobilisation of ACR teams experienced some delay as some ACR members were not readily contactable. There were some instances of ACR members' equipment being damaged by the violent resistance of the prisoners [redacted]. Aside from these issues, the equipment used by the ACR teams was effective and performed as required. The ACR teams' intervention was also hampered by the difficulty in opening the locks on [redacted] doors to [redacted], due to poor maintenance. This prevented the teams being able to exit the unit quickly.

11 The water sprinkler system in the unit was overwhelmed by the extent of the fires. [redacted] the system did not have enough water pressure to prevent the fire from spreading. [redacted]

*What we have learned*

12 The Inquiry has concluded that the immediate cause of the riot was as a result of the actions of certain prisoners in Unit 16B on the morning of 1 June. Two key triggers have been identified. Firstly, the availability and consumption of 'home brew' alcohol by prisoners in the unit. Secondly, the fighting between prisoners which staff intervened to break up subsequently led to staff being assaulted. [redacted]

13 A number of factors have also been identified that contributed to the circumstances in which the riot occurred. None of the factors alone can account for what happened, but the combination and alignment of all of these factors created the pre-conditions in which the riot was able, and more likely, to occur. However**,** the ultimate responsibility for the violence, damage and destruction caused during the riot clearly lies with the actions and decisions of the prisoners directly involved.

14 The overall design and use of SHCF contributed to the conditions in which the riot prevailed, and the degree to which it escalated. [redacted] It was designed as an "end destination" prison focused on rehabilitation, rather than a prison with a focus primarily on security and control.

2 [redacted]

15 Prison population pressure within the Department in 2008/09 resulted in significant changes being made to the facility population at SHCF; this impacted the operating philosophy of the prison. Plans were developed in response to the muster changes, and the implementation of double bunking, to improve the security of some units in the prison. However, these were not approved by senior management at the time. This was a missed opportunity to improve security.

16 The unit in which the riot occurred was a high security unit, mostly single celled, which held unmotivated, difficult and disruptive prisoners who were predominately gang affiliated. This mix of prisoners contributed to the outbreak of the incident, and the escalation into a full-scale riot. It is the view of the Inquiry team that a significant operational risk was created by having a high density of unmotivated, high security prisoners in a site that was not designed to manage them.

17 The Inquiry team has concluded that there was a general lack of capability within the management team at SHCF prior to the riot. The management team were divided and dysfunctional in some aspects, and failed to provide strong and visible leadership for staff.

18 Prison management failed to respond effectively to previous incidents and to the intelligence that indicated a potentially dangerous situation in Unit 16B. Operational intelligence has shown that the manufacture of ‘home brew’ was a recurring problem at SHCF and within Unit 16B in particular. This intelligence should have resulted in more targeted and robust actions by the management team to address the problem before a serious incident occurred.

19 Following a previous incident involving ‘home brew’ in Unit 16B in January 2013, a more restrictive unlock regime was implemented in the unit. While prisoners were still being unlocked each day, on alternate days some prisoners were being locked up for 26 hours consecutively. This response would not only have failed to address the risks it was put in place to manage, but may also have exacerbated prisoner discontent.

20 The combination of the intelligence available and the incident in January should have been significant indicators to SHCF management that rigorous action was required to reduce the risk in Unit 16B. A comprehensive plan should have been developed to address all of the concerns and a strong, visible leadership presence within that unit should have been evident. The Inquiry team have not been provided with any material information that these matters were appropriately addressed.

## Recommendations

21 The Inquiry team recommends that:

1. The Department should investigate further measures to reduce prisoners' ability to make 'home brew', such as: placing limits on fruit purchases or only allowing fruit on site that is not amenable to making 'home brew'; replacing sugar in prisons with artificial sweeteners; providing only perforated plastic bags; or increasing the penalties for prisoners who are found with excessive amounts of fruit.

2. The Department should replace alcohol based cleaners and hand washes within all prisons with non-alcoholic products.

3. The Department should ensure that robust systems are in place so that the Department is able to maintain an effective overview of prisoner placement and prevent high risk prisoners and gang members being held in unsuitable locations.

4. The Department should continue to reduce the number of prisoners held at SHCF and Northland Region Corrections Facility (NRCF)[3] with High Security Classifications.

5. The Department should adopt a system whereby all decisions regarding maximum security classification are made in a consistent manner.

6. The Inquiry has noted that at SHCF there have been occasions where prisoners have been locked in their cells for periods of more than 24 hours, potentially fuelling prisoner discontent. This is a direct result of the two hour rolling unlock regime that some units at SHCF had adopted. While this regime was not identified as a direct causal factor of the riot, this practice should be reviewed as soon as practicable and include all prisons to ensure similar issues are not replicated.

7. The Department should continue to review, consider and implement improvements to design and security enhancements in campus style facilities.

8. The Department should consider introducing Immediate Response Teams, operating at all times in campus style sites.

9. The Department should review the capability and response system for ACR teams in order to improve response times and increase availability.

10. The Department should review the equipment and resources available to sites and ACR teams, in order to improve how teams are deployed and supported and to enhance their ability to operate in a rapid, safe and effective manner.

11. The decision to activate the National Emergency Operations Centre should be made immediately upon request of a Gold Commander[4], when it is clear that a significant event is unfolding, in order to quickly establish what response is

[3] NRCF has been included in this recommendation as it has a very similar design to SHCF.
[4] The Gold Commander is the person who assumes overall responsibility for management of the incident at a regional or national level. The Incident Commander (Silver) is in charge of the incident on site. They report to and request approvals and support from the Gold Commander.

required and what support is available, and to manage communications from a national perspective.

12. The Department should have regard to the reports from Opus and from the NZ Fire Service, and assure itself that adequate fire protection is in place in all prisons. This should include arranging regular site familiarisation visits by Fire Service personnel.

13. The Department should assess the water supply available at all sites. Section 6(c) [redacted]

14. Access Section 6(c) [redacted] was hindered because locks could not be easily opened, due to poor maintenance. The Inquiry team recommends that all locks in all prison facilities be checked on a regular basis to ensure they are operating efficiently.

15. The Department should review the practice of holding the personal files of prisoners within units. Section 6(c) [redacted]

16. The Department should take steps to remind all staff of the importance of timely incident reporting, as per the existing requirements.

17. The Inquiry team is aware that the Chief Executive intends to formally recognise staff involved in the intervention and rescue of prisoners in Unit 16B for their courage and bravery and fully endorses this decision.

## Purpose of the Report

1 The purpose of this report is to present the findings of the Inquiry into the riot that occurred at Spring Hill Corrections Facility (SHCF) on 1 June 2013. Based on these findings, the report makes recommendations aimed at preventing the likelihood of a similar incident occurring and improving the effectiveness of the Department's incident response capabilities.

## Inquiry Process

2 A formal Inquiry into the circumstances surrounding the riot was conducted by a team led by the Department's Chief Custodial Officer. The Inquiry had access to all information, documentation, premises and persons relevant to the incident and, with the approval of the Acting Deputy Chief Executive, was able to call on such additional or specialist assistance as required. The Terms of Reference for the Inquiry team are attached to this report (appendix 1).

3 The Inquiry team has analysed the course of events that occurred at the prison on 1 June, including the immediate causes and trigger events that led to the incident, and the Department's incident response (including the use of the Department's Emergency Management Framework) and post-incident response. The Inquiry also examined the operating context of SHCF prior to the riot, and any relevant issues regarding the prison's facilities.

4 The Inquiry team spent considerable time on site at SHCF and conducted a number of interviews with staff who were directly involved in the riot and with staff who have provided information in a wider context.

5 The Inquiry team also interviewed a number of prisoners who were either directly involved in the riot or locked in their cells in Unit 16B during the riot. The Police had, at the outset of the Inquiry, requested that no-one from the Department's Inquiry team speak to the prisoners who were directly involved, until such time as Police had been able to complete their interviews of the prisoners. On 10 July a list of prisoners was provided to the Inquiry team by the Police, identifying participants that the Inquiry team were able to interview.

6 A large amount of data and recorded information was retrieved and analysed during the Inquiry process. CCTV images and footage was captured and used to create a very detailed timeline of events, which is attached to this report (appendix 2). Additionally, a member of the Inquiry team worked very closely with the Police to review footage frame by frame, and provide them with evidential quality images for prosecution purposes.

*Methodology*

7 The Inquiry team undertook a preliminary planning workshop to ensure that all aspects of the incident were covered during the investigation. The Inquiry Team Leader liaised with a workplace health and safety expert who provided advice about utilising a model known as the Cumulative Act Effect.

8 The Cumulative Act Effect model is used in risk analysis and risk management of human systems to explain accident causation. It has since gained widespread acceptance and use in healthcare, in the aviation safety industry, and in

emergency service organisations. The model examines an organisation's various levels of defence against failure, and argues that when weaknesses or absences in multiple levels come into alignment, this is when accidents or other incidents can occur.

