Commonwealth OMBUDSMAN

Review of ACT Policing's Watchhouse operations

JOINT REPORT BY THE AUSTRALIAN FEDERAL POLICE AND THE COMMONWEALTH OMBUDSMAN

June 2007

Report by the Acting Commonwealth and Law Enforcement Ombudsman, Dr Vivienne Thom under the *Ombudsman Act 1976*

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AFP
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AFP
AUSTRALIAN FEDERAL POLICE

Commonwealth OMBUDSMAN

Commissioner
Commonwealth and Law Enforcement Ombudsman

Review of ACT Policing's Watchhouse operations

We are pleased to present the joint report of the review of ACT Policing's Watchhouse operations. The review has been completed in accordance with the terms of reference that you issued on 12 February 2007.

Andy Hughes
Chief Police Officer

Mary Durkin
Acting Deputy Ombudsman

TERMS OF REFERENCE
REVIEW OF WATCHHOUSE POLICY AND PROCEDURES

Introduction

1. The Australian Federal Police (AFP) considers that it is timely to review the operations of the watchhouse and to determine if there are any areas where they could be improved.

2. The AFP and the Law Enforcement Ombudsman (the Ombudsman) have agreed to conduct a joint review of the watchhouse operations in accordance with these terms of reference.

Aim of review

3. The aim of the review is to examine the policies, practices and procedures applying to watchhouse operations and to make recommendations on any actions required to improve all aspects of watchhouse operations.

4. The review team's methodology will include, but not be limited to, the examination and assessment of:

   - the policies and procedures applicable to watchhouse operations
   - the guidelines available to watchhouse staff
   - the training and supervision given to AFP members working in the watchhouse
   - the functioning of the closed circuit television networks installed in the watchhouse
   - the use of force and physical restraints in the watchhouse
   - the assessment, identification and subsequent treatment of persons with special needs
   - a sample of watchhouse records and videotapes to determine how effectively the procedures are implemented in practice, and
   - the responsibility for oversight and management of watchhouse staff.

5. The review team may also consider, in relation to the current operations of the watchhouse:
   - any other information that has arisen from complaints to the AFP or the Ombudsman about matters relating to the watchhouse, and
   - any comments on watchhouse matters made by courts, oversight bodies or persons with information about watchhouse operations.

6. The review team may interview relevant parties, as it considers appropriate.

7. The review should look at best practice for police watchhouse or equivalent facilities. To the extent that this best practice is appropriate to the AFP, the review should make recommendations to bring current operations up to the best practice standards, if they are not already compliant.

Follow up of recommendations

8. The AFP has responsibility for implementing any agreed recommendations made by the review team. The AFP will report to the Steering Committee on the progress of the implementation six months from the date of the final report or as otherwise recommended in the report.

Composition of the review team

9. The review team will consist of the following members:

   - Federal Agent Rudi Lammers (AFP)
   - Ms Katherine Campbell (Ombudsman's Office)

10. Secretariat support and physical working space is to be provided by the AFP. This includes arranging for the review team to have access to personnel, documents and computer databases.

Time frame for review and reporting arrangements

11. The review is to commence on Monday 12 February 2007 and be completed by Friday 27 April 2007.

12. The review team will report to a Steering Committee consisting of:

   - Deputy Ombudsman
   - Senior Assistant Ombudsman (Law Enforcement)
   - Chief Police Officer Australian Capital Territory
   - AFP National Manager Human Resources

13. Contact with the Steering Committee will take the form of regular meetings, discussion with individual members, and the presentation of a draft report by 18 April 2007.

14. The purpose of the Steering Committee is to provide guidance and direction to the review team. If review team members differ as to the process or outcome of any aspect of the review, they will refer the matter to the Steering Committee for discussion and resolution.

15. If the members of the Steering Committee do not agree on any issue, this difference and the reasons for the differing views may be included in the final report.

Other issues

16. The review team will refer any incidents or complaints requiring investigation to AFP Manager Professional Standards (MPRS) for action in accordance with established processes as soon as practical and MPRS will report back to the review team on any systemic issues that become apparent during the course of its investigations, that may be relevant to the review.

17. If requested, the review team will provide these terms of reference to relevant groups and stakeholders, such as the Australian Federal Police Association, and will give these groups the opportunity to provide input to the review.

18. The final joint report will be made public, with appropriate deletions for reasons of security or the privacy of individuals.

M J Keelty
Commissioner
Australian Federal Police

Dr Vivienne Thom
Acting Commonwealth and
Law Enforcement Ombudsman
7 February 2007

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EXECUTIVE SUMMARY

Introduction

This review was undertaken because the Australian Federal Police (AFP) considered it timely to assess the operations of the City Watchhouse. The review was triggered in part by concerns raised by recent complaints from persons who had been held in police custody in the Watchhouse.

The AFP approached the Commonwealth and Law Enforcement Ombudsman who agreed to participate in a joint review in accordance with s 8D of the *Ombudsman Act 1976.* The aim of the review was to examine whether the AFP and ACT Policing have in place:

- Policies, procedures and practices to deliver adequate care to persons in custody in the Watchhouse, including detainees who may be deemed 'at risk' or have special needs
- Appropriate levels of staff, who are adequately trained, supervised and supported, to care for detainees
- Monitoring and reporting structures that can provide accurate performance information about Watchhouse operations
- Appropriate arrangements to handle problems or complaints that detainees may have, and to handle them in a timely manner.

Conclusions

The Watchhouse facilities are in good condition and largely compliant with the 1991 Recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). However, the review identified deficiencies in many aspects of Watchhouse operations. These deficiencies often appeared to be of long standing, and may reflect the fact that many police do not regard custodial duties as central to police operations.

The deficiencies identified by the review include:

- Incomplete, inconsistent and out of date guidelines for management of persons in custody
- Lack of formal training for staff appointed to the Watchhouse, either before deployment or in-service
- Limited staff understanding of the duty of care owed to detainees who may be at risk or have special needs
- Inadequate numbers of staff to meet the duty of care owed to all detainees during peak periods
- Poor staff supervision and management, including evidence of poor staff morale and inconsistencies in practices between teams in the Watchhouse

- Limited reporting or analysis of Watchhouse performance information that could assist in monitoring the effectiveness of Watchhouse operations

- Inadequate advice to detainees about their rights and obligations when in custody in the Watchhouse, including the right to complain about their treatment

- Limited understanding of the value of complaints to the organisation or how complaint data can be used to improve organisational outcomes.

Despite these concerns, the review team was impressed by the personal commitment to providing high standards of detainee care shown by many of the staff who have worked, and are currently working, in the Watchhouse. They are performing an often challenging and unpopular job in difficult circumstances. In the review team's opinion, this commitment has contributed to the fact that no deaths in custody have been recorded during the history of the Watchhouse.

Recommendations

The review team made the following recommendations to address the concerns identified within the existing Watchhouse management model. The review team noted that other jurisdictions use other models for staffing and managing police custodial facilities, and has commented on these in Part 8 of the Report.

Recommendation 1:

AFP and ACT Policing governance framework for staff on custodial care should be revised. The revision should include the following:

- Ensuring that existing guidelines, including the AFP National Guideline on Custodial Facilities and Persons in Custody and the ACT Policing Practical Guide: Persons in Custody are accurate, complete, current, and internally consistent.

- Drafting standard operating procedures for the Watchhouse, taking account of the work already done on drafting of a Watchhouse Manual and standard operating procedures for police custodial facilities interstate, such as the Brisbane Watchhouse.

- Clear definition of the duty of care owed to detainees, and to staff tasked with custodial duties. Duty of care should cover all aspects of detainee and staff health and well-being, as well as detainee and staff security.

- Establishment of mechanisms for regular review and updating to ensure accuracy and currency of procedural guidance. Consultation with all relevant stakeholders is essential.

- Ensuring that all staff involved in custodial duties are aware of procedural requirements, their obligations and detainee rights. Subject to maintaining Watchhouse operational security, public access to custodial guidelines should be increased in the interests of enhancing community understanding of the role of the Watchhouse.

Recommendation 2:

Action should be taken to improve physical conditions and safety of staff and detainees in the Watchhouse in the following areas:

- Examination of all cells to ensure there are no hanging points.
- Daily checking of cell facilities, including mattress, bubbler, toilet and intercom to ensure they are in good order.
- Searching and cleaning of each cell, including holding cells, after each use to ensure that nothing inappropriate has been left behind by the previous occupant.
- Reviewing the effectiveness of the tinted glass partition between the Watchhouse charge counter and the holding cells to improve direct surveillance of these cells from the charge counter area. Watchhouse staff must have clear visibility of detainees in the holding cells at all times.
- Opening or removal of the Venetian blind between the Watchhouse workroom and the 'at risk' cells to improve direct surveillance of these cells from the workroom.
- Regular monitoring of temperatures and lux levels in different areas of the Watchhouse to ensure they are appropriate. Adjustment may be required to the lighting in the Watchhouse workroom to ensure OH & S standards are being met.
- Regular examination of all Watchhouse blankets to ensure they are serviceable; and provision of tear-proof blankets for use with detainees threatening self-harm.

Recommendation 3:

Arrangements for handling detainee property should be revised to ensure that adequate secure storage, accessible only by authorised staff, is available within the Watchhouse for all detainee property. Procedures should:

- Require the detainee to countersign a list of all property removed in the Watchhouse before it is placed in storage, as well as when the property is returned on release or transfer to another custodial facility. If the detainee is unable or unwilling to sign, the property list should be endorsed by the Watchhouse sergeant and a Watchhouse constable.
- Be developed to ensure that arrangements for dealing with property that may have cultural or religious significance for detainees are appropriate.

Recommendation 4:

Procedures for dealing with emergencies in the Watchhouse should be revised and clear instruction provided for all staff as soon as possible. The revision should include the following:

- Consultation with the ACT Emergency Services Agency and advanced first aid training providers to ensure current emergency evacuation and other emergency procedures are complete, accurate, and exercised regularly, and that training provided for staff is adequate. This should include assessment of best practice for cleanup of biological contamination.

- Development of appropriate administrative arrangements to monitor the implementation and ongoing maintenance of emergency management procedures, equipment and training. This should include an inventory of equipment required to meet all emergency circumstances.

Recommendation 5:

The performance of the new CCTV system should be reviewed against contractual and operational specifications for the system, and shortfalls identified and remedied as soon as possible. Areas that must be addressed include the following:

- Safeguards to alert staff as soon as any aspect of the system fails so that immediate action can be taken to remedy the problem.

- Development of a simpler, faster retrieval process for data directly from the hard drive as well as from backup tapes.

- Development of a more user-friendly means of navigating through stored data during playback of files.

- Provision of adequate training for Watchhouse staff on the use of the CCTV system, including data retrieval.

Recommendation 6:

Procedures supporting the reception, assessment and monitoring of detainees while in custody should be revised to ensure that they are consistent with best practice standards. This revision should include the following areas:

- Preparation of a short list of detainee rights and obligations while in custody, including information about what to expect in the Watchhouse. This could be provided to detainees on arrival or attached to the outside of each cell.

- The Watchhouse assessment questionnaire, to ensure that it is sufficiently comprehensive and rigorous to determine accurately a detainee's health and risk status on arrival. The questionnaire should direct the Watchhouse sergeant to appropriate subsequent action to address any identified problems, including any reassessments required during the period of custody.

- Conduct of cell checks, to ensure that they are undertaken in accordance with the assessed needs of the detainee. Electronic monitoring via the CCTV system should not be a substitute for a physical check on a detainee in the cell.

- Functionality and use of the cell management system, to ensure that the system records are accurate, unalterable, and provide information sufficient to enable a person subsequently accessing the records to understand what has occurred during a detainee's time in custody.

- Development of structured handover arrangements between shifts, to ensure that all relevant and necessary information about the Watchhouse and the care of detainees in custody is provided to incoming staff.

Recommendation 7:

Procedures supporting the delivery of health care to detainees be revised. Particular attention should be given to the following:

- Ensuring all staff are aware of their obligation to obtain medical advice:
    - if requested by a detainee
    - whenever a detainee may have suffered an injury in the Watchhouse
    - whenever a detainee complains of injury, regardless of whether the injury occurred during arrest or in the Watchhouse
    - if the detainee has demonstrated symptoms of an impaired state of consciousness or staff are in any doubt about the detainee's health.

- Development of appropriate arrangements for the dispensing of medication in the Watchhouse. Options could include employment of a nurse or regular daily attendance by a health services nurse. Over the counter medications, including asthma medications, should not be dispensed without medical advice.

- Establishment of regular meetings between the Watchhouse management, medical practitioners and other government health service providers to ensure health services and procedures are meeting detainee needs.

Recommendation 8:

Arrangements for the management and control of detainees be revised to focus on detainee well-being and dignity, as well as on detainee security. Any changes need to give adequate attention to management of any risks of self-harm or harm to Watchhouse staff. Areas that should be covered include:

- Clarifying the number and nature of phone calls detainees are entitled to make or receive, and providing an area where detainees can have some privacy during phone conversations.

- Investigating options for religious observance or access to religious advisers for detainees while in custody.

- Improving access to diversions such as television, radio and soft books/magazines for detainees. This would require the case-by-case management of detainees assessed as being at risk of self-harm on arrival in the Watchhouse. Care would need to be taken to ensure that access to such diversions did not expose detainees to unnecessary risk.

- Respecting a detainee's dignity by providing a private area where clothing required for evidentiary purpose may be removed or a strip search undertaken. Searching and disrobing procedures should also protect the dignity of the detainee, this would include providing a private area for

detainee decontamination following exposure to OC.

- Providing modesty screens around toilets in all cells, except the two padded cells, to ensure that detainees have some privacy when toileting. A detainee at serious risk of self harm could be placed in a padded cell until medical advice has been obtained.

- Reviewing arrangements for providing female detainees with sanitary pads and tampons; and for disposing of sanitary protection in the female cell block.

Recommendation 9:

Procedures, training and reporting requirements relating to use of force should be revised to ensure that they are adequate to deal with the circumstances likely to arise in the Watchhouse environment. Particular attention should be given to the following areas:

- Assessment of the requirements of use of force in the Watchhouse and the provision of specific training for Watchhouse staff in the use of force in a confined environment. This should include negotiation training specific to the Watchhouse.

- Approvals for, and guidance on, the safe use of Oleoresin Capsicum (OC) foam in the Watchhouse.

- Appropriate training for all staff in the use of OC foam in the Watchhouse.

- Requirements for reporting on the use of force in the Watchhouse, including whether each member involved in the use of force should submit a report.

- Requirements for reporting on use of force in the Watchhouse, and for use of force performance feedback to the ACT Policing executive, governance and training.

Recommendation 10:

Procedures and practices for the care of persons with special needs or assessed as being ‘at risk’ should be revised as a matter of priority. This should be done in consultation with medical advisers and relevant special interest groups. Particular attention should be paid to the following:

- Revising and enhancing the screening tools for assessing the risk status and any special needs of detainees. This includes ensuring that staff have adequate training in their duty of care and that they are supported in seeking further advice when uncertain about the status of a detainee.

- Ensuring staff are aware of the risks associated with an impaired state of consciousness and understand the responsibility attached to the custody of a detainee presenting with this symptom. If staff have any doubt about the health of the detainee, medical advice must be sought immediately.

- Ensuring all staff are aware of their duty of care obligations to Indigenous and juvenile detainees; and instituting monitoring arrangements to ensure that these obligations are met.

- Discontinuing the present practice of stripping detainees at risk of self-harm unless detainees are provided with a tear-proof smock and tear-proof blanket. Any detainee assessed as at risk of self-harm should be medically examined as soon as possible.

- Establishing effective arrangements for identification and care of persons assessed as being in need of protection due to the circumstances of their arrest.

- Revising facilities and arrangements for the handling of persons with disabilities and for staff training to ensure that the particular needs of detainees with disabilities and mental health concerns are adequately acknowledged and accommodated.

- Establishing forums for regular discussion with key government and non-government advisory and interest groups. These forums should be used to inform Watchhouse procedures and advise on best practice in managing 'at risk' detainees and detainees with special needs. They should facilitate broader community awareness of Watchhouse operations, and provide opportunities for informal assessment and adjustment of Watchhouse performance, where appropriate.

Recommendation 11:

Staffing arrangements in the Watchhouse should be revised to ensure the efficient and effective operation of the Watchhouse at all times. The revision should cover the following:

- Assessment of the challenges involved in custodial duties and of the competencies and capacities required of staff working in the Watchhouse. Staff deployed to Watchhouse duties should have the skills and experience necessary to perform effectively. Where probationary constables are deployed to the Watchhouse they should be under the close and constant supervision of an experienced member.

- A female staff member, sworn or unsworn, should be on duty in the Watchhouse at all times, irrespective of whether a female detainee is in custody.

- Assessment of the numbers of staff required to cope with all aspects of Watchhouse operations during regular busy periods (Thursday, Friday and Saturday nights), as well as for special events and holidays. Adequate numbers of staff must be available to deliver an appropriate level of care to detainees at all times.

- Early development and implementation of appropriate pre-deployment and in-service training packages for all staff deployed to the Watchhouse.

- Early development and implementation of strategies to address the low status of Watchhouse duties within ACT Policing, the impact this has on the morale of staff deployed the Watchhouse, and on the efficiency and effectiveness of Watchhouse operations.

- The early review of the rotation arrangement for Watchhouse constables. This should include the occupational health and safety aspects of the 8 hour shifts. The views of staff should be given due weight in this process.

Recommendation 12:

Early attention should be given to revising the supervisory and leadership structures in the Watchhouse. Appropriate accountability mechanisms need to be developed to provide effective monitoring of, and reporting on, Watchhouse operations to Watchhouse management and to the ACT Policing and AFP executive. Areas that need to be given priority include the following:

- Revising the chain of command to ensure that it can deliver adequate guidance and support for Watchhouse staff, enforce consistent operational practices, and provide regular and accurate performance information to senior officers.

- Ensuring that staff charged with command responsibilities understand what these entail and particularly their obligations to provide leadership to junior staff and to deliver on organisational outcomes to senior managers. This may require the identification of appropriate training and leadership development opportunities for the staff involved.

- Development of appropriate monitoring and reporting frameworks to ensure delivery of consistent and appropriate care to all detainees. This will require clarification of performance standards, and collection and analysis of qualitative and quantitative data across all aspects of Watchhouse operations, from performance against cleaning contracts to trends in the use of force. Formal reporting structures will need to be developed and staff required to report regularly against these.

Recommendation 13:

Appropriate and accessible materials should be developed to advise detainees about their right to complain about the AFP. This information should also be accessible to persons with language or understanding difficulties.

Recommendation 14:

Complaint handling arrangements in the Watchhouse should be revised to ensure all staff have received training necessary to:

- Advise a detainee of the right to complain and how to go about making a complaint.

- Recognise when a detainee may require assistance in making a complaint; or when it would be appropriate to confirm whether the detainee wants to proceed with an intention to lodge a complaint.

- Distinguish between matters that can be resolved to the detainee's satisfaction by an explanation and do not require further consideration or entry into the Complaints Recording and Management System (CRAMS).

- Record complaints appropriately within CRAMS.

Recommendation 15:

PRS should take a more proactive approach to complaints management and the issues arising from complaints. This includes:

- Reviewing the recording of and reporting on complaint data to ensure that the performance of the Watchhouse can be monitored adequately. As a minimum, reports should be available on the number of complaints in each category, the issues raised, action taken and outcomes, and the time taken for resolution.

- Providing regular feedback to staff about complaint issues, informing staff about the recent legislative and procedural changes, and identifying areas where staff may benefit from reminders about their obligations and responsibilities.

- Developing a framework to ensure that any proposed actions or recommendations for performance improvements arising from complaints are implemented. This includes recommendations arising from individual complaints, as well as from audits or systemic reviews.

Recommendation 16:

ACT Policing should consider examining the feasibility of alternative custodial models, including staffing the Watchhouse with both sworn and unsworn members or drawing on other agencies such as Corrective Services.

Recommendation 17:

The Steering Committee should reconvene by December 2007 and report to the AFP Commissioner and the Ombudsman on progress in implementing the review recommendations.

Acknowledgements

The review team would like to acknowledge the valuable assistance provided by AFP and ACT Policing members, and the representatives of ACT government departments and agencies that were consulted during the review; and those organisations and individuals who made submissions to the review. This enabled the review to take place and this report to be prepared.

PART 1—BACKGROUND TO THE REVIEW

Introduction

1.1 The Australian Federal Police (AFP) considered it timely to review the operations of the City Watchhouse and approached the Commonwealth and Law Enforcement Ombudsman to conduct a joint review of Watchhouse operations. The review was triggered in part by concerns about recent complaints from persons who had been detained in the Watchhouse.

1.2 The Law Enforcement Ombudsman agreed to undertake the joint review in accordance with s 8D of the *Ombudsman Act 1976*. The Terms of Reference for the review appear at the beginning of the report.

1.3 The aim of the review was to examine the policies, procedures and practices applying to Watchhouse operations and to make recommendations on any actions required to improve Watchhouse operations.

Scope of the Review

1.4 The focus of the review was the operations of the Watchhouse attached to the City Police Station. This is the only operational Watchhouse with charge, bail and custody facilities in Canberra.

1.5 The review also considered the arrangements for custody and care of persons taken into detention at other police stations in the ACT. These are Woden, Tuggeranong, Belconnen and Gungahlin Police Stations. All these stations have facilities for holding persons detained for short periods, pending release or transfer to the Watchhouse.

1.6 There is also a Watchhouse in the Police Station in the External Territory of Jervis Bay. Jervis Bay Police Station is not managed by ACT Policing, and was not included in the review. However, the Jervis Bay Watchhouse is operated in accordance with ACT legislation and Watchhouse procedures. It is expected that any recommendations flowing from this review will be taken into account in the administration of the Jervis Bay Watchhouse.

1.7 The review team acknowledges that the behaviour of persons taken into custody and detained in the Watchhouse can be influenced by the actions of the arresting officers. In recognition of this, when looking at complaints concerning persons detained in the Watchhouse, the review has taken into account where possible the circumstances of arrest and the behaviour of arresting officers.

Methodology

1.8 The review methodology was designed to obtain information about the policies supporting the custody of persons in detention in the Watchhouse. These policies could then be compared with the procedures developed to give effect to them, and how well these procedures were being implemented within the Watchhouse.

1.9 The review methodology included:

- Examination of Commissioner's Orders, AFP National Guidelines, AFP Practical Guides and ACT Policing Practical Guides relevant to Watchhouse operations
- Examination of any operating procedures, manuals or checklists available for the use of police responsible for the care and custody of persons detained in the Watchhouse
- Assessment of facilities and amenities provided in the Watchhouse, including their compliance with the Recommendations from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC)
- Assessment of arrangements for the assessment, identification and subsequent treatment of detainees with special needs or considered to be 'at risk' (e.g. indigenous persons, juveniles, intoxicated persons, violent persons, persons at risk of self-harm and persons of non-English speaking background)
- Review of complaints received over the last three years by the Ombudsman concerning persons detained in the Watchhouse
- Review of selected Ombudsman investigations relevant to Watchhouse operations
- Request for submissions from individuals and community groups with an interest in, or experience of, Watchhouse operations
- Review of the operation of the Closed Circuit Television (CCTV) network installed in the Watchhouse
- Review of selected electronic and paper records of Watchhouse operations over the past 12 months
- Assessment of the adequacy of arrangements for training, management and supervision of staff responsible for Watchhouse operations
- Meetings and discussions with
    - ACT Policing Executive
    - Ombudsman Executive and staff
    - Representatives of ACT government departments and agencies
    - Selected superintendents and sergeants who currently are, or recently have been, responsible for the management and supervision of Watchhouse operations
    - Selected ACT Policing sergeants and constables who have worked in the Watchhouse within the last three years
    - Selected ACT Policing sergeants and constables who have not worked in the Watchhouse but who have had regular contact with the Watchhouse over recent years
    - Senior ACT Policing and AFP staff including the Manager Learning and Development, responsible for the training of ACT police

    - Manager AFP Professional Standards
    - Senior AFP and ACT Policing Governance staff involved in the drafting and updating of AFP and ACT Policing procedures and guidelines
    - Representative of ACT Policing Well-being Services
    - Representatives of AFP and ACT Policing Chaplaincy
    - Manager, Medical Services for the AFP
    - Representatives of the Australian Federal Police Association
    - Representatives of selected organisations and individuals who made submissions to the review.

- Visits to view the custodial facilities and procedures at
    - City Watchhouse
    - Belconnen Police Station
    - Gungahlin Police Station
    - Woden Police Station
    - Tuggeranong Police Station
    - Queanbeyan Police Station and court cells
    - Brisbane Watchhouse and court cells
    - ACT Magistrates Court cells.

- Information obtained from custodial facilities in
    - Victoria
    - South Australia
    - Western Australia
    - Northern Territory
    - Queensland
    - New South Wales
    - Tasmania.

- Information obtained from overseas custodial facilities in
    - New Zealand
    - United Kingdom
    - Canada
    - United States.

Benchmarking

1.10 The Recommendations from the RCIADIC have provided the key benchmark for custodial facilities and care across Australia since publication in 1991. Recent, similar reviews of police custodial care, such as the July 2006 review, *Conditions for Persons in Custody*, undertaken by the Office of Police Integrity and the Victorian Ombudsman, have highlighted the dearth of other best practice custodial benchmarks.

1.11 In establishing standards against which to measure the standard of care provided in the Watchhouse, the review team took account of the standards for humane detention established by ACT Human Rights legislation, and international human rights standards such as those established by the International Covenant on

Civil and Political Rights. Areas that the review team focused on particularly in the Watchhouse included access to medical care, monitoring of detainees, detainee privacy, and use of force.