9 Based on this model, the Inquiry team examined factors relating to the riot under four broad categories:

- Organisational and System Factors
- Task and Environmental Conditions
- Individual and Team Actions
- Absent and Failed Defences

**Course of Events on 1 June 2013**

*A detailed timeline has been collated from frame by frame analysis of available CCTV footage and is provided in appendix 2 to this report. The following section provides a summary of events based that footage.*

10 At about 0920hrs on the morning of 1 June 2013, staff in Section 6(c) of Unit 16B became aware that a small group of prisoners were intoxicated, and suspected that they had been drinking home brew. The unit had opened as per routine and 27 prisoners were unlocked. At 0930hrs staff attended a cell, where a quantity of brew was found and removed. Some time after this, staff noticed that a group of prisoners had again congregated around the same cell. Staff returned to the cell and found another container of home brew, which was also confiscated. However, no further action was taken by staff at this time to restrict affected prisoners, or make further searches. The Inquiry team were informed by prisoners who were in the unit but not involved in the riot, that home brew on this occasion had been prepared so that certain prisoners could "celebrate the birthday" of one of their number.

11 An altercation between two prisoners was observed in the compound at approximately 1027hrs, and staff responded quickly to separate the two prisoners. Again, no further action was taken, and a few minutes later the same two prisoners were found to have entered the dining room, along with five other prisoners, and recommenced fighting with each other. The Inquiry team have not been able to establish the reasons the prisoners were fighting.

12 Staff responded to the fighting again. Some prisoners attempted to prevent staff from entering the dining room by holding the door shut, requiring staff to force their way in. Once in however, a clearly intoxicated prisoner punched one staff member, who defended himself by pushing the prisoner away. Other prisoners in the area advanced aggressively on the staff member, who then retreated to the staff base. One staff member was punched on more than one occasion in the back of the head by a prisoner while retreating to the staff base.

13 A Section 6(c) call was activated by radio transmission at approximately 1032hrs; however, within moments the situation clearly began escalating rapidly, so a Section 6(c) Section 6(c) was activated.

14 Up to nine prisoners began attempting to break into the staff base. Section 6 (c)

CCTV footage shows that at this stage, the prisoners momentarily retreated back from the base, apparently (and remarkably) to allow a corrections officer, who had become trapped in the pod and had locked himself in an interview room for his own safety, to re-enter the staff base.

15 The prisoners then returned to attack the staff base, Section 6(c) [redacted] The door was not breached at this point.

16 Although 27 prisoners were unlocked in the Section 6(c) [redacted] compound at the time of the incident, not all of these prisoners were involved in the initial attack on the staff base and camera footage shows some prisoners sitting around the unit watching the event unfold.

17 At 1037hrs camera footage shows at least 24 extra staff responding to the incident and assembling in Unit 16B Section 6(c) [redacted]. They did not enter the pod due to the volatile nature of the prisoners attacking the staff base.

18 The Emergency Operations Centre (EOC) had opened on site and the Emergency Management Framework had been initiated. After being briefed, the Chief Executive directed the Regional Commissioner, Corrections Services, Northern to coordinate the Department's emergency response, which involved calling for support from negotiators, senior managers and Advanced Control and Restraint (ACR) teams. The Police, Ambulance and Fire services were also notified, and quickly attended.

19 At approximately 1112hrs, due to safety concerns, staff were instructed to Section 6(c) [redacted] withdraw from the staff base. Section 6(c) [redacted] At 1118hrs prisoners were seen entering the staff base Section 6(c) [redacted].

20 Section 6(c) [redacted]

21 Over time an increasing number of prisoners were showing signs of being intoxicated. By midday almost all of these prisoners were engaged in the riot. At 1226hrs several fires had started in the compound and the dining room. Section 6 (c) [redacted] he spread of flames and smoke meant that prisoners still locked in their cells were now at high risk from fire and smoke inhalation.

22 Section 6(c) [redacted]

23 A prisoner smashed the windows in the day room facing the external area of Unit 16B. Section 6(c) [redacted] He was making "cut throat" gestures towards various staff. He appeared very intoxicated and was drinking what is believed to be home brew from a milk carton. Section 6(c) [redacted]

24 Prison Negotiator Teams (PNT) arrived from SHCF, Waikeria and Auckland Prisons. They initially tried talking to two prisoners through the dining room window. However, another prisoner came in shouting, highly agitated and aggressive, and the situation became untenable due to the constant noise from the sprinkler system.

25 The PNTs then moved around the external area of the unit and talked to prisoners who were still locked in their cells through the windows. Several of these prisoners were concerned about the incident and were afraid they would get burnt in the fire. The Inquiry team have viewed footage of staff talking to prisoners through their cell windows and advising them they could not get to them to assist. One officer is seen passing a garden hose through to a prisoner to aid in putting out fires.

26 At approximately 1430hrs the fire started to take hold in the Section 6(c) [redacted] roof area. Due to the nature of the incident however, the Fire Service were not allowed to go past the Gate One area.

27 The fire crew provided the PCO Security Officer with six hoses, who assembled a group of corrections officers who were experienced volunteer fire fighters, to assist in fighting the fire externally. The Inquiry team have discussed this with the Hamilton Fire Service. The Assistant Area Commander and Area Commander were very satisfied with this action, and were conscious of the potential danger to their fire crew.

28 Staff fighting the fire tried to slow down the fire from entering the plant room and roof spaces. This proved unsuccessful due to a lack of water pressure from the hydrant Section 6(c) [redacted] The staff members then moved to the front of the building to try and stop the fire from spreading to cells occupied by the prisoners. These officers did not have any normal fire protective equipment and at approximately 1730hrs they had to stop fighting the fire due to the risk posed by smoke inhalation.

29 A number of fire sprinklers had been activated in cells and around the unit. Section 6(c) [redacted] hat there was insufficient water pressure in the system to effectively prevent the spread of the fire.

30 A written plan had been agreed for ACR teams to intervene and was to be initiated at 1730hrs. However, by 1715hrs fires had progressed to the point where the Fire Commander advised that the plan was no longer safe, due to the central entry area being compromised by the fire. He also advised that the lives of the 17 prisoners who were still locked up were now at risk, due to the spread of the fire towards the cells, and immediate intervention was necessary. The situation now became an "intervention, extraction and rescue" operation for the ACR teams.

31 Extraction of prisoners began at approximately 1721hrs. During the extraction the prisoners put up hard resistance, and four ACR team members received serious injuries, including broken limbs. Ten prisoners received minor injuries, and two prisoners required hospital attention, including one with a fractured arm.

32 At about 1824hrs the ACR teams had taken control of Unit 16B. Section 6(c) [redacted] ACR teams were redeployed, and managed to take control of the situation in this unit almost immediately. One prisoner from Section 6(c) [redacted] lit a small fire which was immediately extinguished by a staff member. Section 6(c) [redacted]

33 The situation was finally brought under full control by 2000hrs on 1 June 2013.

34 Throughout the remainder of the night, 117 prisoners (including 35 non-compliant prisoners) were safely transported by prison escort vehicles to Waikeria Prison, Auckland Prison, and Mount Eden Corrections Facility (MECF). Police assisted in the transfer of the rioting prisoners to Auckland Men's Prison, with the Armed Offenders Squad accompanying the escort.

## Operating Context

35 The following section provides details regarding the operation of SHCF prior to the riot. To provide a picture of the operating context in which the riot occurred, the Inquiry team examined the planning and design of SHCF and ways in which its recent operations conformed to, or deviated from, original intentions and specifications. The team has examined the particular characteristics of Unit 16B that may have had a bearing on the riot.

36 The Inquiry also assessed the leadership and management and staffing issues at SHCF, and analysed assurance information that was received prior to the riot in the form of intelligence reports, various internal and external reviews, and health and safety concerns.

*Planning and design of SHCF*

37 The design and build of SHCF and three other regional prisons was managed by the 'Regional Prison Development Programme' (RPDP). The prison began operating in 2007.

38 SHCF was originally designed as a 650 bed prison to meet the demand for high and low security sentenced beds within the South Auckland region. The facility was designed by a team of consultants led by Section 9(2)(a) [redacted] who were also responsible for the design of Northland Regional Corrections Facility (NRCF) and the re-development of MECF.

39 With respect to the prison's design features, the residential accommodation blocks are similar in style to those at NRCF. Section 6(c) [redacted]

40 Originally intended as an "end destination" prison for motivated prisoners, the prison was built with a range of accommodation types and special focus units, and a configuration that differs from other, more traditional prisons. Section 6(c) [redacted]

Section 6(c)
[redacted]

41 This environment included providing a layout which provided for separation of residential and work areas, specific movement zones, and a range of different building types. These features were intended to promote a 'normalised' environment, and to encourage specific types of desirable behaviour. For example, the diverse range of accommodation types was planned to encourage prisoners' more rapid progression from high security through to low-security self-care units. The requirement to provide a normalised environment also extended to the internal environment, impacting on design decisions involving things such as toilet types and window materials.