1.12 Within the limited time available, the review team sought to obtain comparative information on policies, procedures and practices on custodial care arrangements in other jurisdictions, both in Australia and overseas. The review team considered custodial structures and procedures in place in interstate Watchhouse-type operations; and international custodial arrangements in the United Kingdom, New Zealand and Canada. A brief comparative summary of State/Territory arrangements is in Appendix 3.

1.13 The review team selected several facilities that used different custodial models to assess whether any offered approaches to management and care of detainees that could be adopted in the City Watchhouse. Custodial facilities visited for this purpose were:

- ACT Magistrates Court Cells—operated by ACT Corrective Services
- Queanbeyan Police Station Watchhouse—operated by NSW police up to charging of a detainee and by NSW Corrective Services post charging
- Brisbane Police Station Watchhouse—operated by Queensland Police Service using sworn members up to charging and unsworn members to care for detainees post charging.

1.14 The policies, procedures and practices for care and custody of detained persons were assessed against the following criteria:

- *Comprehensiveness and consistency*—the extent to which policies and practices in place are consistent with legal and other obligations for the care of persons in custody. This includes the duty of care to persons in custody, arrangements for managing persons deemed to be “at risk”, and mechanisms in place to handle problems as they arise. The mechanisms for ensuring consistency in Watchhouse practice were also considered.
- *Commitment*—the degree of understanding, among AFP and ACT Policing staff and those tasked with caring for persons in custody in the Watchhouse, of their roles and responsibilities in caring for detainees. This includes the training and support provided for staff in undertaking their roles.
- *Accessibility*—the extent to which detainees understand their rights while in custody, whether they feel able to complain if they consider that their needs are not being met, and how complaint procedures are managed by Watchhouse staff.
- *Responsiveness and accountability*—strategies ACT Policing has in place to monitor the operations of the Watchhouse and whether the care actually provided in the Watchhouse is consistent with best practice. This includes mechanisms for providing feedback on Watchhouse operations to the AFP Executive, and staff responsible for ACT Policing governance and training. It includes how performance information is used to improve outcomes for Watchhouse detainees and custodial staff.

1.15 During the review, issues came to the review team's attention that are not strictly within the review's terms. They are, however, relevant to the Watchhouse or to broader ACT and AFP Policing operations. The review team considered it appropriate to cover these issues briefly in this report. They have been included under 'Other Issues Arising' in Part 8 of this report.

1.16 In particular, the review provided the opportunity to consider several of the different options for the management of detention in a Watchhouse environment that are currently being used in other police jurisdictions around Australia. These range from Watchhouse-type operations managed by the private sector to management of detainees by local corrective services personnel. The benefits and disadvantages of these different custody management models were also assessed.

PART 2—THE WATCHHOUSE

Brief description

2.1 This section provides a brief summary of ACT Policing structure, the purpose of the Watchhouse and how it operates. It outlines the main reasons why persons are detained in the Watchhouse.

ACT Policing overview

2.2 ACT Policing has five police stations throughout Canberra, located in City, Woden, Tuggeranong, Belconnen and Gungahlin. Each operates 24 hours a day, seven days a week with the exception of Gungahlin Police Station, which is open 10am to 6pm every day. Gungahlin also operates a single mobile patrol from 7am to 11pm each day.

2.3 ACT Policing has whole-of-region teams responsible for criminal investigations, traffic, communications, crime prevention and prosecution and judicial support. ACT Policing patrols are divided into two districts—North and South.

2.4 North District covers all areas north of Lake Burley Griffin. Located in this District are:

- City Police Station, which operates the City Watchhouse. The Watchhouse provides a charging and custodial facility that operates 24 hours a day. This is the only Watchhouse in Canberra. Other ACT police stations provide only holding cells that can be used for temporary detention of persons, pending their release or transfer to the Watchhouse. These stations have no charge or bail facilities and are not staffed to provide fulltime custodial care for detainees. All City Watchhouse cells and corridors are covered by a digital CCTV system of 54 cameras that record automatically.

- Belconnen Police Station, which has two holding cells. Both cells are covered by CCTV cameras recording onto VHS video tape manually operated by the arresting officer following the lodgement of a detainee.

- Gungahlin Police Station, part of the Gungahlin Joint Emergency Services Centre, which has one holding cell. This cell is covered by a CCTV camera recording on to VHS video tape manually operated by the arresting officer following the lodgement of a detainee.

2.5 South District covers all areas south of Lake Burley Griffin, including the ACT's rural south. Located in this district are:

- Woden Police Station which has five holding cells. All cells are covered by CCTV cameras activated by movement sensors.

- Tuggeranong Police Station has five holding cells. The station was constructed with a Watchhouse charge counter although it has never been used as a Watchhouse. All cells are covered by CCTV with cameras recording onto VHS video tape manually operated by the arresting officer following the lodgement of a detainee.

2.6 This report addresses only the operations of the City Watchhouse. However, in the course of the review observations were made about the quality of holding cells in other stations and procedures for management of persons temporarily held in those cells. A brief summary of these observations is in Appendix 4.

City Watchhouse

Design and layout

2.7 City Police Station first opened in 1966. It was extensively refurbished in 1995 when all facilities were upgraded. The upgrade included the development of an enlarged Watchhouse with new charge counter, holding facilities and detention cells. Watchhouse surveillance arrangements were improved with the installation of video cameras in each cell and throughout the public areas, enhancing security for both detainees and staff. Prior to the 1995 refurbishment, a second watchhouse had operated in Belconnen Police Station because accommodation available in the old City Watchhouse was limited. The provision of additional cells in the upgraded City Watchhouse allowed closure of the Belconnen facility which did not comply with best practice standards.

2.8 The 1991 Recommendations of the Royal Commission into Aboriginal Deaths in Custody established a national standard of best practice for custodial cell design. The City Watchhouse was the first in Australia to comply with RCIADIC recommendations. Minimum standards for cell construction were recommended to eliminate potential hanging points, such as exposed bars or rails, light fittings and plumbing, and maximised observation of detainees.

Watchhouse functions

2.9 The City Watchhouse operates 24 hours a day and since 1995 has provided the ACT's only charging and custodial facility. In the Watchhouse, detainees are either charged with an offence or, in the case of intoxicated persons, lodged in custody. The law requires that those charged must be brought before a court at the first available opportunity and in any event within 48 hours after being taken into custody. On rare occasions this time period may be exceeded. For example, an intoxicated person arrested on a substantive offence at 3am on a Saturday morning may still be too intoxicated to attend court later that morning, and must be detained until the next court sitting, on the following Monday. The vast majority of people are detained for less than 24 hours.

2.10 Persons are detained and held in custody primarily for one of three reasons: they are charged with a criminal offence; they have been arrested on a warrant; or they are intoxicated in a public place.

Persons charged with a criminal offence

2.11 A person arrested in connection with an offence may be interviewed at a police station and then either:

- released without any further action
- cautioned about their behaviour, and released without further action
- released to appear at court on summons at a later date
- released pending their participation in a diversionary conferencing scheme
- taken to the Watchhouse to be charged.

Persons arrested on warrants

2.12 Detainees may be lodged in custody following arrest on warrant. There are three types of warrant:

- First instance warrant: A person may be arrested, for example, for failing to appear in court. The detainee will be held in custody until brought before the court on the next court-sitting day. Sometimes that day will be the day of the arrest.

- Apprehension warrant: A person who has been fined by an interstate court and has not paid the fine within the time allowed may be arrested on an apprehension warrant. The detainee has the option of paying the fine previously imposed by the court, or if unable to pay the fine, appearing before an ACT court on the next court sitting day.

- Commitment warrant: A person who has been fined by a court in the ACT and has not paid the fine within the time allowed may be arrested on a commitment warrant. The unpaid fine is converted into a commitment to serve time in custody. The detainee is processed in the Watchhouse, and given the opportunity to pay the fine or be transported to the Belconnen Remand Centre to serve the time remaining on the warrant or until the fine is paid.

Intoxicated persons

2.13 Over a third of people detained in the Watchhouse are lodged for being intoxicated in a public place. Under of the *Intoxicated People (Care and Protection) Act 1994*, intoxicated persons may be taken into custody for one of the following reasons:

- behaving in a disorderly way
- behaving in a way likely to cause injury to himself, herself or another person, or damage to any property
- incapable of protecting himself or herself from physical harm.

2.14 Persons who are held in the Watchhouse solely because they are intoxicated are not charged with an offence.

Juveniles

2.15 Young persons under the age of 18 years who are taken into custody for any reason may be taken to the Watchhouse in the first instance, pending charging. However, the Watchhouse is not a juvenile custodial facility and no juvenile should be held there longer than is reasonably necessary. Unless a juvenile is to appear in court soon after being charged, he or she will be transported to the Quamby Youth Detention Centre. Young persons detained for intoxication are usually released into the care of a parent or responsible adult.

2.16 The number of persons lodged in the Watchhouse has increased since 2002. In 2005-06, 4,561 persons were detained in the Watchhouse. Of these 3,000 were detained or charged in relation to an offence or warrant, the remaining 1,563 were in custody for reasons associated with intoxication. A statistical summary of persons held in the Watchhouse 2002-03 to 2006-07 is at Appendix 5.

Being taken into custody in the Watchhouse

2.17 Entry into custody in the Watchhouse follows the same basic process for all detainees, as outlined below. Additional arrangements apply to detainees who are assessed at being ‘at risk’. These are discussed in Part 4.

2.18 Typically, a person taken into custody for any reason will be brought into the Watchhouse by arresting police in a police vehicle. Usually the detainee will be brought directly to the Watchhouse, although there are occasions when persons arrested some distance from the city (Civic) may be taken to a local police station and placed briefly in a holding cell prior to transfer to the Watchhouse. Persons aware that a warrant has been issued for their arrest may decide to surrender themselves at a police station.

2.19 Once at the Watchhouse, a detainee will be taken to the charge counter and the reason for detention explained by the Watchhouse sergeant. Detainees do not receive a standard written explanation of custodial arrangements or their rights and obligations while in custody. A preliminary assessment of the detainee’s health and risk status will be made at that time, and the detainee asked to remove personal property. The detainee will also be given a pat down search before being placed in a holding cell. Procedures governing detainee assessment and search and the removal of detainee property are considered further in Part 3 of this report.

2.20 If a detainee has been taken into custody as a result of intoxication, he or she will be placed directly into an intoxicated person’s cell, rather than a holding cell. Similarly, detainees assessed as violent or ‘at risk’ will generally be placed in an ‘at risk’ cell, rather than a holding cell.

2.21 A detainee arrested for a substantive offence will usually remain in a holding cell until the arresting officers have completed their investigation and a statement of facts about the alleged offence. The arresting officers may interview the detainee in an interview room upstairs in City Station. Time limits apply to the period for which a detainee may be held before charging. These vary and are discussed in more detail later in the report.

2.22 The Watchhouse sergeant will assess the nature and evidence provided in the statement of facts in support of the alleged offence and decide whether there is sufficient evidence to proceed with charging and, if so, whether bail should be granted. If bail is granted, the detainee will be released and required to appear in court at a later date. If bail is refused, the detainee will be moved to the male or female cell blocks.

Duty of care in the Watchhouse

2.23 This section considers the meaning of duty of care in the Watchhouse environment. It examines the duty of care owed by the custodial authority (ACT Policing) and custodial officers to persons in custody. It also explores the duty of care owed by ACT Policing to the members tasked with providing custodial services in the Watchhouse.

Duty of care to persons detained in the Watchhouse

2.24 The duty to take reasonable care to prevent injury to detainees is well known and well accepted. The High Court, referring to the duty in respect of prisoners, noted the position under English law, drawing from Halsbury's Laws of England, in *New*

South Wales v Bujdoso (2005) ALR 663 at 673-674:

> 'The duty on those responsible for one of Her Majesty's prisons is to take reasonable care for the safety of those who are within, including the prisoners. Actions will lie, for example, where a prisoner sustains injury as a result of the negligence of prison staff; or at the hands of another prisoner in consequence of the negligent supervision of the prison authorities, with greater care and supervision, to the extent that is reasonable and practicable, being required of a prisoner known to be potentially at greater risk than other prisoners; or if negligently put to work in conditions damaging to health; or if inadequately instructed in the use of machinery; or if injured as a result of defective premises.'

2.25 The duty to protect detainees is not absolute. It is a duty to do what is reasonable in all of the circumstances, not to prevent injury at all costs. In *Bujdoso*, the court noted that as the respondent was 'a known likely target of other prisoners the appellant was under a duty to adopt measures to reduce the risk of harm.' The court did not suggest there was an absolute duty to prevent harm. Watchhouse staff must take reasonable steps to address any known risks to detainees arising from self harm, and to *protect their health, safety and well being during custody*.

2.26 Detainees are in custody in the Watchhouse for relatively short periods, usually hours rather than days. Nevertheless, a person in custody has been taken from his or her usual environment, is unable to access usual sources of assistance and support, and is dependent on custodial officers for all aspects of personal welfare.

2.27 The requirement on the AFP and ACT Policing is to take reasonable steps to provide

- a safe custodial environment
- an adequate number of competently trained officers to staff the Watchhouse
- appropriate instructions and procedures for the guidance of staff
- supervision of staff by adequately trained and authorised managers.

2.28 Delivery of an appropriate standard of duty of care to Watchhouse detainees also requires that custodial officers

- understand their responsibilities for the care of detainees
- comply fully with training, procedures and guidelines
- act reasonably in all the circumstances.

2.29 These requirements, and the extent to which they are met, are integral to the entire review. The legislative and procedural framework for Watchhouse operations is discussed below. Facilities and amenities are considered in Part 3 of this report; management and care of detainees is discussed in Parts 4 and 5; and training and supervision of staff is covered in Part 6.

Duty of care to Watchhouse staff

2.30 Section 16 of the *Occupational Health and Safety (Commonwealth Employment) Act 1991* (OH&S Act) requires that an employer must take all reasonably practicable steps to protect the health and safety of employees. The AFP

and ACT Policing have a responsibility to provide a safe working environment for staff and to ensure that staff receive the training and support required to undertake their custodial responsibilities.

2.31 All employees should be provided with the necessary information, instruction, training and supervision in performing duties in the Watchhouse. Exposure to risk in the Watchhouse can arise from a variety of sources, from managing violent or drug affected detainees to handling the chemical munition, Oleoresin Capsicum (OC). In view of recent concerns about use of OC in the Watchhouse, the review team considered in Part 4 of this report the extent to which arrangements for use of OC were consistent with the AFP's obligations to staff. The review team also considered arrangements to ensure personal security for staff.

Personal security of staff

2.32 Security of staff, particularly when dealing with violent or disturbed detainees, is essential to a safe working environment. Watchhouse staff are regularly required to enter cells to check on the status of detainees as well as to escort detainees around the Watchhouse. They may also be required to remove uncooperative detainees from cells or from the back of police vehicles in the sally port.

2.33 Only one of the Watchhouse staff spoken to during the review had received training in cell extraction, and his training had been received in the course of previous employment. Some of the more experienced ACT Policing members commented that relatively new members had 'no idea' when it came to entering a cell with a detainee. For example, they suggested inexperienced staff were likely to allow a detainee to come between the member and the door. Some reported seeing a member inadvertently turn his or her back on the detainee inside a cell. Although Watchhouse staff are advised they must not enter cells alone, in practice the pressure of work makes this difficult at times.

2.34 No personal duress alarms were provided for Watchhouse staff. If a staff member were to be attacked by a detainee, or trapped in a cell, it might be some time before other staff noticed. A range of personal alarms is available on the market, and several other custodial jurisdictions considered by the review team advised that such alarms have been issued to their staff. Further, some staff were unaware of the location of the Watchhouse duress alarm. They could not advise the review team on what would happen when the alarm was activated, nor when it had been last tested.

Review team opinion

2.35 The National AFP Guideline on Persons in Custody contains a section on duty of care for detainees at risk, but notes only that 'AFP employees have a duty of care for people in their custody'. Explanation of that duty is limited to observing that certain types of detainees (e.g. Indigenous persons) should be regarded as 'at risk'. The ACT Policing Practical Guide: Persons in Custody contains no section relating to duty of care specifically. Throughout both documents are references to the rights of detainees and how different types of detainees should be managed, but these do not address the obligations of staff.

2.36 The review team was unable to identify any AFP or ACT Policing documents that attempted a definition of duty of care to persons in custody and how that duty should be interpreted in the Watchhouse. Documentation the review team did inspect focused heavily on the legal obligations of police in dealing with the community. The concept of duty of care includes what would, in all the circumstances, be regarded by

a reasonable person as reasonable care for a person who has been deprived of liberty and is totally dependent for all aspects of well-being on custodial staff.

2.37 AFP Learning and Development, which is responsible for ACT Policing training, suggested that the concept of duty of care was integral to all police training and should be understood by all members. However, the review found many Watchhouse staff had a limited understanding of duty of care in a custodial environment. Staff focused primarily on the secure custody of detainees, and gave little attention to maintaining detainee well-being. Ideas of duty of care ranged from 'not letting them get to you' to 'making sure they can't hang themselves'. This focus is reflected in the draft Watchhouse Manual.

2.38 By comparison, the review team found that many other jurisdictions gave specific attention to defining duty of care. For example, the Brisbane Watchhouse Operating Manual contains a discussion that recognises the value of integrating the needs of individual detainees into the arrangements for their care. Staff in Brisbane noted that looking after detainee well-being not only helped ensure their secure custody, it also contributed to greater detainee compliance and a safer environment for everyone.

2.39 In the review team's opinion, early attention should be given to ensuring all ACT Watchhouse staff receive training to ensure an appropriate understanding of their duty of care to detainees. This training should acknowledge that duty of care is as much about the welfare of detainees as it is about their security.

2.40 The review team suggests that there may be value in drafting a standard explanation for detainees about custody in the Watchhouse, including staff and detainee rights and responsibilities. This could be similar to the explanation read to all detainees entering custody in New South Wales. Other jurisdictions provide written advice to detainees. Any explanation must be provided in an accessible form, taking account of the special needs of the detainee. Detainees should be asked to acknowledge in writing that this explanation has been provided by staff on entry to the Watchhouse.

2.41 The review team assessed many of the aspects of AFP and ACT Policing responsibility for the provision of a safe working environment for staff in the Watchhouse. However, our consideration of this issue suggests further investigation is required to ensure that all AFP operational requirements and legal obligations in relation to duty of care to staff are being met.

Legislative and procedural framework—guidelines and procedures

2.42 This section identifies the key legislation, procedures and guidelines relevant to the operation of the Watchhouse. It considers whether the procedures and guidelines are comprehensive and internally consistent; how useful they are to staff as guides to best practice in the management of the Watchhouse; and how well they are understood and practised by staff.

2.43 There is no overall governance framework for Watchhouse operations. A range of laws, Commissioner's Orders, AFP National Guidelines and ACT Policing Practical Guides are relevant to the Watchhouse and its functions. There are other reference sources, mostly informal, that can also provide guidance to Watchhouse

staff on day to day activities. Apart from training in the general principles of policing, such as use of force, that is provided to all ACT policing members, there is no training specifically covering custodial duties in the Watchhouse. The adequacy of training for Watchhouse staff is discussed in Part 6 of this report.

2.44 It is beyond the scope of this review to examine the application of all these legislative instruments and procedural documents. The following provides a summary of the most relevant.

Legislation

2.45 Key legislative instruments that relate to the operations of the Watchhouse are summarised below: they are ACT Acts unless otherwise indicated.

- *Bail Act 1992:* specifies when bail may be granted and to whom. There may be a presumption for bail in certain minor offences, no presumption for bail, or a presumption against bail for matters such as family violence, murder and serious drug offences. The Watchhouse sergeant determines whether bail should be granted in the first instance.

- *Crimes Act 1900:* specifies power to search a person at a police station and defines who will search whom. For example, it sets out the conditions for same gender and transgender searches. The Crimes Act also provides a power to obtain identification material such as fingerprints and photographs. These are usually taken in the Watchhouse.

- *Crimes Act 1914* (Cth): Part 1C defines the investigation period for various categories of detainees. This is the period for which an arrested person may be detained without charge. For example, for non-indigenous detainees, a four hour investigation period is permitted. For indigenous or juvenile detainees, the investigation period is two hours. This time period may be extended with a magistrate's consent. The Crimes Act also provides for a suspect's rights, for example, to contact a friend, relative, lawyer or, in the case of an indigenous person, an Aboriginal interview friend. The Watchhouse sergeant is responsible for ensuring these requirements have been met.

- *Children and Young People Act 1999:* creates an obligation on police to notify parents if a young person is in custody. The Watchhouse may not take identifying material such as fingerprints and photographs unless the young person was over the age of 16 years when the offence was committed. A young person who has been charged and has had bail refused must, as soon as practicable, be taken to a shelter or juvenile correctional centre and detained there.

- *Intoxicated People (Care and Protection) Act 1994:* provides that an intoxicated person may be held in the Watchhouse for a maximum of 8 hours. The period of custody can be extended by a further four hours if the detainee consents. An intoxicated detainee cannot be kept longer than 12 hours, but may be released into the care of the manager of a licensed place such as a Sobering up Shelter. *The Watchhouse sergeant is responsible for ensuring these requirements are met.*

- *Crimes (Forensics Procedures) Act 2000:* provides police with the power to

obtain samples from a detainee, including mouth swabs, blood and hair, and the rules to be observed in taking samples.

- *Road Transport (Alcohol & Drugs) Act 1977:* provides police with the power to detain a person for the purposes of breath analysis or taking of blood sample if it is suspected that a person has been driving a motor vehicle while under the influence of drugs or in excess of the prescribed concentration of alcohol in the blood.

- *Service and Execution of Process Act 1992* (Cth): provides for the service and execution of arrest warrants by police. Many detainees are brought in custody to the Watchhouse on the basis of warrants.

Commissioner's Orders

2.46 Key Commissioner's Orders relevant to Watchhouse operations are:

- Commissioner's Order No 2: Professional Standards: explains the professional standards expected of AFP employees. The Order outlines the AFP complaint management methodology and processes in accordance with the *Australian Federal Police Act 1979*. It also explains the changed arrangements for complaint handling since December 2006. It is important that Watchhouse staff are conversant with the Order so that they can effectively handle complaints from detainees

- Commissioner's Order No 3: Use of Force: provides for the use of reasonable force by police and describes the circumstances in which this can occur. Only section 6.3 of the Order refers specifically to the Watchhouse. It relates to ensuring that a person brought into the Watchhouse who has been exposed to Oleoresin Capsicum does not contaminate other detainees and Watchhouse staff.

National Guidelines, Practical Guides and other procedural guidelines

2.47 A range of AFP National Guidelines and ACT Policing Practical Guides relate to aspects of Watchhouse operations. These include:

AFP National Guidelines

- Police Custodial Facilities and People in Custody
- Complaint Management
- First Aid in the Workplace
- Management of Major Incidents
- Property and Exhibits.

ACT Policing

- Practical Guide: Bail
- Practical Guide: Oleoresin Capsicum (OC) Spray
- Practical Guide: Warrants and Notices of Demand
- Practical Guide: Property, Exhibit and Drug Handling

- Best Practice Guide: Persons suffering from mental illness
- Practical Guide: Children and Young People
- Practical Guide: Interpreters and Translators.

2.48 Principle guidance for managing detainees in the Watchhouse is found in the AFP National Guideline on Police Custodial Facilities and People in Custody and the ACT Policing Practical Guide: Persons in Custody. These are discussed further below.

Other reference sources for Watchhouse operations

2.49 A number of other documents relate to the framework for provision of services in the Watchhouse, or provide information relevant to the management of detainees. These have not been considered in detail but some are referred to later in the report. They include:

- *Memorandums of Understanding* with
    - ACT Mental Health Services—concerning the provision of emergency assistance to detainees who may be suffering from mental health problems
    - ACT Corrective Services, ACT Youth Justice Services and NSW Corrective Services—concerning the transfer of information about the health or risk status of detainees to ensure their continuing safe care
    - ACT Corrective Services—concerning the provision of custody and transport of detainees to and from the courts and other places as required.

- *Reports and other general guidance*
    - Recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) 1991
    - Aboriginal Interview Friends and Interpreters—statutory list pursuant to section 23J of the Crimes Act 1914
    - A Practical Reference to Religious Diversity for Operational Police and Emergency Services
    - Recommendations from Ombudsman investigations.

AFP National Guideline on Police Custodial Facilities and People in Custody and the ACT Policing Practical Guide: Persons in Custody

2.50 The AFP National Guideline on Police Custodial Facilities and People in Custody and the ACT Policing Practical Guide: Persons in Custody are intended to establish benchmarks for managing people in custody. However, the review team found them incomplete or irrelevant in important areas and out of date in others.

2.51 For example, the National Guidelines provide an overview of custodial procedures only. It refers readers to Guidelines for Best Practice and ACT Policing Guideline Supplement Handbooks for more specific information. Unfortunately many of the Guidelines and Handbooks referred to are no longer used or have been superseded by a series of ACT Policing Practical Guides. At its last review in

February 2007, the National Guideline was confirmed without any amendment. AFP Economic and Special Operations, the area responsible for ensuring the currency of the documents, did not communicate with ACT Policing during the review of the Guideline.

2.52 The ACT Policing Practical Guide: Persons in Custody has similar shortcomings. For example, Part 2 of the Guide sets out procedures to be followed in the Watchhouse and section 22 addresses 'video tapes'. The section was written at the time when a manually operated video system was used to record Watchhouse operations. The system was upgraded to digital CCTV in July 2006. However, the Guide was not updated to reflect the new facilities and related procedural changes. The review team was advised that the entire Guide is due for revision. However, there appears to be no arrangement for ensuring procedural changes occurring between scheduled revisions are incorporated into the Guide. In view of the lack of up to date guidance, it is not surprising that staff in the Watchhouse were unable to explain the operation of the CCTV system to the review team.