42 Prison Services managers visited campus style facilities in Australia to inform the design and the operational philosophy of the RPDP. A key feature observed in the Australian facilities was the availability within such prisons of an Immediate Response Team (IRT), made up of specially trained staff that have access to firearms, dogs and tear gas. They operate independently from the normal operational staff of the prison. This capability was not adopted and adjusted for the RPDP sites.

43 Section 6(c)
[redacted]

44 Since construction of the prison was completed, significant changes occurred in the prison's configuration. These changes involved an increase in bed capacity at the site in 2008/09, made in response to continuing muster pressures at that time. Bunk beds were installed in all low security residential units (except self-care) and in a proportion of the high security units. This increased the prison's capacity by 52% (from 674 to 1027 beds).

45 The impact of high musters and the double bunking of a number of cells fundamentally impacted the operational philosophy of the new prison. Some options to increase the physical security of the site to manage these changes were developed but not accepted by senior management at the time.

46 Opportunities were also not taken by local management to adequately mitigate localised risks. They failed to adjust their operating philosophy, leading to an on-going tension among SHCF staff, in regards to whether SHCF was a prison with a focus on security and control, or a facility with a focus on rehabilitation and promoting prisoner self-responsibility. This tension resulted in role confusion both within the site and how the site was used within the national context.

47 The Inquiry team noted that figures compiled on 30 May 2013, comparing prisoner populations across all prison sites, showed SHCF as holding the highest percentage of prisoners with an active violence offence flag, and the second highest percentage of prisoners with an active gang flag. Many of these prisoners were regarded as unmotivated. The site was not designed or intended to hold such a density of this type of prisoner.

*Particular features of Unit 16B*

48 On 1 June 2013 Unit 16B [redacted] had a muster of 89, all except one were high security prisoners and considered more difficult to manage compared to other prisoners at SHCF. [redacted] in particular, where the incident started, held prisoners regarded as "unmotivated". The physical layout of Unit 16B is detailed in the site plan attached to this report (appendix 3).

49 A dashboard report on gangs and organised crime at SHCF as at 13 May 2013 indicated that a total of 50 of the 89 Unit 16B prisoners were gang members. Thirty two prisoners representing six different gangs were housed in [redacted] of Unit 16B.

50 An assessment of the prisoners' security classification in Unit 16B has found that four prisoners that were involved in the riot were initially assessed as Maximum Security, but were overridden to High Security, enabling them to remain in the Unit. Prisoners who score 33 points or more on their internal security classification risk (POM reference M.02.05) are deemed to be Maximum Security. The internal security classification scores for these four prisoners were 43, 44, 62 and 63.

51 The Inquiry has received a number of reports that include detailed data relating to prisoners housed in Unit 16B. They include:

- Incidents in the unit
- Complaints from prisoners (from IOMS and the Inspectorate)
- Prisoner Alerts
- Security Classification of the prisoners and override decisions.

52 A comprehensive analysis of this information has been undertaken by the Inquiry team. This analysis has indicated that generally the number and seriousness of incidents emerging from Unit 16B was not significantly different to those in other units at SHCF. However, what was distinctive about the incidents in this unit was the very high number of home brew seizures.

53 There was also a significant incident involving home brew in [redacted] in Unit 16B in January 2013. The incident report describes approximately 20 intoxicated prisoners fighting, but staff were able to intervene and quell the fighting, and lock the prisoners away. Approximately two hours prior to the fight starting, staff in Unit 16B had seized a quantity of home brew from prisoners in Pod C. One of the prisoners involved in starting this altercation was also involved in the initial fight in [redacted] on 01 June 2013.

54 The Inquiry team were advised that following the incident in January 2013 a very tight and restrictive regime was implemented in the unit. This entailed a third of the [redacted] being locked up, a third unlocked within the unit and a third unlocked and sent to the exercise yard. In practice however, the yards were not used, as they did not have a roof, so the system was adapted to have half the prisoners unlocked in the unit and half locked up each morning and afternoon (0900hrs – 1100hrs & 1300hrs – 1500hrs), rotating on a daily basis. The result of this arrangement was that while prisoners were being unlocked each day, on alternate days some prisoners were being locked up for up to 26 hours consecutively.

*Leadership and management*

55 The Inquiry team have interviewed a number of staff and prisoners (including some that were and some that were not directly involved in the riot) and have heard claims that management presence and visible leadership on the units was minimal. There was evidence of a fractured and, in some respects, dysfunctional management team at SHCF. This correlates with concerns raised in other reports and reviews, in particular the Prison Peer Review (PPR) that was carried out in November 2012.

56 The PPR examined five domains (providing safe prisons, providing secure prisons, operating humane and fair prisons, providing opportunities that reduce the risk of re-offending and managing resources efficiently and effectively). It was not a check against compliance with operational policy. The report stated that overall, staff reported that they felt prison leadership to be insufficiently visible and lacking direction. A number of staff reported that while they liked working at Spring Hill, they lacked confidence in terms of prompt incident response and support. Some reported that they did not feel safe on the site.

57 These concerns were expressed in a number of ways: in reference to inconsistent application of adjudications; slow incident response; lack of visibility by senior managers; and descriptions of the senior management as a "group of individuals pulling in different directions", rather than a team. However, staff still believed that they were making good things happen on site.

58 As a result of the PPR, an Action Plan was developed by the site to address some of the concerns that were raised. While mitigating actions were taken in response to some of the issues identified, the plan did not address the fundamental underlying issues present.

59 It should be noted that there was evidence of progressive and positive initiatives on site at SHCF, for example, the Whare Oranga Ake, the Youth Unit and programmes for Pacific Island prisoners. It was clear that despite the operational issues and challenges faced by managers, there was an intent by the site management to continue focusing on the rehabilitative and reintegrative role of SHCF. There were therefore examples of good practices, however a stronger balance was required to ensure the security and control aspects were appropriately managed.

60 The Inquiry team have noted however, that in the Corrections Workplace Survey (Your Say) published on 20 May 2013, under the measure of 'Organisation and Work Engagement in Prison' SHCF ranked 11% higher than the State Sector Benchmark for Work Engagement (79.5% against 68.9%) and were amongst the top quartile of prisons for Organisation Engagement (averaged at 69.4%).

*Staffing issues*

61 Since opening, SHCF has always experienced difficulty with staff retention. An examination of monthly staff turnover figures shows that over the period between

1 January 2011 and 31 December 2012, the rate of staff turnover was approximately 12% per year.[5]

62 Of those that resigned during this period, the main reasons given included better employment opportunities where cost and time of travelling were a major factor. A small number are no longer employed by Corrections due to retirement or poor health.

63 COs still employed at SHCF gave the following main reasons for considering resignation:

- Poor leadership, which was considered the reason for many on-going issues
- Risk of catching a disease from a prisoner
- A chronic wearing down of staff due to the roster, rotation policy and journey to work
- Assaults against staff.

64 The Inquiry team are aware however, of a significant effort by SHCF and Central Region to prioritise recruitment and mitigate staff turnover. Two weeks prior to the riot, SHCF had only 25 operational vacancies (8% of the custodial FTE). This was one of the lowest rates of vacancies SHCF had experienced. There is no evidence that the issue of staff turnover had a direct bearing on the causal factors of the events of 1 June 2013. In fact, on the day of the riot Unit 16B was fully staffed.

65 On 1 June 2013, Unit 16B had one SCO and four COs on duty. This is the agreed staffing level and in alignment with the published roster.

*Intelligence reports*

66 An Intelligence report produced on 29 January 2013 was provided to the Inquiry and revealed that over a recent three month period (01 November 2012 and 29 January 2013) there were 28 seizures of home brew by staff at SHCF. Of note is the fact that almost 80% of these finds were in Unit 16B Section 6(c) [redacted]

Section 6 (c) [redacted]

[5] Custodial FTE for SHCF is 304: 240 Corrections Officers (COs), 45 Senior Corrections Officers (SCOs) and 19 Principal Corrections Officers (PCOs). Turnover includes terminations, resignations and transfers.