2.53 The deficiencies in the formal guidelines on custodial procedures limit their value to Watchhouse staff. The review team found many staff were not familiar with the National Guideline or the Practical Guide. Those who were, said they did not find them particularly helpful in managing day to day in the Watchhouse. Some sergeants told the review team that they routinely disregarded the procedures in the Guideline and the Guide if they believed their way of doing things was better. Several of the Watchhouse sergeants interviewed said they felt so frustrated by the lack of practical, operational guidance that in April 2006 they decided to write their own manual. This is known as the draft Watchhouse Manual and the staff involved in its development are to be commended for their initiative.

The draft Watchhouse Manual

2.54 The Manual was apparently intended as a guide for Watchhouse sergeants. A parallel guide for constables was planned although it has not been drafted. The Manual has been a work in progress since drafting commenced a year ago, with sections being added or amended as different sergeants pass through the Watchhouse. This piecemeal approach to its writing has resulted in a document that focuses on those areas of practical importance to the writers. Quite reasonably, it provides extensive detail on procedural matters, such as handling bail and completing detainee records on the cell management system. It is short on matters such as duty of care to detainees and managing the well-being of detainees in custody.

2.55 This draft Manual is currently the key source of practical advice for staff on their specific duties in the Watchhouse. It is widely referred to by staff and, despite its informal status, has been cited to the review team as the primary authority for custodial questions in the Watchhouse. Unfortunately, it is incomplete and, in places, inconsistent with formal AFP and ACT Policing guidelines on persons in custody. This is not surprising since governance areas in AFP and ACT Policing were unaware of the draft Manual's existence until advised of it by the review team.

Review team opinion

2.56 Both the AFP National Guideline and ACT Policing Practical Guide on Persons in Custody require revision to ensure they are accurate and complete. Since the AFP National Guideline principally relates to ACT Policing requirements, it is logical that responsibility for maintaining this document should lie with the Chief

Police Officer for the ACT. Procedures need to be put in place to ensure that document updates are undertaken as required to reflect changes in custodial arrangements as they occur, regardless of the scheduled date of revision of the guidelines.

2.57 The lack of standard operating procedures for the Watchhouse is a serious deficiency. In the absence of a rigorous procedural framework, staff have developed their own practices. These are not necessarily consistent with AFP National Guidelines or ACT Policing Practical Guides, and often differ between staff on different shifts. In the absence of formal training, these different practices are passed on through on-the-job training when new staff come to the Watchhouse. As a result, how individual detainees are treated is largely dependent on the views of the Watchhouse sergeant on duty at the time.

2.58 This is not intended to imply that Watchhouse sergeants are uncaring in their approach to detainees, or that they do not endeavour to perform their duties to the best of their abilities. However, the lack of formal operating procedures forces staff to make decisions and take actions without the security of an approved operational framework. The review team notes that all other jurisdictions, national and international, considered in the course of the review placed great emphasis on the importance of a sound procedural framework. They routinely had comprehensive operating procedures addressing all aspects of custodial care within a particular facility.

2.59 The draft Watchhouse Manual is a valuable document in that it provides practical information on some Watchhouse procedures, such as cell management and transfer of detainees. However, it is no substitute for a formal document, endorsed by ACT Policing, covering all aspects of Watchhouse operations.

2.60 In the review team's opinion, standard operating procedures for the Watchhouse should be developed as a matter of urgency. The document must be consistent with AFP National Guidelines and ACT Policing Practical Guide on Persons in Custody. Suitable models for such a document are widely available: the Brisbane Watchhouse Standard Operating Procedures would provide an excellent template. Once such procedures are in place, all staff should be given comprehensive training in, and be required to comply with, them.

2.61 A number of persons who made submissions to the review commented on the unavailability of governance documentation relating to the Watchhouse. The review team was advised that none of the documents covering Watchhouse procedures or standards for care of detainees is easily available to the public. AFP and ACT Policing governance advised that persons seeking access to specific documents could apply under Freedom of Information guidelines and a decision would be made on a case by case basis.

2.62 The public availability of Watchhouse procedures and guidelines should be reconsidered. Greater transparency will encourage public understanding of the role of the Watchhouse and help dispel misconceptions about what happens when ACT Policing takes a person into custody. There may be aspects of guidelines or procedures that police believe should be protected for reasons of security of Watchhouse facilities or staff. In these circumstances, an appropriate exemption from release could be made.

Recommendations

2.63 The review team recommends

Recommendation 1

AFP and ACT Policing governance framework for staff on custodial care should be revised. The revision should include the following:

- Ensuring that existing guidelines, including the AFP National Guideline on Custodial Facilities and Persons in Custody and the ACT Policing Practical Guide: Persons in Custody are accurate, complete, current, and internally consistent.

- Drafting standard operating procedures for the Watchhouse, taking account of the work already done on drafting of a Watchhouse Manual and standard operating procedures for police custodial facilities interstate, such as the Brisbane Watchhouse.

- Clear definition of the duty of care owed to detainees, and to staff tasked with custodial duties. Duty of care should cover all aspects of detainee and staff health and well-being, as well as detainee and staff security.

- Establishment of mechanisms for regular review and updating to ensure accuracy and currency of procedural guidance. Consultation with all relevant stakeholders is essential.

- Ensuring that all staff involved in custodial duties are aware of procedural requirements, their obligations and detainee rights. Subject to maintaining Watchhouse operational security, public access to custodial guidelines should be increased in the interests of enhancing community understanding of the role of the Watchhouse.

PART 3—PHYSICAL CONDITIONS AND SAFETY IN THE WATCHHOUSE

Facilities

3.1 This section describes the location, design and facilities provided in the Watchhouse. It considers whether they are consistent with the standards for detainee safety established by the RCIADIC; and how they compare with facilities provided in other jurisdictions.

Entry to Watchhouse

3.2 The Watchhouse is located on one floor in the basement of City Police Station. It is accessible through two secure entries. One entry is from inside the station by a set of stairs just past the front reception. These internal stairs lead down to a locked door into the Watchhouse with an intercom for visitors to call through to the charge room. The other entry is through a driveway and ramp at the rear of the police station. The driveway leads to a secure vehicle entry yard and detainee set down sally port (garage). External entry to the sally port is secured by a roller door operated by Watchhouse staff from within the Watchhouse or from within the sally port. Police drive a vehicle holding a detainee into the sally port and onto a rotating plate that allows the vehicle to be turned up to 360 degrees. Once inside the sally port the roller door is closed and entry to the Watchhouse is by an internal door. Entry to the Watchhouse is electronically controlled in the charge room. Anyone seeking entry must seek the agreement of the Watchhouse sergeant.

Watchhouse facilities

3.3 The Watchhouse comprises

- a charge room and charge counter
- Watchhouse work room incorporating the surveillance area from which the CCTV screens may be monitored
- medical examination room
- storage areas for blankets and consumables
- cleaner's room
- kitchen for preparing detainee meals
- detainee visitor rooms
- detainee property store
- Watchhouse Manager’s office
- staff facilities, including meals area, locker room and toilets.

Watchhouse cells

3.4 The Watchhouse contains a total of 28 cells sleeping up to 52 detainees. Each cell contains at least one 2.1 metre long built-in bed, raised 39cm above and moulded into the floor, a 9 centimetre thick foam mattress, a toilet, bubbler and hand basin. With the exception of the padded cells and drug evidence cell, the toilet and

bubbler are activated by the detainee from inside the cell. An integrated intercom call button and microphone is installed in each cell to allow the detainee to contact Watchhouse staff or call for assistance. Each cell has a camera linked to a CCTV system monitored by Watchhouse staff. The CCTV system is explained in detail later in this Part of the report.

3.5 Different types of cells are provided. Single cells are about 3.7 metres square and are mostly built to a common design, with the exception of the padded cells and the drug evidence cell. These are explained in more detail below. Cell design took account of RCIADIC Recommendation 3:250 and is intended to maximise interaction between custodial officers and detainees as well as to minimise hanging points. With the exception of the padded cells for high risk detainees, all cells have three concrete walls and a fourth wall constructed of strengthened glass, including a glass door with manually keyed lock.

Pre-charge cells x 4

3.6 The pre-charge holding cells are directly opposite the charge counter. Dividing the Watchhouse counter from these cells is a one-way glass partition. The partition was intended to enable Watchhouse staff at the charge counter to see into the cells to monitor detainees but to prevent detainees seeing back through to the Watchhouse charge counter. Unfortunately this one-way glass is ineffective: the review team found it difficult to see detainees inside the pre-charge cells from behind the charge counter.

Group Holding cells x 2

3.7 The two group holding cells, each measuring approximately 8 x 3.7 metres, back onto the pre-charge holding cells. Each cell can hold up to 20 detainees, and has sleeping accommodation for five. Groups of male and female detainees can be separated using these cells. Each cell has a one toilet, a bubbler and a hand basin. Each has some natural light. The cells are not within direct sight of the Watchhouse staff in the charge room and can only be seen from there via CCTV.

Male and female blocks x 2 (11 individual cells)

3.8 The female block has six cells; the male block has five cells. Cells in both blocks are arranged around a central common area, with a built-in table and benches that provides some natural light. Each block includes two detainee shower rooms.

Intoxicated persons cells x 6

3.9 This is a block of six cells used to accommodate persons who are intoxicated. The block is similar in design to the male and female blocks and includes a common area that provides limited natural light.

Detainee ‘at risk’ cells x 2

3.10 There are two detainee ‘at risk’ cells. These cells are used to accommodate detainees who have been assessed as being ‘at risk’ for some reason and require closer observation than other detainees. They do not differ in design from the standard cells but are located directly across a corridor from the Watchhouse workroom. The Watchhouse sergeant advised this enabled direct observation of the cells from a window in the workroom. However, a Venetian blind at the window in the Watchhouse office, closed to provide privacy for Watchhouse staff, makes direct observation of anyone in the ‘at risk’ cells impossible. The cells have no natural light.

Detainee 'at risk' cells (padded) x 2

3.11 The floor, ceiling and all four walls of these cells are padded, with the exception of small glass panels on the doors that let in some artificial light from the corridor. The cells are used to accommodate detainees who are violent or judged to be 'at risk of harming themselves or others'. They contain no beds or bedding and have no natural light. Each cell has a fully padded toilet that can only be flushed from outside the cell by Watchhouse staff.

Detainee 'at risk' (drug evidence cell) x 1

3.12 The drug evidence cell does not have a toilet, bubbler or hand basin. Detainees suspected of secreting drugs are placed in this cell until they are strip searched. Detainees suspected of carrying drugs internally are transported to hospital and not kept in the Watchhouse.

Review team opinion

3.13 All cells were inspected for compliance with RCIADIC recommendations. They were found to be compliant, with the following exceptions that have been drawn to the attention of Watchhouse management:

- Group holding cells: each contained cupboard doors along one wall with hinge projections that could be potential hanging points.
- Many cells contained a drainage grate in the floor that could be used as a potential hanging point.

3.14 The review team also made the following observations:

- One of the group holding cells (13) contained a large pole. The area behind the pole was not visible through the cell's CCTV camera.
- The padded cells and the drug evidence cell do not contain bubblers and detainees need to rely on staff for fresh drinking water. Care needs to be taken to ensure that detainees placed in these cells are offered fresh drinking water frequently.
- Natural light in many cells is limited and access to an exercise area is available only to those detainees in the male, female and intoxicated persons block. If a detainee is to be held in custody for more than 24 hours, staff should ensure that, as far as possible, the detainee is accommodated in an area that provides opportunity for exercise and access to natural light.
- With the exception of the four pre-charge holding cells and the person at risk cells, direct observation of the cells is not possible from the Watchhouse workroom or charge counter. Visibility of the holding cells is severely limited by a glass partition between the cells and the Watchhouse counter that reflects light. Any monitoring of the condition of detainees in other cells must be done by staff physically visiting the cells or by watching the CCTV screens in the Watchhouse work room.

Amenities and services

3.15 This section considers the nature and adequacy of amenities and services available to persons while in custody.

Physical conditions of detention

Condition of cells

3.16 Watchhouse procedures specify that each cell should be cleaned and checked after use to ensure that it is in good order before being used again. Apart from meeting community expectations of hygienic management of such facilities, cleaning is essential if a cell has been contaminated by body fluids. Cells should also be checked after each use to ensure that nothing has been left behind or hidden in the cell by the previous detainee.

3.17 Daily cleaning is undertaken by an external contractor and generally cells are in good condition and appear well kept. Cells are wiped down with disinfectant after use. The holding cells and the padded cells are steam cleaned fortnightly, and all other cells, monthly. A cell that has been contaminated by bodily fluids usually will be closed until the next day, or the contractor may be called in to clean it. In rare instances, such as a spill of body fluids on the corridor floor after normal working hours, Watchhouse staff may be required to clean up. Three spill kits are available in the Watchhouse but staff interviewed during the review reported that they had not been trained in their use.

3.18 Discussions with staff indicated that if the high volume of detainees requires that a cell be reoccupied, after use but before the next scheduled cleaning, that cell may not be cleaned first. Staff reported that this occurs regularly with the four holding cells that are in constant use throughout the day and night.

3.19 However, cleaning does not include checking that the toilet, bubbler and intercom in the cell are in working order. This is the responsibility of the shift sergeant. Staff report that this checking is not usually done: apparently it is assumed that a detainee will let staff know if there is a problem. If necessary the cell will be closed and the detainee moved to another cell until maintenance staff rectify the problem. Further, staff report that searching of cells after use, to ensure no inappropriate object has been hidden by a detainee, is not routine.

Bedding, warmth and light

3.20 Cell mattresses are thick foam covered in heavy duty vinyl for easy cleaning. Some of the mattresses were cracked and are currently being replaced. No pillows or sheets are provided for detainees although they are usually offered a thick cotton blanket when placed in a cell and can request another if cold. The blankets are cotton, hospital-style blankets and are not tear-proof. This is similar to bedding provided in other custodial facilities considered in the course of the review. One jurisdiction did have a bolster/pillow incorporated into one end of the mattress which would provide greater sleeping comfort than a straight mattress. Staff noted that detainees could also use a blanket as a pillow. Several jurisdictions also had tear-proof blankets available for detainees who may be at risk of self-harm.

3.21 Watchhouse cells have no access to fresh air. All cells are air conditioned in a temperature range of between 18.9 degrees C and 23 degrees C, similar to the temperature in the Watchhouse workroom.

3.22 As noted above, limited natural light is available only outside the group holding cells and in the male, female and intoxicated detainee cell blocks. Standard artificial lighting is provided throughout the Watchhouse, although light intensity varies considerably. For example, light in some cells was measured at 590 lux, while in the Watchhouse work areas light levels were between 164 and 250 lux (except when additional lighting was switched on for filming the charging of a detainee). The recommended light intensity for typing and general office work is 500 lux.

3.23 Lights in most cells are turned off at around 10.30pm to help post-charge and intoxicated detainees to sleep**.** However, the corridors are fully lit at all times and, since almost all cells have clear glass windows and doors, light from the corridors shines directly into the cells. A reasonable level of lighting in cells is required for effective operation of the CCTV cameras.

3.24 The exception to this arrangement is lighting in the padded cells. Mental Health authorities have advised that subdued lighting can help calm highly disturbed persons as long as there is at least some light source available, such as from a corridor. The padded cells have both standard and infrared lighting installed. This enables staff to turn off the standard lighting when, for example, a detainee is suffering a violent, drug induced episode. Padded cells have small panes of glass in their doors to allow limited corridor light to enter. The infrared lighting provides sufficient illumination to operate the infrared CCTV cameras.

Catering

3.25 The Watchhouse provides meals and refreshments for all detainees. Breakfast is prepared by Watchhouse staff. Pre-packed meals for lunch and dinner are prepared by Spotless Catering under a contract that expires shortly. These meals are delivered daily and refrigerated or frozen until required. If a detainee requires a special diet, some Watchhouse sergeants have suggested that it is up to the family to provide it. This is contrary to the ACT Policing Practical Guide: Persons in Custody. The draft Watchhouse Manual is silent on the matter. In practice, no special meals are available for detainees.

Review team opinion

3.26 Best practice requires that comfortable and safe physical conditions, and particularly high standards of cleanliness and hygiene, be maintained in a custodial environment.

3.27 Failure to clean or check a cell adequately after it has been vacated could have serious consequences. For example, it is too late to discover that an intercom is inoperable after a detainee has suffered injury as a result of being unable to summon assistance. The review team was told of an instance when a detainee had secreted a sharp piece of plastic within the toilet bowl in his cell. This object could have been found by another detainee occupying the cell later and used to inflict self harm or injure another person. These matters have been drawn to the attention of Watchhouse management and we understand appropriate cleaning and checking of cells is now occurring.

3.28 Bedding and air conditioning are generally adequate. However, natural light is limited and the lux levels of artificial lighting through the Watchhouse should be reviewed to ensure they are consistent with OH&S requirements. Staff commented on the negative effects of working in a basement area for shifts of up to 9 days, with

rare opportunities to take a break outside. Lighting tests suggest that light intensity in the staff work area is low, by comparison with standards for optimal working environments. It also seems unlikely that 590 lux is necessary for the effective operation of CCTV cameras in cells and the bright light may adversely affect some detainees.

3.29 The review team tested one of the cotton blankets provided to detainees and had little difficulty tearing long strips from the edge, sufficient for a detainee to fashion a noose or similar. The ease with which this could be done may be due in part to the age of the particular blanket. Blankets are essential to provide adequate warmth for detainees in the cells. In our view it would be appropriate to review the entire stock of blankets currently available for detainees to ensure they are serviceable. Watchhouse management may also wish to investigate the acquisition of tear-proof blankets for detainees assessed at being at risk of self harm.

3.30 Little provision has been made for vegetarians or for detainees whose religious beliefs or medical conditions require a special diet to be followed. For example, no Halal food is available and no other formal arrangements appear to have been made to cater for detainees with special dietary needs. Further comment is made later in the report about accommodating the needs of detainees with particular cultural or health concerns.

3.31 The review team examined a number of complaints relating to access to food and water in the Watchhouse. These include alleged failure to provide meals at appropriate times and deprivation of water as a form of punishment for misbehaviour. Complaints about delays in providing food appeared to come from detainees who arrived after a meal time had passed and were obliged to wait for the next scheduled mealtime. Delays in providing meals on time appeared to be due to heavy workloads on Watchhouse staff. The adequacy of staffing in the Watchhouse is considered in Part 6 of this report.

Property management

Procedures

3.32 Current procedures provide that detainee property be removed at the charge counter as soon as the detainee enters the Watchhouse. This includes shoes, belt or cord tie in trousers, hair ties, all jewellery (including earrings and body piercings), all personal items from pockets (including wallet and mobile phone), headwear, and usually coat or jacket. No exceptions are made to these procedures. Detainees are asked to remove their own property but will be assisted by police if unable or unwilling to do so.

3.33 One of the two Watchhouse constables is tasked with itemising the property, including emptying wallets and counting any money or credit cards. The constable is provided with gloves when handling detainee property. Any property required as an exhibit (for example, clothing used in a robbery) will be itemised separately on a property seizure record and a cross-reference made on the property list. Illegal items, such as drugs, are recorded and placed in an audit bag and handed to the arresting officer. The removal and itemising of property is recorded by a fisheye camera installed over the charge counter. Detainees are not, however, required to countersign the property list to verify it is an accurate record of their property. They are asked to sign that the property has been returned to them when they are released from custody or transferred to the Court Cells.

Storage and handling

3.34 Each detainee's property is placed into a separate plastic bucket with smaller, valuable items, such as jewellery and wallet, stored in a small, plastic ziplock bag, and sealed with a numbered security clip. This number is recorded on the property sheet. Should the bag need to be opened for any reason during the period of custody that will be done at the charge counter and recorded. The ziplock bag will then be resealed with a new numbered security clip. Plastic buckets are then placed in an unsecured cupboard adjacent to the charge counter. Storage space exists in the cupboard for the property of 25 detainees. If more detainees are in custody, their property is stored on the floor near the cupboard.

Review team opinion

3.35 Property has traditionally been a source of many complaints about the Watchhouse. Often complaints have related to discrepancies between the amount of money taken from and then subsequently returned to a detainee. The Court Transport Unit has also reported discrepancies between Watchhouse records and the amount of money that is actually sent across with detainees when they transfer to the court cells. Since the installation of the fisheye lens camera over the charge counter in June 2006, the number of complaints of this kind has dropped significantly. Enhanced recording of property procedures has also meant that those complaints that have been made can be more readily and confidently determined.

3.36 Property management in the Watchhouse could be further improved to bring it in line with best practice observed in other jurisdictions. An excellent example was the storage room in the Brisbane Watchhouse. The Brisbane Watchhouse property room contained a separate area for storage of every detainee's property and could be accessed only by authorised staff. Electronic locking and a video camera recorded every access, and whose key was used.

3.37 The provision of secure storage for all detainee property held within the Watchhouse is essential. A lockable storage area is desirable with access limited to Watchhouse staff only. The review team was advised that there is no secure storage in the Watchhouse for larger items of property, such as large suitcases or bicycles. These are stored upstairs in the City Station Property Office. Appropriate secure storage of for all detainee property in the Watchhouse is a matter of priority.

3.38 Requiring detainees to countersign the property list when their property is passed over to Watchhouse staff should help reduce complaints about discrepancies when detainees leave custody. If a detainee is unable or unwilling to sign the list, the property constable and Watchhouse sergeant could countersign for the detainee, providing a brief explanation as to the reason why this was necessary.

3.39 Although the review team was advised the matter had not arisen to date, Watchhouse procedures should provide guidance on the handling of headwear that may have cultural or religious significance. For example, the procedures currently require removal of all headwear, presumably including a Muslim woman's hijab. The review team recognises the importance of ensuring detainee security and acknowledges that staff would need to be assured that headwear was not being used to hide items that could be used to self harm. However, requiring a Muslim woman to remove her hijab, or a Sikh man to remove his turban, would be culturally and personally confronting. In our opinion, closer liaison with community groups could be undertaken to develop new Watchhouse procedures for handling of property that has

cultural or religious significance.

Dealing with emergencies

3.40 Ensuring the physical safety of persons in the Watchhouse requires that adequate procedures for dealing with emergencies are clearly articulated and understood by staff working in the Watchhouse, especially those responsible for the management of detainees.

Emergency evacuation

3.41 An evacuation plan exists for City Police Station, although the draft Watchhouse Manual provides no guidance on procedures for emergency evacuation, for example, in the event of a fire. It was of some concern that many of the current Watchhouse staff interviewed in the course of the review were unaware of emergency evacuation procedures. None recalled being advised about evacuation arrangements on taking up duty in the Watchhouse. None could recall rehearsing evacuation procedures.

3.42 The Watchhouse Evacuation Procedures appeared to lack two important attachments: a diagram showing mustering points for detainees evacuated from cells; and a current list of fire wardens. It is unclear when the evacuation procedures were last updated and whether fire wardens had been nominated and, if nominated, were aware of their role.

3.43 Other concerns noted by the review team were:

- The Watchhouse was apparently designed on the basis that any detainee needing evacuation would be escorted. However, there were only four sets of handcuffs available in the Watchhouse. The Watchhouse can sleep up to 52 detainees.

- At least one of the handheld fire extinguishers (in the sally port) was obscured by bins and other material, hampering access in an emergency. The review team was advised that this had been remedied but monitoring is required to ensure the problem does not recur.

- Staff reported that they had not been trained in use of the available fire fighting equipment. No breathing apparatus was available for use in case of fire.

- The only external emergency entry to the Watchhouse is by an electronic switch operated from within City Station. The switch opens the connecting door into the Watchhouse door for insufficient time for a City Station member to run to the connecting door. This could be a problem if only one person is available in the City Station after normal working hours.

- The Watchhouse has emergency exit lights directing staff and detainees to the three emergency exits, powered by a backup generator. However, there are no torches, and one of the exit doors is operated manually by a key in a fire-related power failure. Staff were unsure where the key was located and the emergency exit lights seemed unlikely to provide sufficient light to put the key in the lock even if it could be found. The Watchhouse is in the basement of the City Station and there is minimal external light, even during daylight hours.

First aid

3.44 All AFP members are required to have a current Senior First Aid qualification, usually provided by St John Ambulance. The qualification lasts for three years and members are 'recommended' to attend a refresher course each year to maintain their skills. However, the onus is apparently on individual staff to ensure that their currency in first aid is maintained, both in undertaking refresher courses and in re-qualifying.

3.45 Given the high proportion of persons taken into custody who have health problems or are affected by drugs and/or alcohol, the capacity to provide appropriate first aid if required is essential. The review team was concerned to find that five of the current Watchhouse staff did not have a current first aid qualification, or for some reason the status of their qualification was unknown. There appeared to be no administrative arrangement in place to ensure that all staff undertaking Watchhouse responsibilities had current first aid qualifications. It was not clear that all those who had qualified or re-qualified had attended annual one day refresher courses or were scheduled for a three day course when their current qualification expired.

3.46 The review team also noted that although advanced resuscitation equipment was stored within the charge area, few of the staff reported that they knew the equipment was there. Only two staff said they knew how to use the equipment: they had received training in the course of previous employment. On further investigation, it became apparent that the advanced resuscitation equipment was inoperable because the oxygen tank was empty. There appeared to be no administrative arrangement in place to ensure that such equipment was maintained in good order and that all staff knew how to use it.

Biological contamination

3.47 As noted above, Watchhouse staff are sometimes obliged to clean up spills of body fluids. Three spill kits are available. The review team did not have sufficient time to explore in detail the adequacy of cleanup arrangements, but identified several areas that may require further examination. They are:

- Lack of training in the use of spill kits. No staff interviewed had received training in the use of spill kits. This may be one reason why staff reported that cleaning up of vomit was done by one of the constables using a cleaner's mop. Cleaners' mops are colour-coded to ensure that red mops are used only in bathrooms, and green mops in kitchens. Most Watchhouse staff appeared unaware of this and used the first mop at hand to clean up. The mop was not disinfected, but simply replaced in the cleaning room after use.

- Shortage of staff lockers for storage of clean uniforms. Several staff raised the limited number of lockers available for storage of uniforms within the Watchhouse. They reported that uniforms could be soiled with blood or other body fluids during a shift and they needed to be able to change quickly.

- Who should undertake biological contamination cleanup. Several members expressed concern that they were required to do this at all. They suggested that it was more appropriate for cleaners who were employed specifically to do this kind of work. They believed cleaners had the necessary training, equipment, skills and experience to do the job safely.

3.48 The review team was advised that a 2006 Occupational Health and Safety audit recommended 13 improvements to ensure appropriate infection control was

practised in the Watchhouse. They related to such matters as daily disinfecting of phones; removal of carpet from the Watchhouse kitchen area; and at least three monthly training on spills management for Watchhouse sergeants. Several of these recommendations, including the proposed spills management training for staff, have not been implemented. The review team drew the OH & S report to the attention of Watchhouse management and we understand action will be taken on the outstanding recommendations.

Review team opinion

3.49 Arrangements for managing emergencies in the Watchhouse are unsatisfactory and require priority attention. The lack of understanding among staff about how to cope with an evacuation or other emergency compromises their capacity to meet the duty of care owed to detainees. To their credit, a number of the staff interviewed had already identified deficiencies in this area and raised their concerns with the review team. Some said they had also raised deficiencies with Watchhouse management without success.

3.50 Emergency evacuation procedures must be clarified and staff training to support those procedures provided immediately. The review team's concerns have been brought to the attention of Watchhouse and senior AFP management. We understand that action to remedy the deficiencies identified is underway. However, in our opinion, the safety and security of detainees and Watchhouse staff would best be addressed by an immediate and comprehensive review of all Watchhouse emergency procedures and training.

The CCTV surveillance system

System overview

3.51 A manually operated video surveillance and recording system was installed in the Watchhouse when City Police Station was refurbished in1995. The purpose of surveillance was to provide a record of Watchhouse operations and to assist in determining what had actually occurred if a detainee were to complain about treatment during custody.

3.52 The Ombudsman first expressed concern about the coverage and reliability of the manual system in 1998. In June 2006, the AFP engaged TAC Pacific Canberra Australia to install a fully digital Closed Circuit Television (CCTV) and an automatic archiving system in the Watchhouse. The contract included the upgrading of the existing analogue system, servicing of 31 cameras, replacement of 21 cameras and installation of an additional 2 cameras.

3.53 Rollout of the new system, which has 54 cameras, commenced operation in July 2006. It provides coverage of all cells and corridors, the sally port and the charge counter, and includes:

- 3 Digital Video Recorders (DVR) with monitors
- One 76cm monitor, three 48cm monitors, and two 34 cm monitors
- A mass storage unit with a single slot tape drive
- Two infrared day/night cameras in the padded cells.

3.54 All the cameras record on a time lapse/motion-based recording schedule.

Cameras are motion-activated and record 10 seconds of video before and after the sensor detects motion. The review team identified a problem with the operation of the motion sensor. Cameras in cells operate only where there is movement above a certain threshold. The review team queried whether subtle movements by a detainee, such as a slow rolling over on a mattress, would trigger the movement sensor and start the recording. This was asked in the context of an intoxicated detainee rolling onto his/her back and vomiting.

3.55 We were advised that such slight movements would not trigger the movement sensors. This limitation, coupled with an intermittent failure of video motion detection software to detect motion in cells, led to the system being reprogrammed during the course of the review. All cameras now record at one image per second at all times unless the motion detecting software identifies movement. The system will then record that camera at the normal speed of 12.5 images per second.

3.56 The charge counter has the most comprehensive coverage of any area within the Watchhouse. There are three cameras, including a fisheye lens camera positioned directly over the counter and a microphone to record audio. When a detainee is being charged, the Watchhouse sergeant activates the audio button and audio is recorded along with the video. When audio is activated the recording speed of all cameras advances to 12.5 images per second, providing real time video and audio recording of activity at the charge counter from three different angles.

3.57 The microphone over the charge counter records the Watchhouse sergeant clearly. However, the words of detainees and constables standing on the other side of the counter are often difficult to decipher on many of the videos examined by the review team. The review team found it was impossible on some videos to understand what the detainee had said. Repositioning of the microphone or installation of a second microphone may remedy this problem.

3.58 Live video of any camera in the Watchhouse can be viewed on one of monitors in the Watchhouse workroom. The screens of the 76 cm and 48 cm monitors can display one image (full screen) or be split to display 4, 9 or 16 images. The two 34 cm monitors permanently display the inside of the two padded cells.

Video archive, backup, storage and retrieval

3.59 Each DVR is capable of storing about 30 days of video. The DVRs constantly record video at a rate that results in the DVR hard drive storage operating at near capacity at all times. Without an archival system, new video material would soon overwrite older video material. To avoid the video being overwritten, it is automatically archived to a backup tape that holds 400GB of data.

3.60 Video is recorded on the DVR and then archived to digital video tapes. Inadequacies in the arrangements for storage of tapes holding archived data quickly came to the attention of the review team. At the time the review commenced, tapes were dated and placed in an open cardboard box on the floor in the Watchhouse workroom. Watchhouse staff, other police members, Correctives Services Court Transfer Unit staff and cleaners had ready access this box. The issue was raised with Watchhouse management and it took about two weeks to arrange alternative secure storage.

3.61 The Watchhouse has now adopted the following practice that will ensure the integrity of the recordings:

- DVR tapes are labelled, and recorded as exhibits and managed in accordance with the AFP National Guideline on Exhibit Handling
- Tapes are secured in a locked cabinet in the Watchhouse to which only the Watchhouse Manager and the OIC of City Station have keys
- Tapes are transferred monthly to the ACT Policing Property Office for subsequent storage in a suitable tape storage facility at Archives
- A tape required for investigation purposes may only be signed out by an AFP member as an exhibit
- Tapes will be held for 10 years, consistent with the *Archives Act 1983* (Cth).

3.62 Video can be retrieved from the CCTV system in two ways. The first and simpler way is to retrieve video still stored on the DVRs. The second and more difficult method involves retrieving video that is stored on the backup tapes. These backup tapes must be reinserted into the recording system and the data copied back onto the hard drive and then onto DVDs, which is a complicated process.

Review team opinion

3.63 The review team expected that the CCTV system would provide a comprehensive, accessible record of day to day activity in all parts of the Watchhouse. Such surveillance would have the potential to provide significant protection for detainees and staff. The review team acknowledges that the system was installed less than 12 months ago and understands it is still receiving adjustments. However, easy and reliable access to video records is critical, and the review team's experience suggests the system currently falls well short in this area.

3.64 The review team experienced long delays in obtaining DVDs of video files, particularly when data had to be recovered from archived tapes. On one occasion, the review team waited for more than three weeks for a ten-hour period of video. When the file was finally available, a problem with the system had apparently prevented the download of audio at the Watchhouse counter to the archive tapes. This failure affected all tapes downloaded between November 2006 and April 2007. In addition, the records that were provided proved difficult to view since only basic navigational controls are available. The system is not user friendly and appears to have limited capabilities.

3.65 Most staff admitted they had little, if any, understanding of how the system worked. For example, one Watchhouse constable thought that all cameras in all cells recorded all the time. Another constable thought that they were all motion activated. Only two Watchhouse sergeants knew how to copy data to a DVD. This lack of knowledge is not surprising since the ACT Practical Guide: Persons in Custody has not been updated to reflect installation of the new CCTV system.

3.66 Staff also appeared unsure about the purpose of the CCTV system or the importance of maintaining the integrity of the CCTV records. They recognised that the system could provide protection for them against vexatious allegations of inappropriate staff behaviour in the Watchhouse. Most did not, however, recognise that secure handling and storage of records was essential to protecting the evidentiary chain should they be required in an investigation. For example, Watchhouse management did not act quickly in providing secure storage for records once that deficiency was identified by the review team.

3.67 Staff were also unclear about how CCTV should be used in monitoring

detainees in cells. Review team observations suggest that many staff use the CCTV to check on detainees, rather than making a physical visit to a cell, especially during busy periods. This issue is considered further in Part 4.

Recommendations

3.68 The review team recommends

Recommendation 2

Action should be taken to improve physical conditions and safety of staff and detainees in the Watchhouse in the following areas:

- Examination of all cells to ensure there are no hanging points.
- Daily checking of cell facilities, including mattress, bubbler, toilet and intercom to ensure they are in good order.
- Searching and cleaning of each cell, including holding cells, after each use to ensure that nothing inappropriate has been left behind by the previous occupant.
- Reviewing the effectiveness of the tinted glass partition between the Watchhouse charge counter and the holding cells to improve direct surveillance of these cells from the charge counter area. Watchhouse staff must have clear visibility of detainees in the holding cells at all times.
- Opening or removal of the Venetian blind between the Watchhouse workroom and the 'at risk' cells to improve direct surveillance of these cells from the workroom.
- Regular monitoring of temperatures and lux levels in different areas of the Watchhouse to ensure they are appropriate. Adjustment may be required to the lighting in the Watchhouse workroom to ensure OH & S standards are being met.
- Regular examination of all Watchhouse blankets to ensure they are serviceable; and provision of tear-proof blankets for use with detainees threatening self-harm.

Recommendation 3

Arrangements for handling detainee property should be revised to ensure that adequate, secure storage, accessible only by authorised staff, is available within the Watchhouse for all detainee property. Procedures should:

- Require the detainee to countersign a list of all property removed in the Watchhouse before it is placed in storage, as well as when the property is returned on release or transfer to another custodial facility. If the detainee is unable or unwilling to sign, the property list should be endorsed by the Watchhouse sergeant and a Watchhouse constable.
- Be developed to ensure that arrangements for dealing with property that may

have cultural or religious significance for detainees are appropriate.

Recommendation 4

Procedures for dealing with emergencies in the Watchhouse should be revised and clear instruction provided for all staff as soon as possible. The revision should include the following:

- Consultation with the ACT Emergency Services Agency and advanced first aid training providers to ensure current emergency evacuation and other emergency procedures are complete, accurate, and exercised regularly, and that training provided for staff is adequate. This should include assessment of best practice for cleanup of biological contamination.

- Development of appropriate administrative arrangements to monitor the implementation and ongoing maintenance of emergency management procedures, equipment and training. This should include an inventory of equipment required to meet all emergency circumstances.

Recommendation 5

The performance of the new CCTV system should be reviewed against contractual and operational specifications for the system, and shortfalls identified and remedied as soon as possible. Areas that must be addressed include the following:

- Safeguards to alert staff as soon as any aspect of the system fails so that immediate action can be taken to remedy the problem.

- Development of a simpler, faster retrieval process for data directly from the hard drive as well as from backup tapes.

- Development of a more user-friendly means of navigating through stored data during playback of files.

- Provision of adequate training for Watchhouse staff on the use of the CCTV system, including data retrieval.

PART 4—MANAGEMENT AND CONTROL OF PERSONS IN CUSTODY

4.1 This part examines duty of care as it is practised by Watchhouse staff in the management and control of persons in custody. It considers the adequacy of arrangements for assessment and monitoring detainees while in custody; managing detainee health and well-being; and use of force in the Watchhouse.

Detainee reception, assessment and monitoring

4.2 A detainee arriving at the Watchhouse may have no idea what to expect. The Watchhouse sergeants advised that they explain to detainees why they have been taken into custody, but many detainees have been in the Watchhouse before and know the procedures. Detainees who are new to the Watchhouse are usually given information only when they ask for it, or call staff through the intercom to ask when they can expect a meal, for example. A short list providing information about detainee rights and obligations, including advice about meal times, phone calls etc could reassure detainees and save staff time. It could be attached to the outside of the glass wall of all but the padded cells. Detainees occupying padded cells would need to be given the advice orally.

Use of holding cells in the Watchhouse

4.3 A detainee on entering the Watchhouse is taken immediately to the charge counter; interviewed and assessed by the Watchhouse sergeant; searched and any property removed; and then placed in a holding cell. The detainee is brought to the charge counter again at the time of charging. This means that every detainee brought into the Watchhouse needs to be processed twice at the charge counter. Processing can take up to half an hour. During busy periods, the current arrangement leads to delays in detainees entering the Watchhouse. This means arresting police may be off the road, and detainees held in the back of police vehicles, for unnecessarily long periods. The risk to detainees who are highly intoxicated, or who may have been exposed to OC spray and remain un-decontaminated, is unacceptable.

4.4 The Watchhouse holding cells were originally designed to be used differently. The intention was that they be used to accommodate detainees on first entry and up to the point of charging. A detainee would be taken by the Watchhouse constables from the sally port directly to one of the holding cells and given a pat down search. The detainee's property would be removed and placed in a container outside the cell. The detainee would remain in the holding cell until brought before the Watchhouse sergeant at the time of charging. The review team was advised that holding cells in the Watchhouse were used this way until about 12 months ago. The reason for the change is unclear, but some staff suggested it stemmed from complaints by detainees about police handling of their property.

4.5 The location of the holding cells—directly opposite the charge counter—was intended to facilitate constant observation by staff at the counter or in the Watchhouse workroom. A similar arrangement for holding newly arrived detainees is in place in many jurisdictions, including the Brisbane Watchhouse and the Queanbeyan Police Station. It enables detainees to be brought into custody quickly and placed under close scrutiny until they are charged. It ensures detainees can be decontaminated as soon as possible if required. It avoids unnecessary queuing by arresting police, allowing them to return to patrol faster. Any detainee obviously at

risk, injured or otherwise in need of medical treatment would be identified by the constables and assessed by the Watchhouse sergeant immediately.

4.6 Watchhouse management may wish to review current arrangements for processing detainees on entry to the Watchhouse to see if they are providing the best outcome for detainees, Watchhouse staff and patrol police. The review team notes that, whatever arrangement is ultimately included in standard operating procedures, the poor visibility of holding cells from the charge counter/Watchhouse workroom must be addressed.

Assessment on arrival

4.7 Early and accurate assessment of detainees is essential to ensure appropriate care. All detainees, on entering the Watchhouse, are assessed by the Watchhouse sergeant to determine whether they require special care or protection during custody. The assessment has two parts:

- A visual assessment. This is based on the appearance and demeanour of the detainee—whether the detainee has been injured, appears intoxicated, is angry or violent. At this point the arresting officers will usually give the Watchhouse sergeant any information relevant to the detainee's behaviour or appearance, for example, involvement in a fight prior to arrest.

- An entry questionnaire. The questionnaire is administered by the Watchhouse sergeant and covers the detainee's medical status and any risk factors of which Watchhouse staff should be aware. Responses by detainees are recorded on the Watchhouse cell management system (PROMIS—discussed below) and attached to the detainee's file. A copy of the questionnaire is at Appendix 6.

4.8 It is on the basis of this initial assessment that a detainee is allocated to a particular cell and a specific monitoring regime. The questionnaire is similar to that used in other jurisdictions. Questionnaires of this kind are widely regarded as standard tools in assessing the 'at risk' status of detainees. The author of the Watchhouse assessment questionnaire indicated that it was designed to be a preliminary guide to a detainee's status only. Responses were not intended to lead to a definitive assessment of a detainee. In practice, some detainees give incorrect answers to questions and others refuse to answer at all. Reassessment of every detainee was expected to continue throughout custody.

4.9 However, review team discussions with Watchhouse staff indicated that the questionnaire is not routinely backed up by ongoing assessment of detainees. This view was confirmed in review team discussions with Corrective Services Transport Unit staff. They noted that sometimes they received on transfer from the Watchhouse detainees incorrectly designated as being 'at risk'. The incorrect designation appeared to have occurred because the detainees had been assessed as 'at risk' on arrival in the Watchhouse and, despite significant change in their behaviour during detention, had not been reassessed. As a result, Corrective Services staff in the court cells were treating detainees as 'at risk' when that was no longer the case. Corrective Service staff time was wasted that might have been used to better effect in managing other detainees who were genuinely 'at risk'. Similar wasting of staff time may also be occurring in the Watchhouse.

4.10 The Watchhouse assessment questionnaire also appears to have become something of a 'tick and flick' procedure, seen by some staff as absolving them of

responsibility to act further on the health or risk status of a detainee. For example, if the response to the question ‘have you been injured recently?’ is ‘yes’, further exploratory questions should be asked and appropriate action taken by the Watchhouse sergeant. Records of assessments examined by the review team suggest this is not always occurring.

4.11 Many of the complaints received about the Watchhouse relate to alleged failure of staff to recognise that a detainee was injured or in need of medical assistance, and to take the appropriate action. The contractors providing medical services to the Watchhouse, and the Manager of AFP Medical Services suggested that the detainee assessment questionnaire could be enhanced by including advice for further staff action, based on the responses provided by a detainee. They have offered assistance in developing an action list.

4.12 Care needs to be taken to ensure any assessment procedures do not require an unreasonable level of medical training or experience for effective use by Watchhouse staff. ACT Policing members are not medically trained and should not be expected to make detailed medical assessments. If there is any cause for doubt, expert medical advice should be sought.

Cell Management data base

4.13 Two interlinked Police Realtime Online Management Information System (PROMIS) data bases are used to record aspects of a detainee’s custody in the Watchhouse: the Apprehensions database and the Cell Management database. Both data bases are elements of PROMIS. This is a Windows based computer application designed to record and manage all AFP operations and operational support activity.

4.14 The Apprehension data base is used by police to record details of persons arrested, charged, summonsed or cautioned. Details of detainees entered into the Apprehensions database are used by the Watchhouse in the charging process. Once lodged, detainee details are automatically transferred to the Cell Management database which is used to record and monitor detainee care while in custody. Only staff who work in the Watchhouse are given access to the Cell Management data base.

4.15 When a detainee is brought in to the Watchhouse, the arresting officer must enter information about the detainee into the Apprehensions database before a record is created in the Cell Management database and charging by the Watchhouse sergeant can proceed. This information includes personal details, such as full name, date of birth, address and whether the detainee is Indigenous. The arresting officer must also record a visual assessment of the detainee on a check list that requires a yes or no answer. If a yes answer is recorded then the database prompts the arresting officer to record additional details. A copy of the visual assessment checklist used by arresting officers is at Appendix 7.

4.16 Information provided by the arresting officers is drawn on by the Watchhouse sergeant in making his or her initial assessment of the detainee, as outlined above, prior to the detainee being placed in a cell. All subsequent information about the management and care of the detainee while in the Watchhouse is recorded in the Cell Management database under one of five fields. These are ‘details’, ‘check’, ‘transfer’, ‘visit’ and ‘note’. A check on the detainee in the cell or on the CCTV monitor will be recorded under ‘check’, and space is available for comment on, for example, what the detainee was doing at the time of the check. Other comments can

be added in ‘notes’ relating, for example, to telephone calls made, or the result of an examination by a medical practitioner.

4.17 The Cell Management database also records details of the detainee’s property, including cash, when entering the Watchhouse; photographs and fingerprints taken and information relating to bail. Entries made in the Cell Management and Apprehensions data bases automatically populate a Prisoner History record. If the detainee is transferred into the custody of ACT Corrective Services, this record may be printed and passed to Corrective Services. This helps to ensure continuity of detainee care and was a recommendation of the RCIADIC.

4.18 The Cell Management database is a key element in effective detainee management. It should provide a complete record of the handling of a detainee from arrest until transferred to another authority or released from custody. It could be consulted by Watchhouse staff at any stage during a detainee’s custody to inform the management of a detainee. Information entered must be accurate and comprehensive to ensure adequate care is provided to detainees and the integrity of detainee custody records is maintained.

4.19 Watchhouse staff reported that they received no formal training in data base use. Some told the review team they had arrived for a shift in the Watchhouse with no knowledge of the database and without access to the system. Others said they ‘just had to pick it up as they went along’. Watchhouse sergeants seemed to be responsible for making sure their constables knew how to use the system. However, some Watchhouse sergeants reported that they, too, had insufficient training in the use of the database and had to learn on the job.

4.20 The draft Watchhouse Manual provides some guidance on use of the system. But it is clear that most staff were simply expected to learn on the job. This has led to inconsistencies in recording of even basic information, such as cell checks, which is discussed further below. Watchhouse staff advised the review team that they were aware of limitations in the Cell Management data base and had raised them with ACT PROMIS management. Although many of the issues had been remedied, Watchhouse staff told the review team that, because of the large number of requests for changes and enhancements to PROMIS, they did not anticipate early action on requests relating to the Cell Management data base. The review team was unable to identify any mechanism for regular review of the effectiveness of the Cell Management data base.

Cell checks

4.21 A key element in ensuring the safety of detainees is regular checking to ensure that they are comfortable and in good health. Cell checks are required for all detainees while they are in custody. According to both the ACT Policing Practical Guide: Persons in Custody and the draft Watchhouse Manual, timing of cell checks should be determined by assessment of the ‘at risk’ status of the detainee. Unfortunately, the Practical Guide and draft Manual do not agree on appropriate timing for checks, nor the manner in which checks should be conducted. Neither provides guidance on when and how a reassessment of risk should be undertaken, and what impact a reassessment might have on checking regimes.

4.22 For example, the Practical Guide specifies that ‘at risk’ detainees, including in padded cells, should be checked every 15 minutes for the first two hours and no greater than hourly after that. Detainees not deemed to be ‘at risk’ should be checked

every 30 minutes during the first two hours and no greater than hourly after that. This regime acknowledges that even for those not at risk, the first two hours in detention are usually the most difficult for a detainee. The Practical Guide also notes that electronic surveillance should not be a substitute for human interaction and that, where possible, checks should be done in person. ‘Close surveillance’ is recommended for any detainee about whom staff have concerns, but there is no explanation of what this surveillance entails.

4.23 By comparison, the draft Manual indicates that detainees ‘are to be monitored on the CCTV system and regular visual checks recorded’ in the cell management system. As a guide, detainees should be checked every 30 minutes unless they are ‘at risk’ in which case it should be at least every 10 to 15 minutes. ‘If in doubt about a (detainee’s) welfare, a manual check of the cell may be required.’ The Manual advises that ‘manual’ checks should be done by staff in pairs when visiting female or juvenile detainees, or entering any cell to check on a detainee.

4.24 Review team discussions with Watchhouse staff suggest that monitoring of detainees in cells is inconsistent at best. This is not surprising given the conflicting guidance provided. In addition, different Watchhouse sergeants have their own views on what is appropriate, and acknowledge that they do not necessarily follow either the Practical Guide or the Manual. Different practices on different shifts are common. Some sergeants apply more stringent checking regimes than recommended. For example, one former Watchhouse sergeant said he routinely placed under constant watch any detainee who was known to self harm, seating a constable outside the cell until medical advice could be obtained.

4.25 Procedures require that all cell checks be recorded in the cell management system. However, review team examination of cell management records revealed that often staff have not undertaken (or have not recorded) the required checks on detainees. For example, records relating to a randomly selected detainee assessed as ‘at risk’ show that, between 16.00 hours and 21.30 hours, the shortest interval between checks was 19 minutes, and four checks were undertaken at intervals of 45 minutes or greater. This is inconsistent with requirements in both the Practical Guide and the draft Manual.

4.26 Cell management records also suggest that many checks are being done via CCTV monitors only. For example, staff reported that if a detainee appeared on the monitor to be sleeping, the cell intercom would be activated to check whether sounds of breathing or snoring could be heard. If so, the record would indicate the detainee has been checked. This is not appropriate when dealing with detainees who may be ‘at risk’. Medical advisers to the Watchhouse have confirmed that snoring can be an indication of health concerns, especially with intoxicated detainees. Heavily snoring detainees should always be closely monitored and woken during cell checks.

4.27 Even more disturbing, it appears that the time when a check has been conducted is not always accurately recorded. The cell management system enables a check conducted at, say, 22.00 to be recorded as though it had actually been conducted at 21.00. There may be legitimate reasons for a cell check undertaken at 21.00 not being recorded until 22.00 – for example, staff required on other urgent duties. However, incorrect recording of this time could undermine the integrity of the entire record of a detainee’s period in custody. This concern has been drawn to the attention of Watchhouse management. We understand it is being rectified and procedures developed to ensure the time of cell checks is accurately recorded.

4.28 A further concern is the lack of information about a detainee that is recorded

when a check has been undertaken. There appears to be no guidance available on this, but commonsense would suggest there is little value in a record that simply says ‘checked’. The purpose of the record is to support the provision of appropriate care, and brief details about the demeanour or behaviour of the detainee would seem appropriate.

Shift handover

4.29 Watchhouse staff shifts are 8 hours, so in the course of any 24 hours, three different teams will be responsible for the care of a detainee. The transfer between these teams of accurate and complete information about a detainee’s status and needs is central to provision of appropriate care. A shift handover receives limited mention in the ACT Policing Practical Guide: Persons in Custody and less than three lines in the draft Watchhouse Manual. The conduct of handovers is left almost entirely to the discretion of the Watchhouse sergeants and approaches vary.