67 A subsequent Intelligence report provided for the period 01 January 2013 to 04 July 2013 recorded 22 seizures of home brew  Seventeen of these were found in the possession of prisoners in Unit 16B Section 6(c)


68 Section 6(c)

*Health and safety observations*

69 Minutes from Health and Safety meetings indicate that there were concerns raised by staff that worked in Unit 16B.  They include comments from the meeting 24 April 2013 and 15 May 2013 as follows:

- *"16B seen as a problem because five of the staff there are under 23 years old, which is a risk.  Older staff needed.  Unit staff need to raise this concern with their Residential Manager to investigate and respond".*
- *"Unit 16B.  Problem with staff aged under 23 years as noted in last month's minutes is not a hazard but needs to go on the issues / risks register".*

70 It should be noted that the mix of ages of staff on duty in Unit 16B on 1 June 2013 was older, which suggests that the concern raised above was not an immediate contributing factor.  On the other hand, it is possible that the greater exposure of prisoners to young and inexperienced staff in the unit may have affected the prisoners' attitudes towards staff in the unit generally.

## Incident Response

71 This section of the report provides an assessment of the timeliness and effectiveness of the initial incident response.  It also examines the implementation of the Emergency Management Framework and discusses the response from the various emergency services.

*Initial response and mobilisation and capacity of ACR teams*

72 Following the initial fight, staff intervention and the subsequent altercation that led to prisoners attacking staff, staff had to exit the pod for safety Section 6(c) [redacted]

73 Emergency management procedures were correctly followed and the National Incident line and the Emergency Preparedness Response Manager at National Office were notified. ACR teams from other prisons were mobilised and prepared to travel to SHCF.

74 The Inquiry notes that a number of ACR vacancies were listed at the time of the incident and some of the members could not respond as their competencies had expired. According to incident reports, the following prisons supplied ACR Teams.

Auckland Prison Section 6(c) [redacted]
Waikeria Prison Section 6(c) [redacted]
Tongariro / Rangipo Prison Section 6(c) [redacted]
SHCF Section 6(c) [redacted]
ARWCF Section 6(c) [redacted]
MECF Section 6(c) [redacted]

75 Section 6 (c) [redacted]

76 Section 6 (c) [redacted]

77 The ACR teams assembled at SHCF from mid-afternoon onwards. As the teams arrived, plans were put in place for intervention and/or surrender as per normal protocols. For the larger part of the afternoon teams were used to provide secure containment.

78 An agreed intervention plan was due to be initiated at 1730hrs, but at 1715hrs it was deemed to be no longer safe, due to the spread of the fire. The plan was changed verbally by the ACR Commander at the scene after considering advice from the Fire Service. There was a delay in getting assistance to the team that intervened due to the need for a quick change of plan and a loss of radio communication with the EOC. Section 6(c) [redacted]

*Management of the Emergency Operations Centre*

79 The EOC opened on site and the Emergency Management Framework was initiated in accordance with Department protocols. As the Regional Commissioner for the Central Region was too far away to attend in time, the Regional Commissioner for Northern Region was directed to co-ordinate the Department's emergency response.

80 Later in the afternoon the decision was taken to open the National Emergency Operations Centre Section 6(c) [redacted]. This was entirely appropriate

given the nature of the event and the fact that it would require a national response. The inquiry team believe that for incidents of this scale, the opening of the National EOC should occur immediately to provide the necessary support to the site and region.

81 The EOC was managed effectively under the circumstances. Attendees from the Fire Service and the Police stated that they considered it was very well run and controlled under very difficult circumstances.

82 The Inquiry team were advised that the EOC did not know that they had access to additional CCTV camera views that were available to Master Control. Section 6(c) [redacted] The Inquiry has been unable to establish why there was this disconnect between the Master Control and the EOC.

*Availability, functionality and use of emergency equipment*

83 The Inquiry team interviewed the ACR Commanders and received a number of reports from the ACR team members, as well as a formal report from the Commanders. This information raised some concerns about the lack, and limited functionality of some of the equipment required for such incidents. Section 6(c) [redacted]

84 It is clear that the ACR teams performed exceptionally well and utilised their training effectively. Overall the equipment used by ACR teams performed as required, although some of the equipment used by the ACR teams reportedly did not withstand the full force of the attacks Section 6(c) [redacted]

85 The sprinkler system was designed (in accordance with the relevant New Zealand Standard) to control a single fire incident. Normally fires will only result in the activation of one or two sprinkler heads. Section 6(c) [redacted] due to the multiple fire sites and rapid spread of the fires, Section 6(c) [redacted] the sprinkler system had insufficient water pressure to effectively control the fire.

86 Section 6(c) [redacted]

87 Section 6 (c) [redacted]

*Staff and prisoner injuries sustained*

88 Injuries sustained by staff and prisoners were consistent with what may be expected in an event where hard resistance and significant violence was directed towards staff. Four staff received serious injuries, including a broken arm and broken hands / wrists during the ACR extraction in Section 6(c). A number of other staff received minor injuries such as cuts and bruising, and were treated for their injuries at Waikato Hospital. Many staff have since reported having sore throats and chests caused by smoke inhalation.

89 Information obtained from Prison Health Services shows that 12 of the 27 rioting prisoners that were transferred to Auckland Prison received injuries during the riot. These prisoners were treated by Health Services Unit at Auckland Prison, for injuries that ranged from a fractured arm to black eyes, cuts and abrasions.

*Emergency Services response*

90 The Police Armed Offenders Squad (AOS) responded to the incident and set up roadblocks on Hampton Downs Road and Halls Road to ensure that only emergency services and Corrections staff were permitted on site. The AOS also provided an escort for the prison vehicles transporting non-compliant prisoners to Auckland Prison.

91 Three St John ambulances with paramedics and volunteers responded to SHCF and the Westpac Rescue Helicopter was on standby in the visitors' car park.

92 The Fire Service initially responded with two appliances. However, this was raised to a Section 6(c) and resulted in the following appliances attending:

- 5 x Fire Appliances
- 1 x Command Unit
- 1 x Snorkel Appliance Unit
- 1 x Mobile Lighting Unit

93 Representatives from each of the emergency services were also based in the EOC and were consulted and briefed throughout the incident by the Incident Controller.

94 The Inquiry team have met with the Area Commander, Hamilton Fire Service and they have provided comprehensive feedback of the event. They were very complimentary about how the incident was managed and praised the staff and managers who were involved. Equally, the Police expressed their view that it was a well handled incident.

## Post-Incident Response

95 This section assesses action taken in the aftermath of the riot, including measures aimed at ensuring staff welfare, and initial work undertaken towards the recovery of the site.

*Muster movements*

96 The immediate transfer of prisoners out of SHCF was appropriate, given the scale of the incident and the loss of accommodation. The assistance of the Armed

Offenders Squad and the Department's ACR teams was necessary under the circumstances.

*Debriefing and staff welfare*

97 A debrief of the incident by the Incident Commander was held on 4 June 2013 at SHCF. The ACR teams undertook a debrief of their own operations and have submitted a separate report to the Inquiry team.

98 Post Incident Response Teams and the Employee Assistance Programme were made available to all staff involved in the incident.

99 The Chief Executive contacted the Chief of Army who provided a specialised team, trained in debriefing soldiers returning from combat zones, to facilitate a debrief to staff who were involved in the incident. Staff have found this to be of great value and responded positively to the initiative. A report from this debrief has been received by the Chief Executive. The debrief team has stated that they will continue to remain engaged with those they feel may be at risk, until they are confident that staff have found the support they require. In general the debrief team were struck by the resilience and cohesion of the officers.

100 The Chief Executive has personally spoken to each staff member who was injured during the riot, and visited the SHCF site with the Minister of Corrections the day after the incident.

*Incident reporting*

101 The Inquiry team had some initial difficulty in being able to establish a full understanding of the event, due to some staff not submitting incident reports within the required timeframes. This did not significantly hamper the investigation, but did delay the team's ability to rapidly establish an understanding of the events.

102 The Inquiry team notes the importance of incident reporting and have recommended that Departmental staff be reminded of their obligations.

*Recovery and future management of SHCF*

103 The Inquiry team have noted the comprehensive and swift response from the Department in regards to the recovery of SHCF.

104 Following the riot, the Acting National Commissioner Corrections Services immediately directed changes at SHCF, to ensure the recovery and management of business as usual activities are maintained. This included a change to the management team with a number of managers, including the Prison Manager, redeployed to other parts of the Department whilst recovery work is on-going. Additionally a number of Corrections Officers from across the Department, including SCOs and PCOs, were seconded to add support at SHCF post the riot. This initiative was to aid the recovery by stabilising and improving business as usual operations.

105 The recovery work programme was broken down into three focus areas:

- Facilities recovery
- Inquiry of events
- Stabilising and improving business as usual operations.

106 Demolition of the damaged facilities was completed on 8 July 2013. Refitting the bars on windows for all other units was completed by 7 July 2013.

107 A draft redesign of Unit 16 has been circulated and was submitted to the Executive Leadership Team for consideration on 5 July 2013. Construction on site commenced on 22 July 2013. The Department expects that the unit will be back in operation by the end of December 2013.

## Facility Issues

108 The Inquiry has examined a range of issues relating to SHCF facilities that had a bearing on the events of the riot, and on the effectiveness of the Department's incident response.