4.30 Most sergeants indicated that they ran through the detainees on the whiteboard in the Watchhouse workroom, identifying any that needed particular attention or were due for release. Otherwise it was up to the incoming sergeant and constables to check each detainee’s cell management record. There is no checklist used and no formal records of handover are kept. As indicated above in the section on physical maintenance of cells, incoming shifts do not undertake regular inspections of unoccupied cells to ensure they are secure and in good order.

4.31 Incoming sergeants generally were not keen on the idea of physically inspecting the Watchhouse with an outgoing sergeant, as a practical check on the status of detainees and the Watchhouse facilities. The reason given was concern that a non-compliant detainee might transfer any antipathy felt towards the outgoing sergeant to the incoming sergeant. However, sergeants reported that they did not routinely undertake a physical inspection of the Watchhouse even after shift change. Incoming constables are expected to obtain a short briefing from outgoing constables on the ‘demeanour, issues and requirements’ of each detainee. However, this is not structured and discussions with staff suggest it is also by no means routine.

4.32 There appears to be no mechanism in place to ensure that critical information about detainees is passed between shifts. A serious example of inadequate handover is the alleged failure of an outgoing sergeant to advise the incoming sergeant that a detainee had recently been sprayed in a Watchhouse cell with Oleoresin Capsicum. Under the circumstances, a detainee could remain without decontamination for some time.

4.33 The lack of formal, structured handover arrangements contrasts sharply with procedures in some of the other jurisdictions examined by the review team. Handover is usually given a high priority. For example, the Queensland Police Operational Police Manual sets out policies, procedures and orders that must be followed during a shift handover. This includes, for example, that the Watchhouse Manager finishing duty and the Watchhouse Manager commencing duty are to physically inspect persons in custody and the cells at change of shift.

Review team opinion

4.34 The structures in place for assessment and monitoring of detainees in custody appear basically sound, however some improvement is necessary. These include an initial assessment questionnaire and a comprehensive cell management system and CCTV monitoring. However, the design of the Watchhouse precludes

extensive ongoing and direct observation of detainees by staff. This means these structures must be backed by comprehensive and rigorous procedures that are consistently practised to ensure effective delivery of care. Unfortunately, current guidelines are neither comprehensive nor rigorous. Detainee monitoring practices particularly are inconsistent and do not meet best practice standards.

4.35 Staff practical understanding of how to deliver on their duty of care to detainees was vague. The discussion of this issue in the ACT Policing Practical Guide: Persons in Custody focused on identifying 'at risk' detainees and how they should be handled. The draft Watchhouse Manual does not clarify detainee well-being issues relevant to duty of care. These have been articulated clearly in the report of the RCIADIC and there would be benefit in drawing on this document to clarify duty of care in the Watchhouse. The review team acknowledges that the Manual is in draft.

4.36 Most of the Watchhouse staff interviewed in the course of the review were keenly interested in how they might better deliver appropriate care to detainees. Many felt frustrated by a lack of procedural guidance and formal training or experience. As a consequence they relied heavily on their sergeants who were often new to the Watchhouse themselves. The selection and training of staff and their impact on effective delivery of care to detainees is discussed further in Part 5 of this report.

4.37 The procedures supporting the assessment and monitoring of detainees should be reviewed to ensure that they:

- Provide adequate advice to Watchhouse staff on all aspects of detainee assessment and care
- Reflect best practice standards in relation to such matters as checking on 'at risk' detainees
- Are consistent with other AFP guidelines and procedures
- Ensure the integrity of custody records can be maintained at all times
- Take account of the level of staffing available in the Watchhouse and do not impose unachievable benchmarks
- Do not place unreasonable expectations on staff in terms of their capacity to accurately assess the status of detainees, especially their medical needs
- Are routinely updated to ensure they comply with changes in legislation or community expectations.

4.38 All staff assigned to the Watchhouse must also be given appropriate training in their duty of care in a custodial environment and an opportunity to acquire any practical skills required. This issue is considered further in Part 6 of the report.

Detainee health and well-being

Detainee health

Medical services

4.39 Until late last year medical services to the Watchhouse were provided by local medical practitioners retained by the AFP. Since October 2006 medical services to persons in police custody have been provided by the Clinical Forensic ACT Service (CFACT) under contract to the AFP. Under the CFACT contract, a senior medical practitioner is on call to provide advice or attend the Watchhouse 24 hours a day. These practitioners have extensive experience in custodial medical services across a range of jurisdictions. A medical examination room is available within the Watchhouse for CFACT use.

4.40 The decision to call a medical practitioner rests with the Watchhouse sergeant. Watchhouse procedures require this to be done whenever there is some doubt about the health status of a detainee. Circumstances in which it would be reasonable to seek medical advice might be: a detainee presenting with symptoms of impaired consciousness; a detainee with a pre-existing injury or an injury incurred in the Watchhouse; the need to dispense prescription medication; or uncertainty about whether a detainee's psychotic symptoms are due to mental illness or to drugs.

4.41 The AFP also has a Memorandum of Understanding with the Mental Health Crisis Assessment and Treatment Team (CATT) for the provision of assistance in the Watchhouse. The Watchhouse sergeant is responsible for deciding when to seek advice or attendance. Costs associated with medical assistance provided to detainees are met by ACT Policing. A detainee also has the right to seek medical attention from his or her own doctor: if this occurs, any costs are borne by the detainee.

4.42 Despite the availability of these services, a failure of Watchhouse staff to provide medical assistance when required has been one of the most common causes of detainee complaint. Many complaints relate to the alleged failure of staff to recognise that a detainee has an injury or is showing symptoms suggesting that medical assistance should be sought. The review team's examination of CCTV records of Watchhouse operations revealed several instances where the Watchhouse sergeant did not respond appropriately to evidence of detainee injury.

4.43 In one case, the detainee entered the Watchhouse with a cut hand that he said required stitching. Medical assistance was not obtained, apparently on the ground that the injury had occurred 24 hours before detention and the detainee had not sought assistance for himself in that time. In another case, a detainee complained on entry to the Watchhouse about being hit in the mouth by the arresting officers. Again, no action was taken to check if the detainee had been injured, or in relation to the complaint. Complaints have also been made about the alleged unwillingness of staff to act on a specific request for medical treatment from a detainee. Complaints about the Watchhouse are considered further in Part 7.

4.44 Some staff acknowledged that they do not always call a medical practitioner at a detainee's request. This is consistent with advice provided in the draft Watchhouse Manual, reflecting the view that some detainees are likely to "try it on". These staff believe that a medical practitioner is only needed if the detainee has an obvious injury or illness. CFACTS, in its submission to the review, confirmed that

there have been instances where Watchhouse staff decided against accessing medical services and this has not been in the interests of the detainee. Other Watchhouse staff believe that they lack the skills and experience necessary to accurately assess the need for medical assistance. In these circumstances, they prefer to take a cautious approach and seek medical advice.

Prescription and other medication

4.45 Medication may be prescribed for detainees if they require medical assistance while they are in the Watchhouse. Some detainees may also bring prescribed medication with them to the Watchhouse. Any required medication is held with the detainee's property and dispensed by the Watchhouse sergeant according to the prescription. There is no separate or secure storage for detainee medicines.

4.46 Watchhouse sergeants are not trained in the dispensing of medicines and generally follow the directions on the box or bottle. Medications brought in by a detainee are dispensed according to any directions on the packaging. Detainees are almost always brought to the charge counter when medicines are to be dispensed so that the action taken can be audio and video recorded. This seems to be done primarily for the protection of Watchhouse staff rather than to ensure proper administration of medicines. Detainees who require methadone are taken from the Watchhouse to a dispensing pharmacist. However, this can only be done when patrol staff are available for escort duty. Nicotine patches are not available and smoking is prohibited in the Watchhouse.

4.47 Despite a procedural requirement to seek medical advice before dispensing prescribed medication, Watchhouse sergeants reported that this did not always occur. Watchhouse staff are most unlikely to have the knowledge required to assess whether the medication being dispensed is in fact what the detainee claims it to be, or whether the dosage is appropriate taking account of the detainee's current condition. For example, the detainee may have ingested alcohol or drugs before being arrested that could, combined with medication, have dangerous side effects.

4.48 Over-the-counter remedies, such as Panadol, are generally not available to detainees without authorisation from a medical practitioner. For example, no medication is provided for a headache unless a doctor is called, and staff report this would not be done unless the headache lasted more than 24 hours. The exception to this rule appears to be the dispensing of Ventolin for treatment of asthma. A Ventolin inhaler is kept at the charge counter and is offered to any detainee with asthma symptoms. However, the review team's observations suggest that the same Ventolin applicator is used by all detainees and is rarely cleaned after use.

4.49 Many Watchhouse staff expressed concern about their lack of knowledge of the medications they were expected to dispense. Alleged failure of staff to provide medication has been a frequent cause of complaints about the Watchhouse. Staff concern may have led to a reluctance to dispense medications about which they were unsure. However, medical advice is rarely sought in these circumstances.

Review team opinion

4.50 The provision of adequate medical care is central to the delivery of a high standard of care in a custodial facility.

4.51 The review found that arrangements in place in the Watchhouse for the provision of medical services are similar to those in similar facilities interstate and

overseas, with medical practitioners on call or, in larger facilities, on the custodial facility staff. The structures in place in the Watchhouse appear appropriate. Generally, staff reported that the new CFACTS arrangements are working well, and response times from medical practitioners are excellent. A greater willingness among Watchhouse staff to seek advice from medical advisers will help to provide a safer environment and enhance outcomes for detainees, as well as give staff greater security in meeting their duty of care obligations.

4.52 Staff were less satisfied with services provided by the CATT. They reported that the response time for CATT staff was variable, and that they found the advice provided was sometimes less than helpful. This was particularly the case in dealing with detainees who presented with psychotic symptoms, the cause of which was unknown, or with detainees who were intoxicated and threatening self-harm. These concerns were raised with mental health authorities in the course of the review and discussions are underway aimed at improving Watchhouse access to the CATT.

4.53 The informal approach to dispensing medication in the Watchhouse compares poorly with the tight administration of medications in place in other jurisdictions. For example, in the Melbourne Custody Centre, medications are kept in a secure location and can only be dispensed by a fulltime registered nurse. This ensures that informed medical assessments can be made about whether and when it is appropriate to dispense medication to each detainee.

4.54 In the case of remedies such as Ventolin, most jurisdictions use a fresh applicator each time it is dispensed to avoid any risk of infection. This procedure protects both detainees and staff. It is also of concern that Watchhouse staff routinely dispense a Ventolin inhaler for symptoms that present as asthma without seeking professional medical advice on any other problems that could lead to a detainee's airways being constricted.

4.55 In our opinion, the current arrangement for dispensing medication in the Watchhouse is unacceptable in terms of the duty of care owed to detainees and the expectations placed on Watchhouse staff. A more formal arrangement is required as a matter of urgency to ensure that medications are managed responsibly. A useful model is that used in the Melbourne Custody Centre. The review team was advised that some years ago AFP Medical Services recommended the appointment of a registered nurse to the Watchhouse. The recommendation was not pursued.

4.56 Appointment of a registered nurse in the Watchhouse would relieve police members of responsibility for medical assessments for which they are not qualified. It could also reduce pressure on other medical and police services. For example, a nurse on staff could provide methadone to detainees as required at the Watchhouse, freeing patrol members for other duties. The nurse could be responsible for other duties such as health education for employees to make the role more viable. However, the Watchhouse is a relatively small custodial facility, and a full time nurse may not be required. It may be sufficient for an ACT health services nurse to attend the Watchhouse three times a day to assess detainees and dispense medication as required. These visits would coincide with times that medication is usually taken—breakfast, lunch and dinner.

4.57 Many of the detainees who pass through the Watchhouse suffer from significant health problems—these include infectious diseases, drug and alcohol addiction, and mental health problems. All police jurisdictions considered reported that the incidence of drug-induced psychotic behaviour among detainees appears to be increasing with the use of methamphetamines, most notably, the drug Ice.

Watchhouse staff are required to manage this often violent or self-harming behaviour in the first instance. This will continue to be a challenge and additional training and support for staff will be required.

Detainee well-being

Exercise and social interaction

4.58 There is no exercise yard available to all detainees, and many have limited opportunity for physical exercise within the Watchhouse. Each of the male, female and intoxicated detainee blocks has access to a common area where detainees can walk about or talk with other detainees. The group holding cells are generally only used to accommodate large numbers of detainees taken into custody at big events, or riots. They are not used to provide exercise.

4.59 Visits from family and friends are usually limited to detainees who are in custody overnight or over a weekend. Visitors can bring items for detainees, but it is at the discretion of the Watchhouse sergeant whether the items are passed on to detainees. Other visitors, such as counsellors, are at the sergeant's discretion. However, the review team was unable to locate any guidance for the sergeant in exercising these discretions. Some Watchhouse sergeants advised that they make an exception to these arrangements for juveniles in detention. They allow young people to have visitors for extended periods, as long as the non-contact visitor cells are not required by other detainees.

4.60 Detainees are permitted to contact a relative, friend and/or legal practitioner while in custody. The ACT Policing Practical Guide: Persons in Custody states that the facility to make contact should be provided as soon as possible following a detainee's request to do so. An interpreter service must be provided for any detainee with difficulties in speaking, hearing or understanding English. However, there is no guidance on how many phone calls are permitted, and in practice it is a decision for the Watchhouse sergeant.

4.61 Some sergeants reported to the review team that they allowed as many calls as the detainee wanted, providing the requests were reasonable. Others said that one call ought to be enough and they would not offer a call, the detainee had to ask for it. Phone calls cannot be made in private. All calls are made using the Watchhouse phone located at the charge counter, and in full hearing of any staff in the Watchhouse workroom.

Religious observance

4.62 There appears to be no provision for religious observance of any kind. No chaplain or other religious advisers are available to detainees. Watchhouse records indicate that Friday, Saturday and Sunday, keys days for religious observance in many religions, are usually the days when most detainees are in custody. No guidance is available to assist Muslims who may be in custody to undertake daily prayers.

4.63 The AFP has five chaplains, covering a range of religions and providing pastoral care to police. This includes visiting AFP workplaces, liaising with AFP caring agencies and welfare organisations and sharing in police activities. The chaplaincy provides support to police learning and development programs, develops and delivers education and training programs, and provides advice on cultural and religious knowledge. ACT Policing has its own chaplain and the review team

considers that the AFP and ACT chaplains could assist in developing a framework to educate Watchhouse staff and to better cater for the religious needs of detainees.

Other occupations in the Watchhouse

4.64 Little provision has been made to occupy detainees while in custody in the Watchhouse. One television is provided in the each of the common areas attached to the male, female and intoxicated detainee cell blocks. The group holding cells and the individual holding cells, high risk, and padded cells have no access to television. No radio or reading materials are available to detainees in any part of the Watchhouse. Many detainees have nothing to do but eat or sleep.

4.65 This is in contrast to other custodial facilities considered by the review team. For example, Queanbeyan police cells have a television visible from every cell and a library of reading material for detainee use. Similarly the Brisbane Watchhouse has television and radio access for every detainee, as well as soft cover books and magazines available on request. Both facilities also have a more lenient approach than that adopted in the Watchhouse to the use of spectacles by detainees. For example, most Watchhouse staff reported routinely removing spectacles from detainees because they were seen as a possible instrument of self harm. Other custodial facilities assessed each detainee individually and usually allowed detainees to keep plastic spectacles.

Review team opinion

4.66 Isolation in a cell with little or no stimulation is boring. Commonsense, supported by experience in other custodial facilities, suggests that boredom is likely to lead to inappropriate detainee behaviour, particularly if detainees are emotionally disturbed or in custody for more than 8 hours.

4.67 Watchhouse staff emphasised the poor behaviour of many detainees, but most staff also said they saw no need to provide distractions or occupations for them during their custody. They argued that most detainees were not in custody for more than 24 hours. They saw a serious risk of self harm in giving detainees access to such items as spectacles and books and felt that this risk outweighed the benefits to detainee well-being of providing a more comfortable environment.

4.68 However, the review team's examination of the handling of detainees in other jurisdictions suggested that risk of self-harm can be minimised by assessing and managing detainees on a case by case basis. If detainees have been assessed on arrival in the Watchhouse as not being at risk, then it would appear reasonable to base their management on that assessment, at least initially. Of course, if a detainee's behaviour suggests the assessment should be reviewed, a new risk management approach could be adopted. Custodial staff in Queanbeyan police cells regularly use this case management approach. They noted that giving detainees the opportunity to take their minds off their custody greatly enhanced detainee well-being, resulting in a marked improvement in compliance.

4.69 In our opinion, consideration should be given to providing detainees with improved opportunities for physical and mental activity while in custody. This should include access to radio, television and selected reading material. Watchhouse management should also investigate options for providing detainees with appropriate religious support while in custody.

Personal hygiene and privacy

Search arrangements

4.70 The pat down search given to all detainees when they arrive at the Watchhouse is conducted at the charge counter. If a detainee is required to remove outer clothing, for example, to enable police to retain it as an exhibit, this will generally take place at the charge counter and in view of any staff present. No special arrangement is made for female detainees needing to remove outer clothing. Detainees whose clothing is required for evidentiary purposes, or who have had soiled outer clothing removed, will be offered white paper overalls. Overalls are provided and usually put on by the detainee at the charge counter.

4.71 Strip searches are rarely done and require a superintendent's approval. Approval will only be given if police have reasonable grounds for suspecting the detainee may be carrying evidentiary material or a seizable item. Internal cavity searches are not permitted. Anyone suspected of secreting items such as drugs would be transferred to hospital. None of the staff on duty in the Watchhouse during the review could recall a strip search being undertaken there. Procedures for strip searching do not specify how clothing should be removed to maximise the dignity of the detainee. No specific facility is available for strip searching although staff advised that a shower area or the medical examination room, neither of which has CCTV, would most likely be used.

4.72 A body search of any kind is always conducted by an officer of the same sex as the detainee being searched. If a female officer is not on duty in the Watchhouse when a female detainee requires searching, a female will be called down from City Police station or from a patrol.

Decontamination following exposure to OC

4.73 Following exposure to OC, decontamination of a detainee usually occurs either in the sally port or in a cell. It is sometimes necessary during decontamination for a detainee to remove some clothing. To ensure the dignity of the detainee is protected, Watchhouse staff try to ensure that, where possible, decontamination occurs in a private area of the Watchhouse.

Toileting and showering

4.74 As outlined in Part 2 above, all cells have toilet facilities with the exception of the drug evidence cell. However, only the two group holding cells have toilets with modesty screens to provide a degree of privacy for persons using the toilet. Screens were provided in the group cells because more than one detainee is expected to occupy the cell, and detainees could reasonably expect privacy from others in the cell when toileting. In all other cells, however, the toilets are unscreened. The toilets and detainees using them are in full view of anyone passing the cell. They can also be viewed at all times by staff or cleaners in the Watchhouse workroom through the CCTV monitoring system.

4.75 The six showers for detainees are located separately from the cells. Detainees are escorted to the shower rooms by Watchhouse staff as required and provided with soap and a towel. A Watchhouse staff member stands outside the shower room to monitor a detainee during showering. Male detainees are not permitted a razor in the Watchhouse but are able to shave at the court cells prior to a court appearance. Detainees in some other jurisdictions have access to razors under supervision.

Female sanitation

4.76 Around 15% of persons detained annually in the Watchhouse are female. The report has already commented on arrangements to accommodate females separately from males and to ensure searches of females are undertaken only by female staff. However, little consideration appears to have been given to meeting female sanitation needs.

4.77 Sanitary pads and tampons are available for female detainees in the Watchhouse on request. However, it appears few female detainees wishing to change their sanitary protection are able to do so in private, given that toilets have no modesty screening. Arrangements for disposal of used tampons and sanitary pads are unclear. Tampons should not be flushed down the toilets in the Watchhouse, since they may block the sewerage system, but the review team was advised no sanitary protection disposal unit is available in the female cell block or showers. There are extended periods when only male staff are on duty in the Watchhouse. Staff reported that females would not be called in simply to assist a female detainee with sanitation requirements. Female staff in the Watchhouse are considered further in Part 6 of this report.

Review team opinion

4.78 The level of privacy afforded to detainees in the Watchhouse is below that provided in other custodial facilities considered during the review. For example, the Brisbane Watchhouse had privacy screens for all toilets; the Queanbeyan Police cells did not have toilets in the cells and detainees were escorted to separate facilities as required. It is certainly preferable to have toilets available in each cell, but the lack of privacy, especially when cells are constantly monitored through CCTV, is of concern. The vast majority of staff working in, or passing through, the Watchhouse is male. In our view it is inappropriate for detainees, females particularly, to be on full view when engaged in intimate, personal activity. This view was generally endorsed by those making submissions to the review.

4.79 In reaching this opinion, the review team was mindful of the safety concerns expressed by those responsible for detainee welfare. These concerns include the risk of a detainee self-harming while hidden from view behind a toilet privacy screens or, as occurred in the ACT Supreme Court cells where a detainee was seriously injured after jumping from the top of a privacy screen. One person interviewed by the team noted that ‘privacy is of no use if you are dead’.

4.80 We acknowledge that there is some risk associated with providing privacy screens if detainees are determined to injure themselves. However, the review team was persuaded by the experience of the Brisbane Watchhouse that does use screens. They have advised that, provided a reasonable assessment of the individual detainee’s risk of self harm is made on arrival in custody, and an appropriate watch is kept on those of concern, the risk is minimal. The benefit to other detainees in terms of preservation of dignity and privacy is considerable. Of course, this approach requires a consistently high standard of monitoring of detainees in cells.

4.81 Search arrangements are appropriate with the exception of the dignity and privacy afforded detainees during searching. Detainees, both males and females, required to remove outer clothing should be able to do so in greater privacy than a corner of the wall near the charge counter is able to provide.

4.82 If clothing is required for exhibit, the evidentiary chain could be maintained by providing a separate disrobing room, with CCTV recording viewable only by staff of the same sex. This room could also be used for strip searching. It would maintain the privacy of detainees and the CCTV coverage would ensure staff and detainees are protected in the event of accusations of inappropriate conduct. Procedures for strip searching in the ACT as well as in interstate jurisdictions commonly provide for removal of a detainee's upper clothing and its replacement before removal of lower clothing. This helps protect the dignity of the detainee being searched. Consideration could be given to adopting this approach in the Watchhouse search procedures.

4.83 In our opinion, arrangements for maintaining detainee hygiene and privacy should be examined further. Sanitary provision for female detainees must be addressed as a matter of urgency.

Use of force

4.84 Reasonable use of force underpins the AFP's and ACT Policing's strategies for managing conflict. Reasonable force is the minimum force reasonably necessary in the circumstances of a particular case.

4.85 This section considers use of force in the Watchhouse, including guidance and training provided to staff, and recording and monitoring of when force has been used. Special attention is given to the use of the chemical agent, Oleoresin Capsicum (OC). Alleged misuse of OC has resulted in disciplinary and criminal action being taken against former Watchhouse staff.

Guidelines and training

4.86 AFP Commissioner's Order on the Use of Force (CO 3) sets the framework for use of force in the AFP. It specifies the types of force available to staff trained in their use, the circumstances in which different types of force may be used, and the reporting required when force has been used. It covers use of firearms, batons, handcuffs, chemical agents and electric incapacitants. CO 3 does not include specific reference to the OC foam used in the Watchhouse.

4.87 CO 3 must be read in conjunction with the AFP Safety Principles Model (copy at Appendix 8). The model illustrates use of force as a continuum which requires police to assess and constantly reassess a confrontational situation and what level of force may be required to manage it. The model emphasises the importance of negotiation and conflict de-escalation as alternatives to increasing the level of force required to control a situation.

4.88 The ACT Policing: Practical Guides on Oleoresin Spray and Persons in Custody supplement the information in CO 3. The review team noted that the OC Spray Practical Guide has not been revised since 2003. No satisfactory explanation was given to the review team of the process used to update the Practical Guide. There appears to be no advice sought from users of the spray or any analysis of the frequency or circumstances of its use that might inform a review of the Guide. In any event, the Guide does not differentiate clearly between OC Spray, OC foam and OC fogger, which are used for different purposes. OC foam is the only form of OC available in the Watchhouse but the review team was unable to locate any guidance on its use.

4.89 Training in use of force and de-escalation techniques for ACT Policing is

delivered by the Operational Safety Training Team within AFP's Learning and Development. ACT Policing and Jervis Bay perform the only community policing roles in the AFP and are therefore more likely to find themselves in circumstances that require the use of force than other operational arms. Specific skills are therefore required for these employees, and ACT Policing members do receive additional training through the School of Community Policing. However, none focuses on use of force in the Watchhouse, or the use of OC foam.

4.90 Use of force training is delivered initially as part of recruit training through a series of Operational Safety Assessments (OSAs). All AFP members are required to undertake annual recertification in use of force which takes the form of a three day OSA. The recertification focuses on police demonstrating competence in the use of the particular equipment or type of force. Members who had been through recertification recently commented that little attention was paid to the art of negotiation to minimise use of force. The review team was advised by Learning and Development staff that the general use of force training provided to all AFP staff was adequate for the circumstances staff would experience in the Watchhouse.

4.91 However, many Watchhouse staff told the review team they found use of force in the Watchhouse to be different from use of force in other areas of general policing. They believed specific training for the Watchhouse environment is required. For example, they noted that firearms are not available in the Watchhouse since all police entering the Watchhouse are required to remove and safely store their firearms. They also noted that the confined spaces of the Watchhouse precluded use of some of the techniques available in the use of force model, such as 'hard empty hands'. Getting too close to a detainee could be dangerous. They suggested that within a cell it was sometimes necessary to use more force than might be appropriate on the street because it was difficult for staff threatened by a detainee to withdraw safely. Staff also noted that although OC foam was used in the Watchhouse, very few staff had received training in its use.

Oleoresin Capsicum

4.92 Irritant sprays containing OC have been used by the AFP since 2000. They were introduced following research into use of chemical agents in incident management by the Australasian Centre for Police Research. In 1998, the Centre published National Minimum Guidelines for Incident Management that recommended OC as the most appropriate agent. The active ingredient, in an alcohol carrier, is derived from Jalapeno peppers and causes a strong, burning sensation in mucus membranes that have been exposed to it. Decontamination is with cool water. OC is available in a spray streamer for use on an individual in the open air; in a fogger for use on large groups of people in the open air; and a spray foam for use in confined environments. The foam adheres to the person sprayed, preventing contamination of air conditioning that might expose others to the effects of OC.

4.93 OC foam was introduced into the Watchhouse in February 2002 and two canisters of foam are available permanently at the charge counter. It is also used by several other police jurisdictions in Australia (see Appendix 9). The foam contains 10% OC, twice the active ingredient in the OC spray streamer. The distributor of the foam, Grycol, advised that the higher quantity of active ingredient in the foam is because some of the foam can be wiped away by the person who has been sprayed. The higher quantity of active ingredient in the foam ensures that the remainder of foam on the person still has the desired effect.

4.94 As the foam dries more slowly than the spray and its effects may be delayed,

untrained staff might be encouraged to use the foam more than is necessary. The review team was unable to determine whether the decontamination requirements for foam differ from those for the streamer. The review team was also unable to locate any formal approval for use of OC foam in the Watchhouse, or any standards regulating its safe handling and use.

4.95 The review team sought the views of Watchhouse staff on the circumstances in which they believed it would be appropriate to use OC foam. Most Watchhouse sergeants said they had never found it necessary to use the foam. They believed that most situations were resolvable by negotiation and said that physical force was rarely required. The use of OC has also come under scrutiny in other police jurisdictions. For example, in October 2005 the report of the Queensland Crime and Misconduct Commission considered use of OC spray by Queensland police. The Commission's report concluded that police were increasingly using OC to enforce detainee compliance with police instructions. Such use by the AFP is not consistent with CO3.

4.96 Since the commencement of this review, there has been no use of OC foam in the Watchhouse. Staff have confirmed to the review team that, in light of the Professional Standards investigations into use of force in the Watchhouse, they are reluctant to use OC without clear advice from Watchhouse management on when it would be regarded as appropriate. This has operational implications. For example, in a recent incident where a detainee refused to step out of the police vehicle in the Watchhouse sally port, the Watchhouse sergeant sought the assistance of the AFP's Specialist Response and Security team**.** The review team was advised that this is the kind of situation when OC would normally have been used. Clear guidance on the use of OC would help ensure that the detainee could be removed from the vehicle with minimum risk of injury to the detainee or Watchhouse staff, and without calling in extra assistance.

Use of force reporting

4.97 The safe and appropriate use of force by police in maintaining public order is of significant interest to the community. Ensuring staff have the skills and techniques necessary to manage confrontational situations with minimum force is recognised in the requirement that all AFP members undergo annual use of force recertification. Reporting arrangements have also been developed to assist management in monitoring use of force and maintaining effective training.

4.98 An Operations Safety Committee (OSC) was established in 2000 to oversee use of force in the AFP. The OSC's role includes assessing the operational requirements of, and risks associated with, any proposed additional use of force options; and to recommend any required amendments to CO 3. Until recently, the OSC comprised AFP senior executives and was chaired by the Director, Learning and Development. ACT Policing is represented on this committee by the Deputy Chief Police Officer Response. Acknowledging the need for higher level National representation this committee is now chaired by the National Manager Human Resources.

4.99 Use of force reports were developed to provide information to PRS and the OSC on the frequency, type and reasons for use of force; injuries to police and members of the public resulting from use of force; and the effectiveness of available equipment and techniques. A use of force report must be completed on every occasion that force is used. A report should be completed by the member who used the force, and in cases where several members were involved, one member will be nominated to complete the report.

4.100 Full details of the force used and circumstances in which the force was applied must be covered in a use of force report. In relation to the Watchhouse, this would apply to situations where a member:

- uses a baton against another person
- uses a chemical agent against another person
- uses any compliance or restraint hold, strike, kick or other operational safety application against another person
- uses handcuffs or similar restraint against another person.

4.101 Throughout the AFP, use of force reports are examined by senior officers before being passed to PRS and the OSC. In the case of the Watchhouse, the reports are examined by the Watchhouse Manager, the OIC City Station and the Superintendent, North District. This examination is apparently limited to ensuring that a report includes an adequate description of the nature and circumstances of the use of force. There is no attempt made to check the report content against other sources, such as the CCTV system, or to confirm that a use of force report had been completed when required.

4.102 Recent PRS inquiries into use of force in the Watchhouse have confirmed that some use of force reports were inconsistent with CCTV records, particularly in relation to the circumstances in which force had been used. In other instances, it became apparent that although force had been used, no report had been completed. The review team raised these matters with Watchhouse management and we understand that enhanced checking of reports is now being undertaken.

4.103 Learning and Development School of Operational Safety Training collates all use of force reports from across the AFP and prepares a basic statistical report for the OSC monthly. Analysis of use of force reports appears limited to identifying trends. The minutes of the OSC meeting record that use of force in the Watchhouse was a standing item on the OSC agenda for a number of meetings between 2003 and 2004. During this time, ACT Policing sought an exemption from reporting escort holds on detainees in the Watchhouse, on the ground that many detainees entering the Watchhouse required application of these holds. The Ombudsman agreed in 2004 that a use of force report was unnecessary for routine Watchhouse duties where minor force (ie verbal force and soft hand holds) was used, provided that the CCTV system was fully functional and working correctly. Unfortunately, the review team's observations of the CCTV system suggest that this cannot be guaranteed.

Review team opinion

4.104 Extensive guidance is available on use of force, through formal guidelines and initial and annual training. However, it appears there are significant gaps in both guidance and training in relation to use of force in the Watchhouse. The review team was not persuaded that use of force in the Watchhouse was the same as use of force in the street. Nor was the review team convinced that general use of force training was adequate to deal with the circumstances likely to arise in the confined environment of the Watchhouse.

4.105 In our view, there would be value in providing Watchhouse specific guidance and training on use of force to Watchhouse staff. It was clear to the review team in discussions with Watchhouse staff that lack of training in, for example, the use of OC foam or cell extraction techniques, limited members' capacity to deal effectively with

the work environment. Of particular concern is that ignorance of the delayed effects of OC foam may lead to staff to using the foam more often than necessary, possibly causing unnecessary discomfort or injury to detainees.

4.106 The review team found that although general approval provisions for the use of OC exist in the AFP, nothing specific to the approval for the use of OC foam in the Watchhouse exists. Similarly, no information exists in the Watchhouse of the occupational health and safety requirements for its safe handling. Clarification of the status of OC foam should be obtained as a matter of urgency, and appropriate staff training and instruction provided as soon as possible.

4.107 Use of force reports are useful in providing performance information for analysis and consideration by the AFP executive. However, this does not seem to be occurring. The reports have the potential to provide valuable information about the effectiveness of training and to highlight areas where closer scrutiny of member activities might be appropriate. Combined with complaint information, this can give the executive insight into how the organisation is performing and early warning of potential problem areas. This issue is discussed further in Part 7.

Recommendations

4.108 The review team recommends:

Recommendation 6

Procedures supporting the reception, assessment and monitoring of detainees while in custody should be revised to ensure they are consistent with best practice standards. This revision should include the following areas:

- Preparation of a short list of detainee rights and obligations while in custody, including information about what to expect in the Watchhouse. This could be provided to detainees on arrival or attached to the outside of each cell.

- The Watchhouse assessment questionnaire, to ensure that it is sufficiently comprehensive and rigorous to determine accurately a detainee's health and risk status on arrival. The questionnaire should direct the Watchhouse sergeant to appropriate subsequent action to address any identified problems, including any reassessments required during the period of custody.

- Conduct of cell checks, to ensure that they are undertaken in accordance with the assessed needs of the detainee. Electronic monitoring via the CCTV system should not be a substitute for a physical check on a detainee in the cell.

- Functionality and use of the cell management system, to ensure that the system records are accurate, unalterable, and provide information sufficient to enable a person subsequently accessing the records to understand what has occurred during a detainee's time in custody.

- Development of structured handover arrangements between shifts, to ensure that all relevant and necessary information about the Watchhouse and the care of detainees in custody is provided to incoming staff.

Recommendation 7

Procedures supporting the delivery of health care to detainees should be revised. Particular attention should be given to the following:

- Ensuring all staff are aware of their obligation to obtain medical advice:
    - if requested by a detainee
    - whenever a detainee may have suffered an injury in the Watchhouse
    - whenever a detainee complains of injury, regardless of whether the injury occurred during arrest or in the Watchhouse
    - if the detainee has demonstrated symptoms of an impaired state of consciousness or staff are in any doubt about the detainee's health.

- Development of appropriate arrangements for the dispensing of medication in the Watchhouse. Options could include employment of a nurse or regular daily attendance by a health services nurse. Over the counter medications, including asthma medications, should not be dispensed without medical advice.

- Establishment of regular meetings between the Watchhouse management, medical practitioners and other government health service providers to ensure health services and procedures are meeting detainee needs.

Recommendation 8

Arrangements for the management and control of detainees be revised to focus on detainee well-being and dignity, as well as on detainee security. Any changes need to give adequate attention to management of any risks of self-harm or harm to Watchhouse staff. Areas that should be covered include:

- Clarifying the number and nature of phone calls detainees are entitled to make or receive, and providing an area where detainees can have some privacy during phone conversations.

- Investigating options for religious observance or access to religious advisers for detainees while in custody.

- Improving access to diversions such as television, radio and soft books/magazines for detainees. This would require the case-by-case management of detainees assessed as being at risk of self-harm on arrival in the Watchhouse. Care would need to be taken to ensure that access to such diversions did not expose detainees to unnecessary risk.

- Respecting a detainee's dignity by providing a private area where clothing required for evidentiary purpose may be removed or a strip search undertaken. Searching and disrobing procedures should also protect the dignity of the detainee, this would include providing a private area for detainee decontamination following exposure to OC.

- Providing modesty screens around toilets in all cells, except the two padded cells, to ensure that detainees have some privacy when toileting. A detainee at serious risk of self harm could be placed in a padded cell until medical advice has been obtained.

- Reviewing arrangements for providing female detainees with sanitary pads and tampons; and for disposing of sanitary protection in the female cell block.

Recommendation 9

Procedures, training and reporting requirements relating to use of force should be revised to ensure they are adequate to deal with the circumstances likely to arise in the Watchhouse environment. Particular attention should be given to the following areas:

- Assessment of the requirements of use of force in the Watchhouse and the provision of specific training for Watchhouse staff in the use of force in a confined environment. This should include negotiation training specific to the Watchhouse.

- Approvals for, and guidance on, the safe use of Oleoresin Capsicum (OC) foam in the Watchhouse.

- Appropriate training for all staff in the use of OC foam in the Watchhouse.

- Requirements for reporting on the use of force in the Watchhouse, including whether each member involved in the use of force should submit a report.

- Use of force performance feedback to the executive, governance and training.

PART 5—CARE OF DETAINEES WITH SPECIAL NEEDS OR ASSESSED AS 'AT RISK'

5.1 Procedures for management of persons in custody recognise that a duty of care is owed to all persons who have been deprived of their liberty. That duty of care is heightened when a detainee has been assessed as having special needs or being 'at risk' for any reason.

5.2 The AFP National Guidelines on Police Custodial Facilities and People in Custody, the ACT Practical Guide on Persons in Custody and the draft Watchhouse Manual identify a number of 'at risk' or 'special needs' categories of detainee. The latter two guides specify actions that must be taken by Watchhouse staff caring for these categories of detainees. A range of informal practices has also developed in the Watchhouse for managing 'at risk' detainees or detainees with special needs. Some practices are widespread, others are unique to individual staff members.

Care of persons assessed as 'at risk'

Indigenous detainees

5.3 Around 11.44% of Watchhouse detainees identified themselves as Aboriginal or Torres Strait Islanders (ATSI) in 2005-2006. This percentage has remained relatively constant over the last few years. Since the findings of the RCIADIC, all jurisdictions have been sensitised to the risks associated with custody of Indigenous detainees. The focus has been largely on the safety of facilities and protecting detainees at risk of self-harm, for example by eliminating hanging points. The review team noted earlier in this report that the Watchhouse facilities were designed to take into account the Recommendations of the RCIADIC.

5.4 Requirements for managing ATSI detainees are covered comprehensively in the guides available to Watchhouse staff. The AFP National Guideline on Police Custodial Facilities and Persons in Custody refers staff to the Recommendations of the RCIADIC as the source of appropriate standards of care. However, no information about the RCIADIC appears to be available in the Watchhouse or on the AFP Hub (intranet site).

5.5 The ACT Practical Guide outlines the relevant requirements of the *Crimes Act 1914.* The Act provides, at s 23H, that an Aboriginal Legal Aid organisation and an interview friend must be contacted on behalf of any ATSI person taken into custody. Watchhouse staff are required to notify the Aboriginal Legal Services (ACT and NSW) (ALS) and, if the detainee does not nominate a friend, contact an ACT Aboriginal Interview Friend. A roster of Interview Friends has been established by the Aboriginal Justice Centre (AJC).

5.6 The draft Watchhouse Manual also refers to contacting ALS but makes no mention of the Interview Friend. Review team discussions with representatives of the AJC suggest that, while Watchhouse staff routinely notified ALS of an Indigenous detainee, Interview Friends were not always contacted. The AJC acknowledged that sometimes the rostered Friend may not be contactable but advised the program coordinator was always available. The AJC understood that some Watchhouse staff did not contact a Friend if one of the detainee's parents was available. However, the role of Friends in providing advice and support to Indigenous detainees was

especially important for young detainees whose parents did not feel confident in supporting their children in dealings with the police.

5.7 Watchhouse staff interviewed by the review team were aware of the risks associated with custody of an Indigenous detainee. However, no specific training had been provided and some were not clear about best practice. For example, staff had differing views on whether two Indigenous detainees were better accommodated in the same cell or in separate cells. There appeared to be no regular liaison between Indigenous community representatives and Watchhouse management at which advice on such issues could be sought.

5.8 AJC representatives were keen to establish a closer working relationship with the Watchhouse. They sought a clearer understanding of procedures in the Watchhouse, and particularly how these gave effect to the Recommendations of the RCIADIC. The AJC also had limited access to information about the numbers and circumstances of Indigenous detainees in the Watchhouse. Greater knowledge would help the AJC to assess how well Indigenous assistance services were meeting the needs of Indigenous detainees. The AJC offered assistance to Watchhouse management in the development of training to improve staff awareness of cultural and communication issues useful in dealing with Indigenous detainees.

Juvenile detainees

5.9 Persons under the age of 18 are acknowledged by the community as requiring a higher level of care and protection than adults. Juveniles are generally less careful and at greater risk of harming themselves and others as a result of their shorter life experience. The Watchhouse has not been designed as a juvenile custodial facility although detainees under the age of 18 are often taken there in the first instance, pending charging and transfer to Quamby Youth Detention Centre. In 2005-06, 11.3% of detainees held in the Watchhouse were juveniles.

5.10 The Watchhouse is required to comply with the protections for juveniles taken into custody that are incorporated in legislation such as the *Crimes Act 1914* and the *Children and Young People Act 1999*. For example, the investigation period for juveniles is two hours, compared to four hours for a non-Indigenous adult. Identification material, such as fingerprints, may not be taken from a young person under the age of 16 years at the time of the alleged offence, unless authorised by a magistrate. The AFP National Guideline on Police Custodial Facilities and Persons in Custody states that 'whenever possible, juvenile detainees should be kept in separate custodial facilities' but provides no guidance on how to manage juveniles within an adult facility like the Watchhouse. The Guideline does not recognise juveniles as persons 'at risk'.

5.11 ACT Policing Practical Guide: Persons in Custody is more helpful. It specifies that where a juvenile is detained in a watchhouse, no contact with adult detainees should be allowed. Other requirements in the Guide include:

- The young person's parent or guardian must be notified as soon as possible
- Before the young person is charged, written consent is required from an authorised officer, who is a senior officer not otherwise involved in the investigation of the offence allegedly committed by the young person
- When a young person needs to be detained overnight in the Watchhouse, staff will attempt to arrange for a parent, guardian or friend to stay with the detainee

- A young person should only be interviewed in the presence of a parent, guardian or other responsible adult of the detainee's choosing.

5.12 The draft Watchhouse Manual identifies juveniles as having 'special needs', but then goes on to note that they should be 'treated like any other' detainee with the exception that they are

- To be placed in an 'at risk' cell or group cell
- Transferred to Quamby Detention Centre after charging.

5.13 Watchhouse staff generally acknowledged that juveniles required special consideration, but how that was delivered appeared to vary according to the staff on duty and their level of experience. For example, placement of a juvenile in an 'at risk' cell was routine. However, it did not necessarily lead to the frequency of monitoring checks normally expected following an 'at risk' assessment. The review team was particularly impressed by the approach of one Watchhouse sergeant who took time to explain to a young detainee the reasons for, and nature of, his detention. The sergeant spoke softly and slowly, and regularly checked with the young detainee that he understood what was happening, and why.

Intoxicated detainees

5.14 The *Intoxicated Persons (Care and Protection) Act 1994* decriminalised public intoxication in the ACT. However, it permits police to take intoxicated persons into custody for a limited period without charge. Over a third of persons detained in the Watchhouse annually are taken into custody because they are intoxicated and have been assessed as being unable to protect themselves from harm, at risk of harming themselves, or of harming others or the property of others. An intoxicated person can be taken into custody only if police are satisfied that there is no other reasonable alternative for the person's care and protection. A reasonable alternative to custody includes release into the care of adult friends or family.

5.15 All detainees on arrival at the Watchhouse are asked if they have consumed alcohol or drugs, and if so how much. They are also asked what effect that quantity of drugs or alcohol is likely to have on them, and whether they have any concerns about their level of intoxication. Heavily intoxicated detainees may be unable to answer these questions, or may be aggressive and unwilling to answer. Intoxication can also mask the effects of injuries. Conversely injuries, particularly head injuries, can impair functioning in such a way as to mimic the effects of alcohol. Some detainees, in addition to intoxication with alcohol, may have ingested unknown quantities of unidentified drugs.

5.16 Extensive guidance is available to Watchhouse staff on care for intoxicated persons. The AFP National Guideline on Police Custodial Facilities and Persons in Custody notes that the level of intoxication of a detainee should be taken into account in determining whether the detainee requires medical attention. It also notes that 'if a person affected by alcohol or some other drugs is lodged in the Watchhouse, a sensible verbal response is required at least every half hour. Remember: NO TALK = NO CUSTODY.'

5.17 The ACT Policing Practice Guide: Persons in Custody discusses the Intoxicated Persons (Care and Protection) Act and notes that an intoxicated detainee will require careful monitoring. It urges particular care in transporting intoxicated detainees in police vehicles. Instructions for managing heavily intoxicated detainees in the Watchhouse include placement of the detainee in the coma position and

‘checked at regular intervals in order to ensure that they remain in the coma position…to reduce the risk of choking on their own vomit’. Elsewhere, the Guide indicates that cell checks on intoxicated persons should be conducted half hourly. Staff are reminded that ‘electronic surveillance …should not be used as a substitute for human interaction ...’

5.18 These formal instructions, taken with those provided in the National Guideline, indicate that the well-being of an intoxicated person should be checked at least half hourly. This should be done by visiting the detainee’s cell and engaging the detainee in a brief conversation. Highly intoxicated persons should be monitored more closely, the frequency of monitoring dependent on the degree of intoxication.

5.19 Review team discussions with staff suggest that intoxicated people are in practice handled quite differently by different staff. For example, some staff felt their knowledge and experience was sufficient to manage intoxicated detainees, regardless of the level of intoxication. Their views on appropriate monitoring ranged from checks at intervals from half an hour up, involving a visit to the detainee’s cell; to looking at the CCTV monitor in the Watchhouse workroom and turning up the volume on the intercom every so often to check if the detainee was asleep. If the detainee could not be heard breathing or snoring, a physical check of the cell would be done when time permitted. Contrary to the belief of Watchhouse staff, the review team was advised that snoring should not be regarded as a healthy sign in an intoxicated person.

5.20 Other staff were very mindful of the dangers inherent in heavy intoxication, particularly the risk of vomiting during sleep. Some felt that such detainees required 15 minute monitoring that involved entering a cell and waking the detainee. Others who advocated a physical visit to the cell on each check were reluctant to wake a sleeping, intoxicated detainee.

5.21 The difficulty of managing intoxicated detainees effectively was also emphasised in several submissions. For example, the CFACT medical adviser suggested that medical advice should be sought in all cases of apparent heavy intoxication, and especially when there is any suspicion that other drugs or injury may be involved. Seeking medical advice was in the interests of the intoxicated person’s health and also protected staff charged with the detainee’s care. Medical advisers emphasised that best practice in caring for intoxicated persons required that they be woken at half hourly intervals and asked to respond to simple questions. If a detainee was unable to respond appropriately, medical advice should be sought immediately.

5.22 The review team noted that the draft Watchhouse Manual does not identify intoxicated detainees as being at risk or having special needs. The section on lodgement of intoxicated persons notes that ‘intoxicated persons are treated the same as regular (detainees)’. Advice in the Manual relates primarily to the importance of detaining intoxicated persons for no longer than eight hours. The review team was advised this focus resulted from concern expressed in an Ombudsman report in June 2001 on *The AFP’s use of Powers under the Intoxicated Persons (Care and Protection) Act 1994* (ACT) about cases where intoxicated persons were detained for longer. The Manual notes that an intoxicated person may be detained for up to 12 hours with the agreement of the detainee, for example where a longer period is required for sobering up. However, no advice is provided on how that agreement should be obtained or whether it is practical to ask a detainee, who might still be intoxicated, to agree to spending further time in custody.

5.23 Watchhouse compliance with legislated detention periods for intoxicated

detainees is important. However, the purpose of taking intoxicated persons into custody is often for their protection. The standard of care required to ensure detainee safety during custody is equally important, as is the decision on whether an intoxicated person needs to be detained at all. Little guidance is given to staff on assessment of alternatives to detention for intoxicated persons, for example, transfer to the Sobering Up Shelter.

5.24 The Sobering Up Shelter is run by Centacare and operates on Thursday, Friday and Saturday nights. The Shelter will only accept non-violent intoxicated persons who enter the facility voluntarily. It provides beds for up to five intoxicated persons who need a safe environment in which to sleep off the effects of alcohol. One bed is reserved for an intoxicated female and can be locked off from the remaining sleeping areas. The Shelter is staffed by nurses and drug and alcohol counsellors.

5.25 Complaints to the Ombudsman and submissions to the review questioned whether the arresting police are deciding to detain intoxicated persons who might reasonably be accommodated at the Sobering Up Shelter. For example, the ACT Department of Health noted that police use of the Shelter had reduced significantly over the last 12 months. The review team decided not to pursue this issue because the Ombudsman is currently conducting an investigation into intoxicated persons in the Watchhouse that, among other things, will consider use of the Sobering Up Shelter. Irrespective of the Ombudsman's investigation, the review team notes that all ACT Policing supervisors, including patrol and Watchhouse sergeants, must give due consideration to all alternatives to custody when dealing with intoxicated persons.

Violent detainees and detainees threatening self-harm

5.26 Watchhouse staff are routinely required to deal with detainees who are violent or are known self-harmers. Violent or self-harming behaviours can include head-banging, slashing of the body and self-choking. Some detainees have a reputation for attempting to injure themselves in custody, and will secrete harmful items such as razor blades or shoe laces on or inside their bodies. Thorough searching cannot always locate these items. Often, and increasingly, detainees exhibiting self-harming behaviours may be suffering the effects of drugs, such as Ice. These drugs not only contribute to psychotic episodes that involve violent and unpredictable behaviour, they also have the effect of raising a detainee's pain threshold. This can make control of the detainee's behaviour difficult.

5.27 As outlined in Part 2 of this report, the Watchhouse has four cells identified for accommodation of 'at risk' detainees, two of which are padded. The formal guidance on management of persons in custody places emphasis on ensuring that detainees likely to be at risk of self harm are identified early and appropriate monitoring is provided. Seeking advice from the CATT is recommended, although Watchhouse staff have advised that CATT will not usually assist until the detainee is no longer under the influence of drugs or alcohol. The draft Watchhouse Manual indicates that detainees who are at risk of self-harm should be placed in the unpadded 'at risk' cells in the first instance. They will be moved to the padded cells if they subsequently exhibit self-harming behaviours. Violent detainees are placed in the padded cells immediately.

5.28 No advice is given about how detainees should be handled once in the padded cell, apart from 'close' monitoring. Each Watchhouse sergeant reported different reasons why a detainee might be placed in the padded cells. For example,

several sergeants stated that they would routinely strip naked any detainee threatening self-harm when he or she was placed in a padded cell. They said this action was necessary to manage the risk of access to any item that could be used to cause injury. The authorities cited for this practice were the *Crimes Act 1900* and 'that's how it's done'. Other sergeants felt that usually they could manage a risk of self-harm effectively by increasing monitoring. Some were uncomfortable about the idea of any person, particularly a female, being naked in a cell and on view constantly through the CCTV monitor to those in the Watchhouse workroom.