*Staff base security*

109 The staff base provided the required level of resistance. Section 6(c) [redacted] Staff had evacuated the area at 1112hrs.

*Maintenance of keys and locks.*

110 Section 6(c) [redacted]

111 During the intervention and rescue by ACR teams, attempts to unlock the rear Section 6(c) [redacted] doors Section 6(c) [redacted] proved difficult and prevented the ACR teams being able to exit the unit quickly. The cause was believed to be the lock either seizing up or being rusted up. Section 6(c) [redacted]

112 What is not evident is whether these locks are part of the required Unit security checks. Such a check – Section 6(c) [redacted], would have ensured that the lock was in good working order or required maintenance.

*Water capability*

113 Section 6 (c) [redacted]

Section 6(c) [redacted]

114 Additional water supply was supplied to the site by portable tanker when it became apparent that the water supply was running low.

*Fire investigation reports*

115 On 21 August 2013 the Inquiry team were provided with a copy of the Fire Service Investigation Report. Key findings from that report are as follows.

- As the security cameras showed the fires as having been started by the inmates of the prison, it was clearly evident that this fire was incendiary.
- Ten seats of fire were found during the Origin and Cause Investigation.
- Section 6(c) [redacted]
- Section 6(c) [redacted]
- Section 6(c) [redacted]
- The complex was protected from fire by a sprinkler system that included areas such as the service areas above the cells and the plant room above the guard house. Manual call points and smoke alarms were installed in the guard house and plant room.
- It would appear that the fast spreading fire was so severe that the sprinkler system was overwhelmed Section 6(c) [redacted] This resulted in insufficient water pressure to effectively control the fire.
- Section 6(c) [redacted]

116 Following the Fire Service report, the Department commissioned Opus to undertake a technical review of the design of the buildings in relation to the Building Code at the time of construction, as well as undertaking a full review of the Fire Service Report.

117 The conclusions from the Opus review were as follows:

- The building design and construction was undertaken in accordance with the Building Code. Section 6(c) [redacted]

- Section 6(c) [redacted]
- Section 6 (c) [redacted]
- The sprinkler system was specifically designed for life protection and property protection appropriate for the situation. Section 6(c) [redacted]
- Section 6(c) [redacted]
- Section 6(c) [redacted]

118 The Opus report also provided the following recommendations to the Department:

- Section 6(c) [redacted]
- Section 6(c) [redacted]
- Section 6(c) [redacted]
- The NZ Building Code provides minimum fire safety and fire protection requirements to meet the requirements of the Building Act. A workshop maybe considered to explore important points of note arising from the Spring Hill incident and the key areas for future prison construction, taking account of the combination of fire systems, building design, and management.

119 The Inquiry team notes that the first three of these recommendations have now been resolved as part of the SHCF rebuild and enhancement projects. The final recommendation has been incorporated into the work Opus are currently undertaking for the Department in developing Design and Security Standards for our prisons. The Department is also engaging with the Fire Service as part of this project.

120 As a result of the Opus report, the Department met with the Fire Service to discuss the conflicting conclusions regarding fire separation and passive fire protection. Following this meeting, the Fire Service issued a letter to the Department on 2 December 2013 confirming that their review of the as-built documentation provided to them found no evidence of any non-compliance with building consent documentation or regulations.

121 There seems to be little evidence prior to the riot of SHCF engaging with the Fire Service. Spotless report that they were unaware of the Fire Service carrying out any routine walk around or training exercises.

122 The Inquiry team understand that other sites have regular visits by Fire personnel where they are able to familiarise themselves with access to site, the location of

alarm panels, hydrants, water supply and the like. It is understood that since the investigation by the Fire Service following the riot, these visits are now in place with Spotless and SHCF staff involved.

*Spotless response*

123 Spotless had one person on site during the incident. Having this person on site was beneficial to all, and no criticism is made of their assistance, but what was required during the riot taxed Spotless' ability to respond to site needs.

*Storage and security of chemicals/cleaning products*

124 All Department sites are required to safely manage and secure such items. This is checked and reported under the Internal Control Assessment Tool and by audits undertaken by the Department's Risk and Assurance processes. All chemicals must be correctly labelled and correspond to contents, including being stored in the correct type of container. Only minimum quantities are to be made available to prisoners and are to be decanted into smaller containers as required. Additionally, Material Safety Data Sheets must be in place for checks and audits and securely held at the point of use and produced on request.

125 The Inquiry team has reviewed a health and safety hazardous substance register that is specific to Unit 16B. The register lists all the cleaning products and their locations in the Unit, but does not list the quantities of products that were stored in Unit 16B on the day of 1 June 2013.

126 Section 6 (c) [redacted]

127 Section 6 (c) [redacted]

## Findings

*Immediate triggers of the riot*

128 The most significant precipitating factor contributing to the initiation of the riot was the availability and consumption of home brew by prisoners in the unit. Staff in Unit 16B had made a number of finds of home brew in recent months, with two

finds in the two days immediately preceding the riot, and further finds earlier in the day itself. The Inquiry team has been advised by Unit 16 staff that there was a plan in place to conduct daily searches for home brew, although on the morning of 1 June this had yet to be carried out.

129 Unit staff did not take the opportunity to immediately lock down the unit on discovery of the home brew. Staff advised that they did discuss doing so, and had made a phone call to request extra staff to assist in this process. However, this plan was interrupted when the second fight between prisoners occurred, approximately one hour after the first find of home brew.

130 The second trigger was fighting between two prisoners, which staff intervened in twice to break up. During interviews, staff told the Inquiry team that a prisoner had punched one of them and the Officer pushed the prisoner away. The prisoners believed the Officer had assaulted the prisoner. Section 6 (c) [redacted] Section 6 (c) The Officer is seen being assaulted [redacted] but his hands and forearms can be seen coming up in a defensive stance to protect his head.

131 It is the view of the Inquiry team and the Police who have viewed the footage, that the Officer raised his arms in defence of the assault. Any strike to a prisoner was carried out to protect himself. The reaction of other prisoners to this incident was the event which most immediately resulted in the rioting commencing.

132 Once the number of prisoners involved in attacking staff and the staff base reached a certain level, the five staff present had little choice but to retreat to safety, and then to evacuate the unit.

*Contributing factors*

133 Based on the Cumulative Act Effect model, the Inquiry team has identified a range of factors that contributed to the riot breaking out on 1 June, and impacted on the subsequent response. While none of these factors alone can account for what happened during the incident, the combination and alignment of these factors created an underlying situation that enabled the incident to begin and to escalate. However, the ultimate responsibility for the violence, damage and destruction lies with the actions and decisions of the prisoners directly involved.

<u>Organisational and System Factors</u>

134 The Inquiry team has concluded that there was a general lack of capability within the management team at SHCF prior to the riot. The management team was divided and dysfunctional in some respects, and failed to provide strong and visible leadership for prison staff.

135 The Inquiry team is of the view that the rate of staff turnover at SHCF would have exacerbated any problems in its operation and created an environment where staff were continually under pressure due to the number of vacancies and challenges faced by inexperienced staff. The team acknowledges however, that a significant recruitment effort had been made by the prison in the months preceding the riot. This had resulted in some of the lowest levels of vacancies since SHCF had been opened. It should also be noted that on the day of the riot, Unit 16B was fully resourced.

136 SHCF was originally designed as an “end destination” prison focused on rehabilitation, rather than a prison with a focus on security and control. However, the changes made in 2008-09 to increase the muster and implement the double bunking of a number of cells impacted the operating philosophy of the prison. While these changes were appropriate, given the muster pressures across the Department at the time, the changes to the prison were not reflected in a changed approach to security. Opportunities were not taken by senior management at the time to increase the physical security or by local management to appropriately adjust to these changes.

Task and Environmental Conditions

137 The design of SHCF differs from more traditional prison designs. Section 6(c) [redacted] Given the subsequent changes to the original operating philosophy since the site opened and changes in prisoner demographics, the Inquiry team are of the view that a significant operational risk was created by having a high density of unmotivated, high security prisoners in a site that was not designed to hold them.

138 The incident occurred in a high security unit that held a number of unmotivated, difficult and disruptive prisoners who were predominately gang affiliated. The site was not physically designed or intended to hold such a density of this type of prisoner. This mix of prisoners significantly contributed to the outbreak of the incident, and the escalation into a full-scale riot. In particular:

- The high prevalence of gang members in one unit may have been a factor in the incident. Gang members are much more likely than non-gang members to involve themselves in incidents of prison violence and disorder, and once a serious incident commences, gang members are more likely to feel obliged to join in, rather than distance themselves from the fray.
- The presence of four prisoners in the unit who were initially classified as maximum security may have been a contributing factor. The Inquiry team are aware that overrides are used across the Department when considering security classifications, but are of the view that in this unit, the override should have been reconsidered.