5.29 The practice of some Watchhouse sergeants in stripping detainees considered to be at risk of self-harm is not recommended in any formal or informal guidelines identified by the review team. It appears to have developed as an extreme response to protecting detainees from self-harm and, in the absence of formal training for Watchhouse staff, has been passed on by word of mouth. In our view, any detainee assessed as at risk of self-harm should be medically examined as soon as possible. Stripping of detainees is unnecessary, especially when they are under constant CCTV monitoring. Commonsense would suggest that stripping a person who is agitated is likely to have the effect of increasing that agitation.

5.30 Removal of clothing that could be used to self-harm, such as belts or ties, is routinely practiced in all jurisdictions, including the Watchhouse. Detainees at risk of self-harm require a higher level of monitoring and this should considerably reduce the risk. However, some detainees do attempt self-harm using items of clothing and custodial staff need to take protective action. In other jurisdictions, protective action includes removal of those items of clothing but the detainee is instead provided with a tear-proof smock. The smock provides protection for the detainee from self-harm as well as helping to maintain a degree of modesty.

Detainees in need of protection

5.31 On occasion, a detainee requiring protection from other detainees will be held in the Watchhouse. For example, a detainee who is, or has been, in custody for reasons associated with paedophilia should not be placed in a cell with other detainees who may be aware of this. The ACT Policing: Practical Guide: Persons in Custody refers to persons at risk 'due to the circumstances of their incarceration'. However, there is no guidance for staff on how to assess the risk associated with this type of detainee, particularly when Watchhouse staff do not have personal knowledge of the detainee and the detainee's record is unavailable.

5.32 The review team was advised that whenever staff are aware that a detainee has been arrested for, or has a history of, offences that may lead to risk of harm from other detainees, the detainee will be accommodated separately.

Review team opinion

5.33 The care of detainees who are assessed as 'at risk' is a challenge in any custodial environment. It is particularly so in the Watchhouse, where staff may be required to make judgments about people they have not seen before and who may be under great stress as a result of being taken into custody. Accurate initial assessment of the degree of risk is the key to safe management, and as noted above, enhanced training is required for staff tasked with those assessments. In our view, the expectations currently placed on police in relation to making accurate medical assessments of detainees presenting as being highly intoxicated, for example, are unreasonable. The protection of detainees and those staff tasked with their care would be best served by obtaining informed medical advice on their care.

5.34 From our discussions with staff and inspection of Watchhouse records, it appears the cell inspection requirements for at risk detainees are met intermittently. Failure to record cell checks accurately compromises the integrity of the entire risk management process. Similarly, failure to reassess formally the risk status of all detainees during their period of detention in the Watchhouse could result in detainees whose risk status worsens during custody receiving less than adequate care. This lack of attention to detail by some staff may result from a lack of understanding of their responsibilities for detainee care in a custodial environment.

5.35 The handling by some staff of detainees at risk of self-harm in the Watchhouse is unacceptable and requires immediate change. Stripping of detainees by staff is not appropriate under any circumstances unless alternative clothing is provided. Watchhouse management may wish to investigate the provision of tear-proof smocks and blankets for detainees who have attempted self-harm. These items are currently in use in the ACT court cells managed by Corrective Services staff.

5.36 Discussions with ACT government agencies and interest groups in the course of the review revealed that they have little regular liaison with the Watchhouse. Lack of communication appears to have led to misunderstandings about how 'at risk' detainees are treated in the Watchhouse. Numerous anecdotal accounts of problems experienced by 'at risk' detainees in the Watchhouse were reported to the review team. Inaccurate or incomplete information can result unnecessarily in distrust of police intentions.

5.37 Co-operation between staff in the Watchhouse, government agencies and interests groups must provide the best outcome for 'at risk' detainees. Regular opportunities for exchange of views and clarification or enhancement of Watchhouse procedures would help ensure this occurs. This is not a case of 'meetings for the sake of meetings'. More formal channels of communication are necessary to ensure that communication does not break down when staff move on.

Detainees with special needs

Provision of culturally sensitive services

5.38 None of the formal or informal guidelines identifies detainees from non-English speaking backgrounds as having special needs beyond the possible need for an interpreter. The *ACT Practical Guide: Interpreters and Translators* provides guidance in accessing interpretation services. Statistics on the number of non-English speaking detainees held in the Watchhouse are not available, but Watchhouse staff report the interpretation service is rarely used.

5.39 The submission to the review from the Canberra Multicultural Community Forum (CFCM) suggested that the needs of non-English speaking detainees should be interpreted much more broadly. For example, many migrants come from societies where contact with police can result in violence and intimidation. These people may well be very fearful about being taken into custody. Even if they can speak English well, their capacity to understand and respond to what is being said to them in a Watchhouse environment can be seriously compromised by stress. The Forum also raised the need to recognise cultural differences in Watchhouse procedures. This includes arrangements for removal of property, provision of appropriate food, and catering for religious observance.

5.40 Limited cultural awareness training is provided in general AFP training, and no special training is provided for Watchhouse staff. Few staff interviewed by the review team identified NESB detainees as having special needs. Options suggested by the Forum for enhancing care for NESB detainees in the Watchhouse included:

- Development of a cultural awareness training package for Watchhouse staff
- A brief information sheet in a range of languages, covering what happens to a person detained in the Watchhouse and a detainee's rights, that could be given to detainees on arrival
- Provision of culturally appropriate food while detained
- Provision of appropriate opportunities for religious observance
- Improved liaison between the CFCM and Watchhouse management to encourage greater understanding about the police and what happens when a person is taken into police custody.

Detainees with mental illness

5.41 Recent Australian research has confirmed that the incidence of mental illness is significantly higher among those held in the criminal justice system than in the general population. Around 50% of persons taken into custody suffer from some form of mental illness. Evidence also suggests that the number of mentally ill offenders has increased since deinstitutionalisation of persons with mental illness. Although mental illness is a health problem, unfortunately there are few places for mentally ill people to go, and often police are the first point of contact.

5.42 If a mentally ill person is behaving irrationally, police have limited options. They can try to resolve the situation themselves, but they are not specifically trained to deal with mental illness and find managing mentally ill persons difficult. They can obtain medical assistance, by taking the person to hospital or calling for mental health crisis assistance. Often medical staff are reluctant to deal with mentally ill persons who are violent or intoxicated. Often police may have no alternative but to take them into custody.

5.43 The procedural guidance available to Watchhouse staff notes that detainees with psychological illnesses require careful assessment and monitoring. The Watchhouse assessment questionnaire administered to all detainees on arrival is the primary screening tool for any detainee illness. The two questions most relevant for identifying detainees with mental illness are 'are you ill in any way?' and 'have you ever tried to harm yourself?' To be useful to staff, both questions require truthful answers that a mentally ill detainee may be unable to provide. If the detainee is not known to Watchhouse staff, there may be some record on the PROMIS system alerting staff to the detainee's medical condition. Watchhouse staff may decide that medical advice is required and seek an opinion from a doctor or CATT staff. Reference was made earlier in this report to the difficulty Watchhouse staff reported in obtaining CATT attendance when a detainee suspected of being mentally ill has consumed drugs or excessive amounts of alcohol.

5.44 Watchhouse staff do not receive sufficient training to enable them to recognise whether a person is mentally ill at first contact, nor do they have a structured screening tool to assist them. This is a deficiency common to many police custodial facilities, highlighted in a recent report by a Criminology Research Council Consultancy, 'The Identification of Mental Disorders in the Criminal Justice System'. Some jurisdictions have addressed the problem by appointing mental health staff to

undertake assessments of all persons entering detention. The review team was advised by Mental Health ACT that they provide such a service to all detainees when they are transferred to the Court cells from the Watchhouse. This assessment provides the basis for subsequent care of detainees who enter the correctional system.

5.45 The Australian Institute of Criminology report recommended strategies that should be adopted across Australia to improve police training in identifying and caring for mentally ill detainees, and to develop a standardised mental illness screening tool. These recommendations address many of the concerns identified in the course of this review and are endorsed by the review team. Within the Watchhouse, assessment of any detainee about whose mental health status staff have doubts might best be undertaken by qualified, on call, mental health service providers.

Detainees with physical or intellectual disabilities

5.46 Statistics on the number of detainees with physical or intellectual disabilities are not available. However, the Watchhouse capacity to cater for detainees with physical disabilities is limited. Detainees with mobility problems can enter the Watchhouse by either the lift from City Station to the lower ground floor or by police vehicle through the sally port. A wheelchair is available and a mobility impaired detainee is usually carried by police from the police vehicle to the wheelchair and then wheeled into the Watchhouse. No other mobility aids, such as crutches, are available.

5.47 Entrance to each cell and cell block is sufficiently wide to allow wheelchair access although a physically disabled detainee will be placed in an unpadded ‘at risk’ cell if one is available. Normal practice is for any wheelchair or mobility aid (including the detainee’s own aids) to be removed once a detainee is inside the cell. The review team was advised this ensures that no potential hanging point is available.

5.48 Cells are not fitted with handrails to assist disabled persons accessing toilets, hand basins or bubblers. If these facilities need to be used, a mobility impaired detainee must seek assistance from Watchhouse staff. The non-padded ‘at risk’ cells have the intercom button within easy reach of the bed. It is not clear how a detainee with very limited mobility who had to be accommodated in one of the other cells would be able to summon assistance.

5.49 There appears to be equally limited provision for detainees with physical disabilities such as hearing or sight impairment. It is not clear how a sight impaired detainee would be able to negotiate an unfamiliar cell or locate the intercom to call for help. An interpreter can be provided for a hearing impaired person who may not understand the reason for detention or what is being said by Watchhouse staff.

5.50 More importantly, the assessment of detainees on arrival does not include any screening tool for early identification of those with less obvious disabilities. For example, it may not be obvious that a detainee has a hearing impairment. Failure to follow Watchhouse staff instructions as a result of poor hearing could easily be interpreted by staff as lack of cooperation and treated accordingly.

5.51 Failure to identify detainees with intellectual disabilities can also occur without an adequate screening tool for this condition administered on arrival. A detainee with an intellectual disability is likely to require assistance in understanding the reason for detention and what is going to happen during custody in the Watchhouse. This could

take the form of extra care in explanations provided by staff or perhaps making a friend or health worker available to reassure the detainee.

5.52 These may seem simple, commonsense approaches to meeting the special needs of detainees with disabilities, but they are not included in any procedural guidance for staff. Watchhouse staff advised that they rarely have disabled people in custody, and that they receive no training in their care. However, in the absence of adequate screening tools, it is difficult to be confident that all disabled detainees are being identified. Without adequate staff training or procedural guidance, the needs of detainees with other disabilities can easily be overlooked.

Review team opinion

5.53 Detainees with special needs, as opposed to those assessed as 'at risk', receive little attention in the current procedures. Understanding among staff of the care required is limited, even when the nature of the detainee's special need is obvious. In the case of an NESB detainee, for example, the broader implications for care and management of the detainee have not necessarily been recognised.

5.54 In the case of persons who are mentally ill or have some form of physical illness that may not be readily apparent, screening tools available to Watchhouse staff are either non-existent or relatively unhelpful. Screening procedures and how they are to be administered require sensitive handling to ensure they do not offend or intrude unnecessarily into detainee privacy. The ACT government agencies and community interest groups contacted in the course of the review expressed great willingness to work with the Watchhouse to improve screening arrangements. They are also keen to improve liaison with the Watchhouse to enhance staff understanding of all detainees with special needs.

Recommendations

5.55 The review team recommends:

Recommendation 10

Procedures and practices for the care of persons with special needs or assessed as being 'at risk' should be revised as a matter of priority. This should be done in consultation with medical advisers and relevant special interest groups. Particular attention should be paid to the following:

- Revising and enhancing the screening tools for assessing the risk status and any special needs of detainees. This includes ensuring that staff have adequate training in their duty of care and that they are supported in seeking further advice when uncertain about the status of a detainee.

- Ensuring staff are aware of the risks associated with an impaired state of consciousness and understand the responsibility attached to the custody of a detainee presenting with this symptom. If staff have any doubt about the health of a detainee, medical advice must be sought immediately.

- Ensuring all staff are aware of their duty of care obligations to Indigenous and juvenile detainees; and instituting monitoring arrangements to ensure that these obligations are met.

- Discontinuing the present practice of stripping detainees at risk of self-harm unless detainees are provided with a tear-proof smock and tear-proof blanket. Any detainee assessed as at risk of self-harm should be medically examined as soon as possible.

- Establishing effective arrangements for identification and care of persons assessed as being in need of protection due to the circumstances of their arrest.

- Revising facilities and arrangements for the handling of persons with disabilities and for staff training to ensure that the particular needs of detainees with disabilities and mental health concerns are adequately acknowledged and accommodated.

- Establishing forums for regular discussion with key government and non-government advisory and interest groups. These forums should be used to inform Watchhouse procedures and advise on best practice in managing ‘at risk’ detainees and detainees with special needs. They should facilitate broader community awareness of Watchhouse operations, and provide opportunities for informal assessment and adjustment of Watchhouse performance, where appropriate.

PART 6—STAFFING AND MANAGING THE WATCHHOUSE

6.1 This Part considers the level of staffing in the Watchhouse, the adequacy of training and support provided to staff in undertaking custodial duties, and the effectiveness of management and supervisory structures.

Staffing the Watchhouse

6.2 The Watchhouse is staffed by 6 teams each comprising a Watchhouse sergeant and two constables. Five of these teams operate on eight hour shifts of five lines, rotating every 10 weeks. Shifts are 7am—3pm; 3pm—11pm; and 11pm to 7 am. Constables in the sixth team are used to backfill when staff in the other teams are absent on leave or training commitments. The sixth team sergeant is currently filling the role of Watchhouse Manager. The Watchhouse sergeants are oversighted by the Watchhouse Manager. The Watchhouse Manager reports to the Officer in Charge (OIC) of City Station who reports to the Superintendent of North District.

Watchhouse sergeants and constables

6.3 The review team was advised that a Watchhouse sergeant is deployed to the position for 12 months, although over the last year there has been a high turnover, prompted by concerns about Watchhouse operations. Historically, the Watchhouse sergeant (almost invariably male) was a highly experienced police officer with a detailed understanding of custodial issues. The sergeant was regarded as a valuable resource throughout ACT Policing for advice on handling difficult situations and an authority on relevant legislative requirements. Most Watchhouse sergeants had some years of Watchhouse experience.

6.4 Newly appointed sergeants have generally been deployed to the Watchhouse in recent years. Current Watchhouse sergeants interviewed by the review team reported that they had limited or no experience of Watchhouse operations before taking up their role, other than that gained when delivering persons arrested into Watchhouse custody. This lack of experience is compounded by the dearth of formal guidance or training available on Watchhouse procedures.

6.5 The review team was advised initially that the constables, one each from North and South Districts, were deployed on 20 week rotations in the Watchhouse. The start times for the rotations of the two constables on a given team were staggered at ten-week intervals. The constable with ten weeks experience was designated Number 1 constable, the incoming constable was Number 2. When the Number 1 constable completed the 20-week rotation, the Number 2 constable was promoted to Number 1 and a new Number 2 came in. This arrangement was intended to ensure that at least one constable had experience and could train the other. The review team was also advised that no probationary constables were deployed to the Watchhouse because they were too inexperienced.

6.6 Deployment practices observed by the review team did not comply with this model. Variances included:

- In July 2006, five of the six teams replaced all their constables within a three week period. Since that time, the two constables on most teams have commenced their rotations within days of each other, sometimes in the same

week, rather than at 10-week intervals.

- Constables did not necessarily adhere to the 20-week rotation period. Replacement constables would arrive at very short notice, sometimes too short to arrange for access to the cell management system before commencing a shift.

- On one occasion during the review, a Watchhouse sergeant found that both constables on his shift were replacements. Neither constable had any prior Watchhouse experience, and neither had access to the cell management system.

- The sixth line of constables was insufficient to back-fill for constables in the other five lines on all occasions when they were absent. Probationary constables were not infrequently deployed to the Watchhouse on relief.

- Sometimes inexperienced constables were rostered on with an inexperienced Watchhouse sergeant.

6.7 Deficiencies in staff deployment arrangements are compounded by the lack of formal training and procedural guidance for Watchhouse staff. Many of the staff interviewed reported that they felt ill prepared for their duties and uncertain about what was required of them. In these circumstances, it is difficult to feel confident that all staff tasked with the care of detainees understand fully their duty of care obligations or have the knowledge and skills required to meet them.

6.8 By comparison, other Watchhouse-type custodial facilities considered by the review team had far more structured and permanent staffing arrangements. For example, in the Perth Watchhouse, the minimum tenure for all staff is 12 months. The ACT Court cells are staffed by Corrective Services personnel who are employed solely in custodial duties and many have extensive experience in custodial work. Staff in both facilities undergo specific, custody-related training prior to commencement. In-service custodial training is also provided.

Adequacy of staffing in the Watchhouse

Requirements of staff working in the Watchhouse

6.9 Custodial duties in the Watchhouse call for a mix of skills and personal attributes in staff that may not necessarily be the same as those required in other community policing roles. To do the job effectively, a Watchhouse sergeant needs to demonstrate a high degree of competency in the following areas:

- Understanding of the AFP core values

- Understanding of the duty of care owed to all detainees in custody in the Watchhouse and sound judgment in delivering that care.

- Knowledge of relevant legislation and the capacity to adjudicate on briefs of evidence prepared by arresting officers.

- Capacity to manage frequent confrontational situations. This requires understanding of personal behaviours and mannerisms that can inflame situations and a willingness to de-escalate problems when possible.

- Understanding of Watchhouse monitoring systems and the importance of sound record keeping, especially in relation to management of detainees.

- Capacity to model for junior or inexperienced staff appropriate, non-judgmental behaviour in dealing with all types of detainees. This requires an ability to rise above inappropriate behaviour by detainees.

6.10 It could be argued that all serving police should have these competencies. However, the responsibility placed on Watchhouse sergeants for the safety and well-being of detainees goes beyond that normally required in other policing duties.

6.11 No one wants to be taken into custody. No one is happy about being detained in the Watchhouse. Detainees are often at their worst when relating to Watchhouse staff. Generally, problems that arise in the Watchhouse need to be dealt with immediately. There is rarely the option to withdraw and consider the best way to deal with a situation. Further, there is no capacity for respite during busy periods. The Watchhouse sergeant sets the standard for behaviour in the Watchhouse, especially with inexperienced constables. In the absence of clear procedural guidance, the sergeant's approach will deeply influence the handling of detainees by all other staff.

Staff training

Recruit training and probation

6.12 All ACT Police recruits complete 100 days of training at Barton College. Recruit training, which is provided by AFP Learning and Development, covers relevant legislation, the use of police powers, dealing with mental health and family violence issues, and urgent duty driving training. Around 25% of training is devoted to Operational Safety, including negotiation techniques, use of firearms, baton and OC spray, and defensive skills. (Use of force training and its application in the Watchhouse is covered in more detail in Part 4 of this report.) Recruit training does not cover human rights although the review team was advised that, consistent with the requirements of the ACT *Human Rights Act 2004,* a training package is being developed. No generic recruit training is provided on the custodial functions required in ACT Policing.

6.13 An important element in recruit training is the instilling of AFP values. Professional Standards briefs recruits during their first week of training, explaining the importance of police behaviour reflecting those values at all times. Learning and Development has advised that AFP values are reiterated throughout training and related to the issues covered in each training session.

6.14 However, there is some evidence that further values training may be required. During recruit training, all new members participate in Observation Week where they rotate between police stations in the ACT. Each recruit must report back to the class on their experiences and the lessons learned during the rotations. Learning and Development staff reported considerable change in some recruits, particularly in their attitudes and behaviour. For example, some have slipped into slang or jargon that is derogatory to certain groups in the community.

6.15 Graduation from Barton College is followed by 13 months probation during which new members must complete a workbook covering the different duties involved in ACT Policing. The new member's team leader is required to confirm that the workbook duties have been successfully completed. Unfortunately, supervisors often have limited experience in ACT Policing themselves. They may not be best

placed to provide advice and support to recent graduates, or to judge whether new members have demonstrated required competencies.

6.16 During probation, new members must spend two weeks with Traffic Operations and one day with ACT Communications. ACT Communications is located at the Winchester Police Centre in Belconnen and is responsible for dispatching police to respond to calls for assistance from the public. These placements are considered essential to provide new members with the skills they require in communicating with a range of people. Probationers are not given a placement in the Watchhouse, and the review team was advised this was because it would take too much time from their required workbook activities. Consequently, new members are offered no formal training in, or experience of, custodial duties.

Training in the Watchhouse

6.17 The review team was advised by all Watchhouse staff that they received no structured training, either prior to or after posting to the Watchhouse. Any training for Watchhouse sergeants that did occur was ad hoc and on-the-job. Many constables reported that they were deployed to the Watchhouse at short notice to relieve for absent staff. They had no knowledge of the duties they were expected to perform. Any training they received was provided by the Watchhouse sergeant as time permitted, or by the other constable on duty, if he or she happened to have prior experience.

6.18 Sergeants received on-the-job handover training of only a few days or, in some cases, a few hours. During this time, the incoming member was expected to learn procedures and duties for Watchhouse constables as well as for the Watchhouse sergeant. This includes use of the Cell Management data bases in PROMIS and the CCTV electronic monitoring system. The review team was advised that no structured training on the Apprehensions and Cell Management data bases has occurred for many years. This means that each sergeant must learn from the previous sergeant.

6.19 Despite generic training in AFP values, the review team found that the behaviour of the member training an incoming sergeant strongly influenced the values the new sergeant demonstrated in managing detainees. For example, in one CCTV record examined by the review team, an incoming sergeant with no prior Watchhouse experience was shown by a senior constable how to process a detainee. In the review team's opinion, the approach taken by the senior constable was inappropriate and led to detainee hostility and lack of compliance. It was a poor model for the new sergeant and other constables present. In the absence of formal training and comprehensive written guidance on custodial management, Watchhouse procedures change over time and standards of behaviour towards detainees vary.

6.20 Constables received even less training than sergeants. Some constables, although knowing well in advance that they were to be deployed to the Watchhouse, had no opportunity to familiarise themselves with Watchhouse operations until the day they arrived. There was no advice or guidance from exiting Watchhouse sergeants or constables on legislative practices, care and custody requirements, the CCTV system or detainee monitoring requirements. As noted earlier, some Watchhouse constables arrived for their first shift without having access to the Cell Management system.

Staffing levels

6.21 Delivery of appropriate care to detainees also requires that an adequate number of qualified staff is available to provide that care. The number of detainees in custody in the Watchhouse and the reasons for their detention vary according to the time of day, and the day of the week. Staffing levels in the Watchhouse rarely vary.

6.22 Typically, few persons are taken into custody between 9am and 9pm. Those who are will probably have been arrested in relation to alleged offences or on warrants. After 9pm, most detainees arriving in the Watchhouse have been taken into protective custody as a result of intoxication. Watchhouse staff are usually busy between 6am and 9am, providing breakfasts and processing those detainees who are transferring to the Court Cells prior to appearing in court. Thursday, Friday and Saturday nights are generally the busiest, and it is not unusual for between 20 and 30 detainees to be in custody in any 24 hour period. During occasions such as New Year's Eve, detainee numbers can be much higher. A sample of a month's operations during the period of the review is at Appendix 10.

6.23 However, Watchhouse staffing remains the same at all times, with the exception of New Year's Eve, when an extra sergeant and constables are rostered on. Additional beat and patrol police are rostered on duty during special events and holidays to meet the expected increase in need for community policing services. It is not clear why additional staff are not similarly provided in the Watchhouse for those periods when experience suggests a large number of persons are likely to be taken into custody. The review team was advised that there is capacity for the Watchhouse sergeant to request assistance from the City police station or from other stations when required. In practice, this rarely occurs.

6.24 Watchhouse staff interviewed by the review team had differing views on the adequacy of staffing levels. However, most felt that while three staff was too much during quiet periods, it was too little over the weekends and during special events in Canberra. Many staff reported it was not possible to manage all duties effectively on these occasions. All three staff members are required to process a detainee on arrival in the Watchhouse, and sometimes processing can take half an hour or more. Little or no attention can be given to detainees in cells during this time.

6.25 The proportion of staff to custodial beds in the Watchhouse is low by comparison with similar facilities considered by the review team. For example, in the Perth Watchhouse, which has 17 cells that can house up to 65 detainees, two sergeants and nine constables are on roster for each shift. Rostered staff are supported by back up staff during peak periods—Thursday, Friday and Saturday nights—including a registered nurse. The Perth Watchhouse is similar in size to the City Watchhouse. The Brisbane Watchhouse, which has 51 cells sleeping up to 84 detainees, has two sergeants and four to six constables on duty on each shift to undertake custodial and judicial functions. They are supported on each shift by at least four assistant Watchhouse officers who are responsible for the care of detainees in cells. Brisbane Watchhouse also provides a surge capacity for busy periods.

6.26 Failing to provide enough staff to handle high numbers of detainees can have serious implications. On busy nights, several police vehicles can be queued up outside the Watchhouse waiting to bring in detainees. Arresting police occupied in this way are not available to respond to calls. Detainees, some of whom may have been exposed to OC spray and remain un-decontaminated, are required to spend long periods in police vehicles. Once detainees have entered the Watchhouse, staff

capacity to care for them is also compromised. The review team's observations confirmed that when large numbers of detainees were being processed in the Watchhouse, attention to cell checks declined, sometimes to the point where checks were not undertaken at all.