139 The mobilisation of ACR teams was delayed Section 6(c) [redacted] These factors impacted on the Department’s ability to prepare and intervene earlier.

140 The ACR teams’ intervention was also impacted by the difficulty opening the locks on Section 6(c) [redacted] doors Section 6(c) [redacted], which prevented the teams being able to exit the Unit quickly. Regular checks of these locks would have ensured they were in good working order.

Individual and Team Actions

141 The prevalence and consumption of home brew within the unit provided the initial catalyst for this incident. The manufacture of home brew was a recurring problem at SHCF and in Unit 16B in particular. Operational intelligence provided to the Inquiry team shows this to be the case. This information should have resulted in

more targeted and robust actions by the management team to address the problem before a serious incident occurred. The incident in Unit 16B in January 2013, also involving home brew, should have highlighted to management that immediate corrective action was required at this stage to prevent a similar occurrence.

142 The Inquiry team were advised that following the incident in January 2013 a tight and restrictive unlock regime was implemented in the unit. This resulted in some prisoners being locked up for 26 hours consecutively. This response would not only have failed to address the risks it was put in place to manage, it may in fact have exacerbated prisoner discontent.

143 The combination of the intelligence available and the incident in January should have been significant indications to SHCF management that rigorous action was required to reduce the risk in Unit 16B. A comprehensive plan should have been created that addressed all of the concerns raised and a strong, visible leadership presence on that unit should have been in evidence. The Inquiry team have not been provided with any information of significance that these matters were appropriately addressed.

144 The Inquiry team also believe that there was an opportunity earlier in the day, prior to the riot, when an initial find of alcohol was made, to call for extra assistance and lock the unit down and arrange for a full search. This opportunity was not taken.

Absent and Failed Defences

145 In similar campus style prisons in Australia, Immediate Response Teams, made up of specially trained and equipped staff, are available to manage incidents of this type. Despite the design of SHCF being informed by this type of prison design and operation, New Zealand's campus style prisons do not have this capability.

146 Intelligence reports from SHCF should have alerted prison management to the potential problem caused by home brew in Unit 16. This intelligence provided an opportunity to take steps to eliminate the problem before it resulted in a serious incident, but the opportunity was not taken.

147 The team in the EOC did not know that they had access to some available footage from Master Control, which potentially hampered the incident response. Section 6(c) [redacted] The effective use of CCTV footage was also limited Section 6(c) [redacted] by the CCTV power supply to the unit inadvertently being cut.

148 The equipment available to ACR teams was effective and performed as required. However, there were a few instances of equipment not withstanding the full force of attacks Section 6(c) [redacted]

149 The sprinkler system was designed Section 6(c) [redacted] While it was capable of performing well

beyond the required New Zealand Standard for this purpose, the system was overwhelmed Section 6(c) [redacted] As a consequence, the system did not have enough water pressure to prevent the fire from spreading. Section 6(c) [redacted]

150 Section 6 (c) [redacted] However, this was refuted following a review by Opus. The Fire Service has subsequently reviewed its finding and has confirmed with the Department that there was no evidence of non-compliance with building consent documentation or regulations.

*Other findings*

151 Following the Section 6 (c) [redacted] and Section 6 (c) [redacted] activations, staff responded in an appropriate manner, attempting containment, negotiations and then progressing the emergency response as events escalated.

152 Despite the serious nature of the incident and lives being at risk, effective staff training and collaborative working across multiple agencies helped to contain significant risks of serious harm. Overall, management of the incident was well handled, under very difficult circumstances, and all staff involved in the resolution of this incident demonstrated great courage and bravery.

153 The ACR teams performed in an exceptionally courageous manner and operated in extremely dangerous circumstances. Not only did they have to face a significant number of violent, dangerous and intoxicated prisoners, they also had to work in an environment that was being engulfed in fire and smoke, and collapsing around them. Additionally, they needed to rescue prisoners who had been locked in their cells throughout the incident. All of this was achieved without loss of life and the Inquiry team's endorses the Chief Executive's intention to formally recognise the individuals involved.

154 The Inquiry team endorse the actions taken by the Department directly post the riot by moving prisoners regarded as high risk out of SHCF. The team particularly notes the full and prompt responses taken to normalise the environment, strengthen leadership and make right the structural damage.

## Recommendations

155 The Inquiry team recommends that:

1. The Department should investigate further measures to reduce prisoners' ability to make home brew, such as: placing limits on fruit purchases or only allowing fruit on site that is not amenable to making home brew; replacing sugar in prisons with artificial sweeteners; providing only perforated plastic bags; or increasing the penalties for prisoners who are found with excessive amounts of fruit.
2. The Department should replace alcohol based cleaners and hand washes within prisons with non-alcoholic products.
3. The Department should ensure that robust systems are in place so that the Department is able to maintain an effective overview of prisoner placement and prevent high risk prisoners and gang members being held in unsuitable locations.
4. The Department should continue reducing the number of prisoners held at SHCF and NRCF with High Security Classifications.
5. The Department should adopt a system whereby all decisions on maximum security classification are made in a consistent manner.
6. The Inquiry has noted that at SHCF there have been occasions where prisoners have been locked in their cells for periods of more than 24 hours, potentially fuelling prisoner discontent. This is a direct result of the two hour rolling unlock regime that some units at SHCF had adopted. While this regime was not identified as a direct causal factor of the riot, this practice should be reviewed as soon as practicable and include all prisons to ensure similar issues are not replicated.
7. The Department should continue to review, consider and implement improvements to design and security enhancements in campus style facilities.
8. The Department should consider introducing Immediate Response Teams, operating at all times in campus style sites.
9. The Department should review the capability and response system for ACR teams in order to improve response times and increase availability.
10. The Department should review the equipment and resources available to sites and ACR teams, in order to improve how teams are deployed and supported and to enhance their ability to operate in a rapid, safe and effective manner.
11. The decision to activate the National EOC should be made immediately upon request of a Gold Commander, when it is clear that a significant event is unfolding, in order to quickly establish what response is required and what support is available, and to manage communications from a national perspective.
12. The Department should have regard to the reports from Opus and from the Fire Service, and assure itself that adequate fire protection is in place in all prisons. This should include arranging regular site familiarisation visits by Fire Service personnel.

13. The Department should assess the water supply available at all sites. Section 6(c) [redacted]

14. Access Section 6(c) [redacted] was hindered because locks could not be easily opened, due to poor maintenance. The Inquiry team recommends that all locks in all prison facilities be checked on a regular basis to ensure they are operating efficiently.

15. The Department should review the practice of holding the personal files of prisoners within units. Section 6 (c) [redacted]

16. The Department should take steps to remind all staff of the importance of timely incident reporting, as per existing requirements.

17. The Inquiry team is aware that the Chief Executive intends to formally recognise staff involved in the intervention and rescue of prisoners in Unit 16B for their courage and bravery and fully endorses this decision.

**Appendix 1 – Terms of Reference**


# *Inquiry into the prisoner riot at Spring Hill Corrections Facility on Saturday June 1 2013*

**TERMS OF REFERENCE**

Ray Smith
Chief Executive

Date: 7 June 2013

## Background

Spring Hill Corrections Facility (SHCF) is a purpose-built prison set on a 215 hectare site just outside Meremere. The prison opened in 2007 and has been designed to aid successful rehabilitation and reintegration.

The facility accommodates minimum to high security prisoners. It employs 304 custodial staff, 449 support staff and holds 1050 male prisoners.

On Saturday 1 June 2013, a riot broke out on Unit 16B at approximately 11am and reports suggest that initially it involved six prisoners. By midday it was confirmed that 27 prisoners were out in the Unit pod and were damaging property. The Regional Commissioner Northern coordinated the Department's emergency response, which involved negotiators, senior managers and Advanced Control and Restraint teams. Police, ambulance and fire services were also in attendance. The situation was under control by 8pm on the 1st of June. Non compliant and compliant prisoners were dispersed to several prisons as a result.

## Inquiry

A formal inquiry into the circumstances surrounding this incident will be conducted by an inquiry team led by the Chief Custodial Officer, Neil Beales. The inquiry team membership can be found in the table below. Section 9(2)(a) [redacted], an independent Investigator, will represent the Ombudsman on the inquiry, reporting directly to the Chief Ombudsman.

The inquiry will have access to all information, documentation, premises and persons relevant to the incident and may, with the approval of the Deputy Chief Executive (Acting), call on such additional or specialist assistance as may be required.

A draft report is expected to be submitted for consideration to the Deputy Chief Executive (Acting) by 5 July 2013.

## Membership

| Role | Individual |
|---|---|
| ***Inquiry Sponsor*** | **Graeme Carruthers**, Deputy Chief Executive (Acting) |
| ***Inquiry Team Leader*** | **Neil Beales**, Chief Custodial Officer |
| ***Inquiry Team Members*** | **Brenden Mackinson**, Principal Custodial Adviser, Northern |
| | **Colin Ropiha,** Principal Custodial Adviser, Central |
| | **Walker Manaena,** Principal Custodial Adviser, Lower North |
| | **John Kinney**, Inspector |
| | **Trevor Riddle,** Inspector |
| | **Martin Bell,** Security Manager |
| | **Tony Hodgett**, Assistant Director, Inmate Classification & Placement, Corrective Services New South Wales |

## Terms of Reference – Content

### 1) Operating context prior to riot

The inquiry report will provide a synthesis of relevant assurance information the Department received on Spring Hill in the period leading up to the riot. This context will cover:

- findings from recent internal and external reviews (including Prison Performance Reviews, inspection reports and routine compliance monitoring)
- staffing levels and the approach to managing staff absences
- complaints received and relevant Intel reports
- Health and Safety concerns raised and action to date
- facilities improvements underway at the time and the rationale for this work.

### 2) What happened, how and why

The inquiry report will provide an objective summary of the immediate lead up to the riot and what then transpired. It will identify trigger events and causal factors.

### 3) Incident response

The inquiry report will provide an assessment of the timeliness and effectiveness of both the initial incident response and the implementation and management of the subsequent Emergency Management Framework. The evaluation of the incident response will address in particular:

- staffing levels on site on the day
- the initial response
- the mobilisation and capacity of Advanced Control and Restraint (AC&R) teams
- the quality of inter-agency cooperation
- the availability, functionality and use of emergency equipment
- the nature, extent and cause of staff and prisoner injuries sustained
- decision-making around muster movements following the incident.

### 4) Post-incident response

The inquiry report will assess the quality of staff welfare post-incident and the initial work undertaken on site towards recovery.

### 5) Findings and recommendations

The inquiry report will identify any areas where processes, systems and structures may be improved that will reduce the likelihood of a similar disturbance occurring. It will address in particular:

- facilities issues
- muster management
- AC&R team deployment
- staffing levels
- inter-agency cooperation.

The inquiry will report on any other matters relevant to the incident that may arise in the course of the inquiry.

## Appendix 2 – Timeline of events as seen via DVM footage

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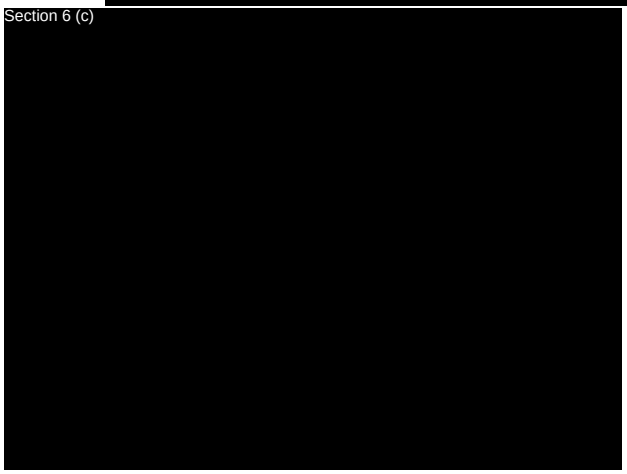

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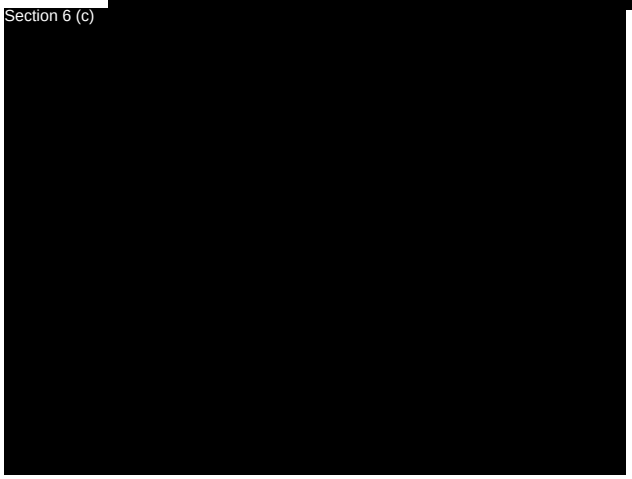

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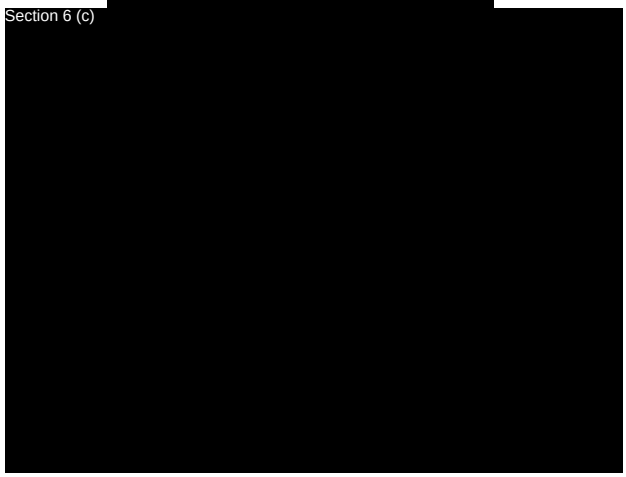

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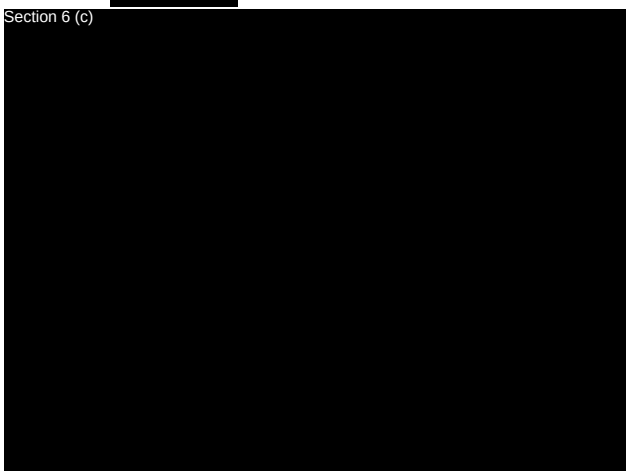

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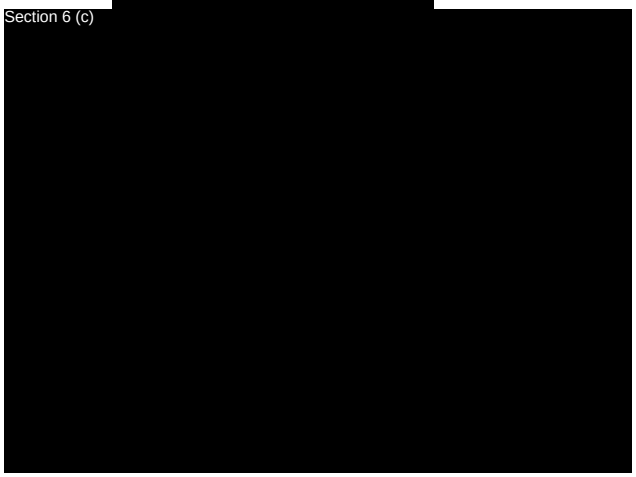

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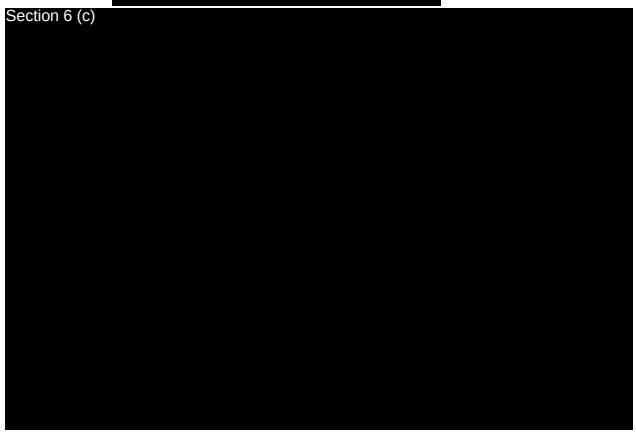

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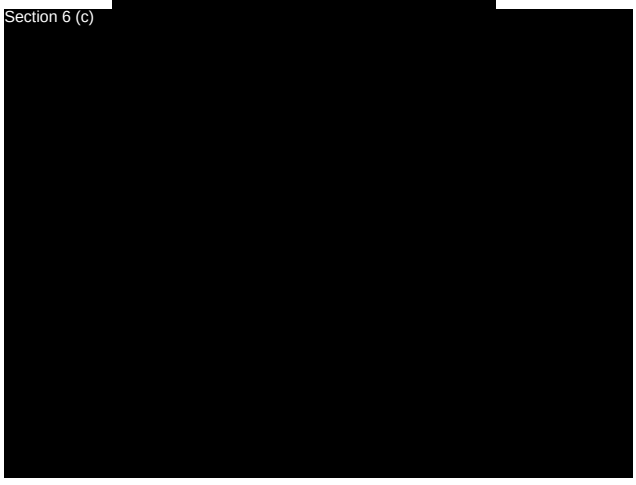

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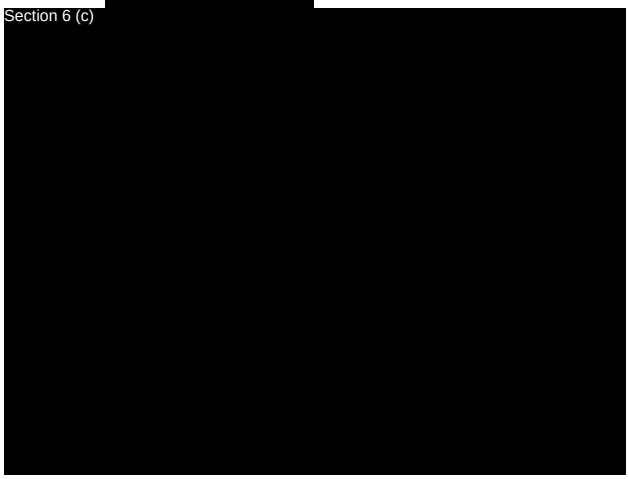

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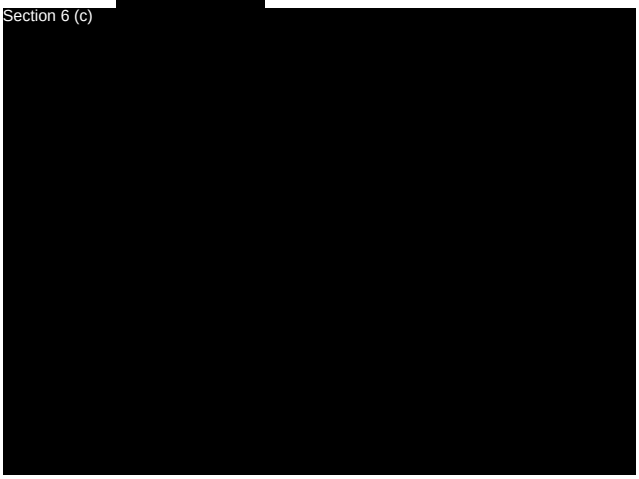

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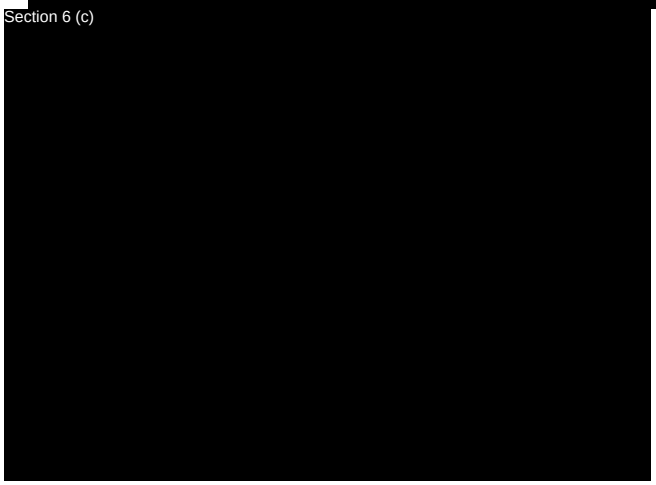

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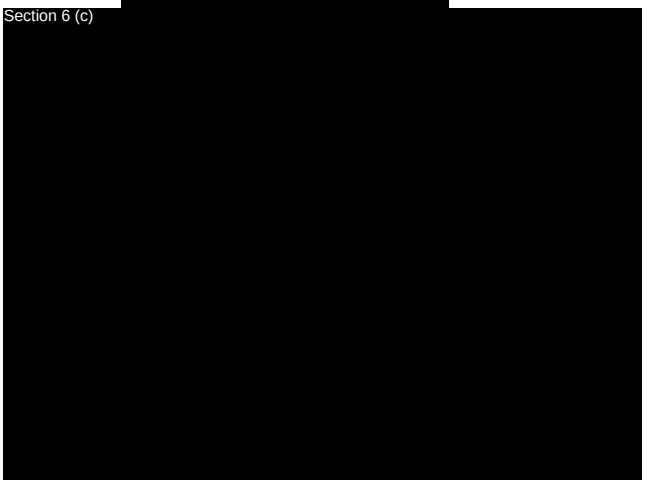

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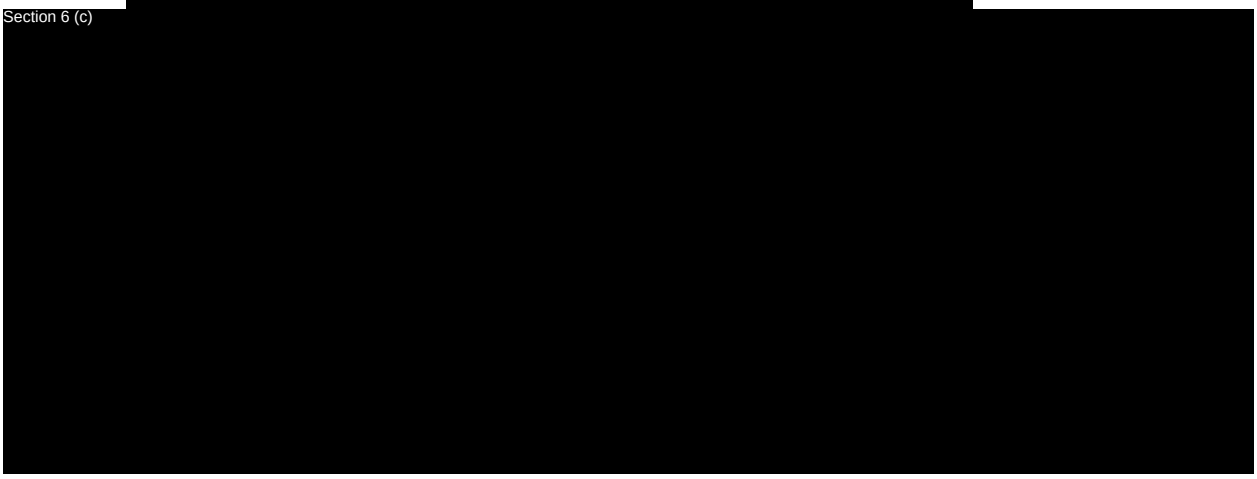

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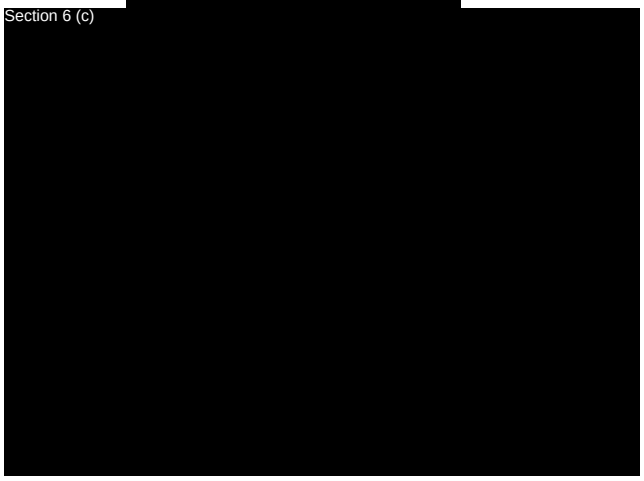

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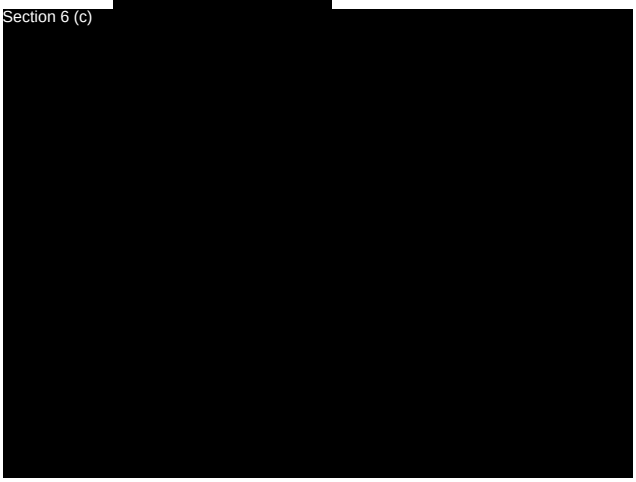

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## Appendix 3 – Unit 16B site plan