Female staff in the Watchhouse

6.27 Around 23.4% of ACT Police are female, yet the percentage of females among Watchhouse staff is usually much lower. When the review commenced, only one of the 18 staff was female. Four females are now working on Watchhouse rosters. This means that not all shifts will have a female on duty, even when a female is in detention. As noted earlier, in these circumstances a female member will be called down from City Station or in from patrol if a female in custody requires searching. A female member may also be called in if a female in custody needs close surveillance or is removing her clothing in a cell, although this seems to depend on the view of the Watchhouse sergeant on duty. Several female staff members noted that females in custody may feel uncomfortable asking a male staff member for sanitary pads or tampons.

6.28 Many of the staff interviewed by the review team commented that having a female on duty tended to improve the behaviour of detainees. Several Watchhouse sergeants said that they found a female staff member could reduce the emotional temperature in confrontational situations, particularly if the female presented as an empathetic and helpful figure.

6.29 By comparison, most of the jurisdictions considered during the review ensured that a female was always on duty in the custodial facility. In some cases this was achieved through using a female nurse during business hours.

Morale in the Watchhouse

6.30 The best outcomes for detainees will be achieved when staff are confident in the nature of the job they are asked to do, provided with adequate training and support, and believe that the job is important and their contribution to the organisation is valued.

6.31 The review team's discussions confirmed that working in the Watchhouse was perceived to be among the least important jobs in ACT Policing. Almost everyone interviewed regarded being deployed to the Watchhouse as a form of punishment. Some senior staff said they sent staff to the Watchhouse who were not performing well in general duties, or who had misbehaved in some way. Experienced staff were seen as being more usefully employed on the beat or on patrol. Many of the constables sent to the Watchhouse told the review team they knew they were being punished. They did not want to be there and were serving time until they could leave. This attitude affects the performance of their duties in the Watchhouse.

6.32 Morale in the Watchhouse is low. It is evident, for example, in the generally untidy and disorganised appearance of staff areas in the Watchhouse, staff uncertainty about their duties, and the lack of attention to detail in procedures and record keeping. Reasons offered to the review team for poor morale included:

- Lack of training and understanding about duties in the Watchhouse. Those staff who were keen to improve their understanding or remedy what they thought were procedural deficiencies said they felt discouraged by the lack of interest shown by management.

- The nature of the work. Custodial duties were not seen as exciting or even appropriate work for police. Staff said they did not feel they were contributing positively to the community – detainees do not say 'thank you' for holding them in custody. Some Watchhouse staff felt other police looked down on them.

- Isolation and lack of freedom. The Watchhouse environment is underground and very limiting. There is little opportunity for the short breaks from work that other policing duties allow. For example, taking ten minutes off to do the banking can be impossible. In busy periods, staff can go for many hours without a break.

- The eight hour roster. Almost all staff expressed dissatisfaction with the roster that requires staff to work up to 9 days straight. Some said they found it impossible to plan regular activities outside work hours because the rosters changed every 10 weeks. Others said they were required to work too many weekends: one constable reported working 8 out of 10 weekends. Most other police, including City Station patrols, worked rosters of 8, 10 and 12 hours, predominantly with four days on followed by four days off. Most staff preferred this routine as giving them more opportunity to take a break from the Watchhouse and to plan family activities.

6.33 Poor morale has been exacerbated by recent investigations launched by AFP Professional Standards into the activities of Watchhouse staff. These ongoing investigations have resulted in criminal charges being laid against some serving and former police. Discussions with AFP and ACT Policing Chaplaincy and Welfare Officers confirmed poor morale and uncertainty among Watchhouse staff about their role in the Watchhouse. Many current Watchhouse staff felt uncomfortable about the work of the review team and expressed anxiety about being under constant scrutiny without being sure what they should be doing. The review team is grateful for the professionalism of many of the staff who, despite this anxiety, shared their experiences and concerns about Watchhouse operations with the team.

Review team opinion

6.34 In our view, staffing levels in the Watchhouse should be reviewed as a matter of priority. There is clear evidence that in busy periods the workload on available staff is compromising the efficiency and effectiveness of Watchhouse operations. The review team was unable to determine why there was no surge capacity for peak times built in to staffing arrangements. This is common practice in some other jurisdictions and, indeed, in other aspects of ACT community policing. The implications of inadequate staffing for delivery of the duty of care to all detainees, and to high risk detainees particularly, is obvious. Failure to provide enough staff to deliver appropriate care is also inconsistent with the AFP's duty of care to ACT Policing members tasked with custodial duties.

6.35 Procedures for the selection of staff for deployment to the Watchhouse also require review, in particular the practice of selecting less experienced or allegedly underperforming staff. Use of probationary constables to relieve when Watchhouse staff are unavailable for duty is not advisable. Where possible, a female should be on staff at all times.

6.36 In our view, the competencies required of all staff in the Watchhouse should be clearly articulated and selection of staff undertaken accordingly. The safety and

well-being of detainees is a significant responsibility that must be acknowledged in staffing decisions. The Watchhouse is a challenging and potentially very dangerous environment and the consequences of misjudgement can be severe, for detainees and for staff.

6.37 Poor morale and dissatisfaction among Watchhouse staff with their working conditions has undermined performance standards in the Watchhouse. Raising the status of the Watchhouse as a workplace is likely to be a long term project. The concerns of staff, especially in relation to the 8 hour shift, cannot be ignored. The review team was advised that in a recent referendum on Watchhouse shift length, 96.96% of staff voted for an increase. Apparently the proposal to bring Watchhouse shifts in line with City Station shifts was rejected by the AFP executive on grounds including occupational safety. However, research considered by the review team suggests that the longer shifts provide the opportunity for full recovery between rosters, improving outcomes for staff. We suggest the question of shift length be explored further.

Supervision, leadership and accountability

6.38 The delivery of consistently high standards of care to detainees is not achievable unless Watchhouse staff understand their duties and are adequately prepared to undertake them. However, it also requires high level organisational commitment to proactive management of Watchhouse operations. This includes sound supervisory structures, comprehensive reporting arrangements and leadership that is informed about, and responsive to, the challenges of custodial care.

The chain of command

6.39 The chain of command for Watchhouse operations comprises the Watchhouse Manager, who reports to the OIC of City Station, who in turn reports to the Superintendent of North District. The Superintendent reports to the ACT Policing executive through the Deputy Chief Police Officer (DCPO) Response.

The Watchhouse Manager

6.40 The position of Watchhouse Manager was created in 2004. There is no formally approved duty statement for the position. The role of the Manager appears to fall somewhere between providing operational support to the Watchhouse, for example, oversighting rostering, leave and supplies, and acting as a source of advice and support for Watchhouse sergeants. The Watchhouse Manager's hours are generally 8am – 4pm, Monday to Friday, but may also relieve if one of the Watchhouse sergeants is absent.

6.41 A draft list of the Manager's duties, prepared in October 2006 and provided to the review team, referred to responsibility for 'oversight of all operational matters pertaining to the efficient and effective operation…' of the Watchhouse. The review team saw little evidence that this is occurring. For example, the Manager has no proactive strategy to ensure that operational requirements, like emergency procedures for the Watchhouse, are current and understood by all staff, and that emergency equipment is accessible and in good order. Although the Manager should be responsible, in principle, for ensuring staffing is adequate to meet expected detainee numbers, the review team saw no evidence that this occurred. Staffing was not increased during recent major public events and staff on duty reporting that they felt seriously stressed by detainee numbers.

6.42 Matters of this kind are fundamental to the efficient and effective operation of the Watchhouse, but no one appears to be taking responsibility for them. The review team noted that the Manager's position has been staffed only intermittently since 2004. It is currently filled by the sergeant from the 6th line of the Watchhouse roster. The position is at the same level as other sergeants working in the Watchhouse, limiting the role's authority in the hierarchical command structure of ACT Policing. Some Watchhouse sergeants commented to the review team that while they might discuss how to handle an issue with the Manager, they saw no reason to take direction from a sergeant at the same level.

OIC City Station

6.43 The review team was advised that the Watchhouse Manager reports to the OIC City Station. The reason for this is unclear, since the Watchhouse appears to operate quite independently from City Station. In practice, the oversighting role of the OIC in relation to the Watchhouse appears limited to checking use of force reports (that have already been checked by the Watchhouse Manager) and reports about any issues that the Watchhouse Manager believes should be brought to the Superintendent's attention. Beyond noting the content of the reports, the value added by the OIC seems minimal. The OIC rarely visits the Watchhouse and was not observed by the review team contributing to its management. The OIC represents Watchhouse interests at the monthly management meetings held by the Superintendent of North District with staff responsible for District management.

Superintendent, North District

6.44 The Superintendent of North District is responsible to the ACT Policing Executive for the effective operation of the Watchhouse. The Superintendent advised the review team that he visited the Watchhouse two or three times a week. No regular meetings are held with the Watchhouse Manager or Watchhouse staff, although ad hoc meetings take place 'as required'. This seems to be when the Watchhouse Manager thinks a problem in the Watchhouse warrants discussion with the Superintendent.

6.45 The Superintendent provides to the DCPO Response monthly summary reports on use of force in the Watchhouse, covering the number of reports and type of force used. These reports are based on information provided by the Watchhouse Manager through the OIC. The reports offer limited analysis of this information. No other regular reports on Watchhouse operations are provided to the ACT Policing executive.

Reporting and monitoring

6.46 Formal reporting on Watchhouse operations, other than exception reporting, is minimal. The only regular reporting required appears to be in relation to use of force. Commissioner's Order 3: Use of Force stipulates that a use of force report must be completed whenever force is used in ACT Policing, including in the Watchhouse. Watchhouse staff appeared to be unclear about when these reports should be completed. Some thought exemptions applied to certain types of force used in the Watchhouse, while others thought that CCTV recording of Watchhouse operations meant reports did not need to be completed.

6.47 No procedures appear to be in place to monitor trends in delivery of care to detainees, for example, the proportion of detainees affected by the drug Ice being

taken into custody, whether staff are able to manage them, or what additional staff training might be required. No checking is done to ensure that all staff deployed to the Watchhouse have the necessary basic requirements, such as current first aid qualifications. Even regular reports about complaints relating to the Watchhouse are not available, and the review team was unable to obtain consolidated information from the Watchhouse or the AFP Professional Standards about complaints and their outcomes. (This matter is discussed further in Part 7 of this report.) Consequently trends in Watchhouse operations and staff competencies are not being identified by management so that procedures and training can be adjusted accordingly.

6.48 There is no ongoing monitoring of day-to-day maintenance of the cells, for example, the adequacy of cleaning or the condition of the mattresses in the cells. Deficiencies in such areas seem to be picked up only if an alert staff member notices them and takes the trouble to report them. Without regular monitoring and reporting, inconsistencies in procedures and operational standards can remain undetected. The high staff turnover over the last 12 months and the lack of records against which to assess current performance meant the review team could not determine whether deficiencies observed were recent or of long standing.

6.49 Reports or briefings appear to be prepared for senior management or ACT Policing executive attention only when a serious problem arises or a complaint is investigated by Professional Standards. By then, the inappropriate behaviours or inadequate standards that have led to the problem may have become the norm. For example, failure of staff to complete reports on all occasions on which force was used in the Watchhouse emerged only during investigation of a complaint. Staff ignorance of Watchhouse emergency evacuation procedures was only noted when new staff arrived and asked what to do in an emergency. When new staff did ask this question, it appears no one in Watchhouse management saw providing an answer as being their responsibility.

Consistency in Watchhouse operations

6.50 This report has already discussed the lack of specific custodial training provided to staff deployed to the Watchhouse; the limitations on available procedural guidance; and the relative inexperience of many of the staff. Ensuring consistency across the 24 hours, 7 days a week of Watchhouse operations in these circumstances is difficult. The review team's inspection of Watchhouse records exposed inconsistency in many aspects of Watchhouse operations. They range from the attitudes demonstrated by Watchhouse sergeants in dealing with detainees to the content of cell check records completed by constables.

6.51 The staff guidance provided on custodial responsibilities focuses heavily on meeting the requirements of the judicial system. The draft Watchhouse Manual, for example, devotes considerable space to the procedures to be followed in granting or refusing bail to a detainee. The rules in these areas are clear and compliance with legislation and avoidance of judicial criticism are strong motivators. The degree of consistency observed in these aspects of detainee management was high. However, staff interviewed often reported different practice in those aspects of detainee management that related to detainee well-being. The guidance available is largely silent on these aspects of detainee care, and the review team found few mechanisms in place to promote consistent practice.

6.52 For example, Watchhouse sergeants reported that they do not meet or communicate regularly as a group with the Watchhouse Manager or other staff in the chain of command to discuss issues of detainee care. No one was tasked with

ensuring a standard approach in, say, handling intoxicated detainees, even after complaints drew attention to inconsistencies in their treatment. A sergeant may obtain advice on a particular issue, but that advice may not necessarily be made available to all staff. Ad hoc musters might be held to address a particular issue that has come to the attention of senior management or the executive. However, there is no formal mechanism to ensure that all staff are aware of the advice provided at such briefings, and no one is tasked with checking to ensure that any advice provided is followed consistently by all staff.

6.53 Failure to follow up on ad hoc briefings to ensure all staff understand what is required of them is illustrated by the outcome of a recent muster on use of OC foam in the Watchhouse. This briefing addressed use of force and reporting on its use, after alleged misuse of OC foam in the Watchhouse. The review team met with Watchhouse staff over the weeks following this briefing. Staff who attended the muster reported different understandings of what they should be doing, including when they should be reporting that force had been used. Those staff who did not attend because they were not on duty at the time of the muster were confused by the differing views of their colleagues. The review team suggested that a statement be issued clarifying the requirements covered at the briefing but we understand this did not occur. It is unreasonable to expect consistent practice when staff are unclear about what is required of them.

6.54 Articulating appropriate guidelines and ensuring that all staff are aware of requirements is the first step. Good administrative practice also requires a mechanism to monitor consistent application by staff. In the case of the arrangements for reporting on use of force in the Watchhouse, the review team was advised that the Watchhouse Manager, OIC City Station and the Superintendent would be tasked with checking every report to ensure that use of force had been appropriate. However, this would be of limited value without some assurance that the reports accurately reflected the force used and the circumstances of use. The review team suggested that this could be achieved by cross-checking use of force reports against other records, such as CCTV footage, on a random basis.

Review team opinion

6.55 Review team interviews with Watchhouse staff provided evidence that members at times feel isolated and unsupported by management in performing their duties. This inevitably affects how they feel about their job and their approach to detainees. Many staff expressed ignorance about fundamental aspects of Watchhouse operations, such as how the CCTV system works, and almost all felt exposed by that ignorance. Staff felt vulnerable to investigation by Professional Standards, and sought reassurance that what they were currently doing was appropriate. Some commented that the only feedback they received was when they were told they were doing something wrong. This level of insecurity not only compromises staff capacity to care for detainees, it is unfair and unreasonable to the staff concerned who are doing a difficult job under often difficult circumstances.

6.56 Good administrative practice in the Watchhouse requires reporting structures that provide accurate and comprehensive advice to management and the executive about the status of all aspects of Watchhouse operations. The review team was unable to identify any regular reporting framework beyond use of force reporting, and the value of those reports in their current form is questionable. The lack of sound reporting and monitoring structures means there is almost no performance information being provided to ACT Policing or the AFP executive. Reporting is almost exclusively exception reporting, informing only when something goes wrong.

Invariably, such reports appear to relate to complaints. It is likely that many could have been avoided had regular status reports been available on Watchhouse operations to identify at an early stage the problems that led to the complaints.

6.57 Appropriate reporting and accountability mechanisms are required in the Watchhouse. They will help facilitate early detection and remedy of inconsistencies so that serious problems can be avoided. They also provide protection for staff who can then be confident that they are handling detainees appropriately.

6.58 Of even greater concern to the review team was the lack of understanding of good administrative practice demonstrated by the Watchhouse chain of command. Watchhouse management showed little appreciation of the importance of comprehensive performance data to inform operational outcomes. There appeared to be no arrangements in place to ensure that any recommendations arising from reviews of Watchhouse operations, such as the 2006 OH & S audit discussed earlier, were implemented.

6.59 Further, during the course of the review, the review team identified a number of deficiencies in Watchhouse operations that required priority action. The team referred these to management with a view to remedying the deficiencies at an early date. The review team noted that the management team supporting the Watchhouse was deployed in September 2006.

6.60 In our view early attention should be given to the development of appropriate reporting and accountability arrangements in the Watchhouse. Leadership and supervisory arrangements should be also reviewed as a matter of urgency.

Recommendations

6.61 The review team recommends:

Recommendation 11

Staffing arrangements in the Watchhouse should be revised to ensure the efficient and effective operation of the Watchhouse at all times. The revision should cover the following:

- Assessment of the challenges involved in custodial duties and of the competencies and capacities required of staff working in the Watchhouse. Staff deployed to Watchhouse duties should have the skills and experience necessary to perform effectively. Where probationary constables are deployed to the Watchhouse they should be under the close and constant supervision of an experienced member.

- A female staff member, sworn or unsworn, should be on duty in the Watchhouse at all times, irrespective of whether a female detainee is in custody.

- Assessment of the numbers of staff required to cope with all aspects of Watchhouse operations during regular busy periods (Thursday, Friday and Saturday nights), as well as for special events and holidays. Adequate numbers of staff must be available to deliver an appropriate level of care to detainees at all times.

- Early development and implementation of appropriate pre-deployment and in-service training packages for all staff deployed to the Watchhouse.

- Early development and implementation of strategies to address the low status of Watchhouse duties within ACT Policing, the impact this has on the morale of staff deployed the Watchhouse, and on the efficiency and effectiveness of Watchhouse operations.

- The early review of the rotation arrangement for Watchhouse constables. This should include the occupational health and safety aspects of the 8 hour shifts. The views of staff should be given due weight in this process.

Recommendation 12

Early attention should be given to revising the supervisory and leadership structures in the Watchhouse. Appropriate accountability mechanisms need to be developed to provide effective monitoring of, and reporting on, Watchhouse operations to Watchhouse management and to the ACT Policing and AFP executive. Areas that need to be addressed include the following:

- Revising the chain of command to ensure that it can deliver adequate guidance and support for Watchhouse staff, enforce consistent operational practices, and provide regular and accurate performance information to senior officers.

- Ensuring that staff charged with command responsibilities understand what these entail and particularly their obligations to provide leadership to junior staff and to deliver on organisational outcomes to senior managers. This may require the identification of appropriate training and leadership development opportunities for the staff involved.

- Development of appropriate monitoring and reporting frameworks to ensure delivery of consistent and appropriate care to all detainees. This will require clarification of performance standards, and collection and analysis of qualitative and quantitative data across all aspects of Watchhouse operations, from performance against cleaning contracts to trends in the use of force. Formal reporting structures will need to be developed and staff required to report regularly against these.

PART 7—COMPLAINTS MANAGEMENT

7.1 Complaints can provide a valuable insight into the administrative health of an organisation. They can give managers early warning of deficiencies that need to be addressed if more serious problems are to be avoided. They can help inform trainers about areas where staff may require additional knowledge or skills. How complaints are handled affects public confidence and perception of organisational transparency.

7.2 The individual's right to make a complaint about the AFP, including ACT Policing, has been set down in legislation since 1981. Complaints about the AFP usually focus on its practices and procedures, or the conduct of individual members.

Complaints about the AFP

Pre December 2006

7.3 Prior to 30 December 2006, complaints from members of the public about the conduct of members of the AFP could be made to the Ombudsman or any AFP member under the provisions of the *Complaints (Australian Federal Police) Act 1981*. Every complaint was jointly managed by the Ombudsman and AFP Professional Standards (PRS). PRS is the operational area responsible for maintaining integrity and professional standards. Usually, PRS undertook the initial investigation unless the complaint related to a PRS member.

7.4 If a complaint was regarded as minor, PRS would refer it to a supervisor (a sergeant or above) in the business area where the officer complained about worked. The supervisor was responsible for conciliating the complaint and hopefully resolving the matter with an explanation or an apology if appropriate. The conciliation process involved speaking with the complainant to clarify the complaint details, speaking with the officer complained about to obtain his or her version of events, and reviewing any relevant documents. If the complaint could not be conciliated or concerned a serious matter, PRS would appoint an Authorised Officer or undertake the complaint investigation directly.

7.5 The Ombudsman examined the reports of all investigations, regardless of whether the original complaint was made to the AFP or the Ombudsman, and decided whether further action was necessary. If action was required, the case might be referred back to PRS for further investigation or the Ombudsman might decide to investigate the complaint independently. Following investigation of any complaint, the Ombudsman could recommend remedial action to the AFP Commissioner. This could include that a member be charged with a criminal offence, a breach of discipline or some other course of action.

Post December 2006

7.6 Following a 2002 review of the AFP's complaints and disciplinary systems (the Fisher Review), the AFP's complaints system has changed. The Complaints Act was repealed and procedures for handling complaints were established in Part V of the *Australian Federal Police Act 1979*. The changed arrangements commenced on 30 December 2006. They are designed to give AFP line managers greater responsibility for the day-to-day professional standards of their staff and to help ensure that AFP and Ombudsman investigative resources are directed to serious and systemic issues. The new system is expected to:

- encourage more timely and efficient resolution of complaints
- provide scope to deal constructively with honest mistakes, or minor lapses of conduct
- acknowledge that the AFP may have contributed to the cause of the complaint through inadequate training, poor supervision or inappropriate practices and procedures.

7.7 Under the new Complaints Management Framework, a complaint is allocated to one of four categories, depending of the seriousness of the matter. Less serious matters (Categories 1 & 2) are dealt with by management action. More serious matters (Category 3) are generally investigated by PRS Investigations, and corruption matters (Category 4) are referred to the Australian Commission for Law Enforcement Integrity (ACLEI). For example, in the Watchhouse, a complaint alleging rudeness to a detainee would be deemed a Category 1 matter, and is likely to be conciliated within the Watchhouse. A complaint alleging the excessive use of force against a detainee would be deemed a Category 3 matter, and investigated by PRS.

7.8 Time limits apply to the handling of complaints. A Category 1 complaint must be completed within 21 days; a Category 2 complaint, within 45 days; and a Category 3 complaint, within 180 days. PRS examines formal records of the handling of complaints.

7.9 The Commonwealth Ombudsman, now designated Law Enforcement Ombudsman (LEO), continues to have external scrutiny of complaints through inspection of files on all complaints and mandatory reporting to LEO by AFP of all Category 3 matters. Consistent with the approach used by the Commonwealth Ombudsman in handling complaints about other agencies, LEO may refuse to handle a complaint until the complainant has exhausted the AFP's internal complaint handling procedures. The Ombudsman may decide to investigate a complaint where the complainant does not feel comfortable dealing directly with the AFP; as well as investigate a matter jointly with the AFP. The Ombudsman is also able to investigate a complaint made directly to him, or conduct an investigation under the Ombudsman Act into 'action relating to a matter of administration'.

7.10 PRS has a central role in complaints management through its Complaint Coordination Team. The team is responsible for

- providing advice to Complaint Management Teams (CMT) and investigating officers
- administering and providing advice on complaints recording
- liaison with the Ombudsman in the exercise of its oversight role and quality assurance reviews of all professional standards matters
- conducting further assessment of complaints prior to allocation to the appropriate CMT in certain circumstances.

7.11 Other PRS teams are responsible for PROMIS Data Integrity; ensuring system consistency in the recording of complaints; and for the development and delivery of integrity training programs and marketing strategies that promote the AFP's Core Values throughout the AFP functional streams.

Complaints recording

7.12 A new recording system for complaints was also introduced in December 2006. The Complaints Recording and Management System (CRAMS) is a web-based facility for recording, managing and storing complaints in an electronic data base. CRAMS enables direct entry of complaint details onto the data base by the member to whom the complaint has been made. The system automatically allocates a category to the complaint based of the nature of the complaint entered. In the Watchhouse, complaints about Watchhouse constables or the arresting officers will be taken by a Watchhouse sergeant. A complaint about the Watchhouse sergeant will normally be taken by a sergeant from City Station.

Complaints in the Watchhouse

Staff understanding of complaints

7.13 The review team was advised by PRS that training in the new Complaints Management Framework was made available for all AFP staff. However, it has not been possible to confirm how many staff in the Watchhouse received training since no attendance records were kept. The review team was also advised that practical training in the use of the CRAMS data base was provided only to PRS staff.

7.14 Most of the Watchhouse staff interviewed by the review team demonstrated limited understanding of complaints management and the value of complaints in providing performance feedback. There was, understandably in light of the current PRS investigations into Watchhouse operations, anxiety about complaints in any form. Complaints were seen as threatening rather than an early warning and an opportunity to learn from experience and improve delivery of Watchhouse services.

7.15 Staff were generally aware of the right of detainees to complain about aspects of their detention in the Watchhouse, and of the role of the Ombudsman. However, very few thought that it was appropriate to remind detainees that they could complain. The common response was ‘we don’t want to ask them to complain.’ Some staff thought it was only to be expected that detainees would complain. Others said they did not necessarily take seriously expressions of dissatisfaction by detainees, especially if they were intoxicated, and did not see them as complaints.

7.16 It is important that detainees who may have difficulty in understanding that they can complain or how to make a complaint are given sufficient information and support. Detainees likely to require assistance include those identified earlier in the report as likely to be ‘at risk’ or who have special needs. For example, the Aboriginal Justice Centre raised with the review team the concerns Indigenous detainees have expressed about retribution if they complain about their treatment in the Watchhouse. Detainees from non-English speaking backgrounds may also be reluctant to complain for similar reasons.

7.17 The review team was advised that no document or handout advising how to complain is available for detainees, or for anyone wanting to make a complaint to the AFP. The Ombudsman was advised some months ago that a brochure setting out how to make a complaint to the AFP was being prepared, consistent with the outcome of the Fisher Review. The brochure was to be published in seven community languages and provided to all potential complainants. Progress on this brochure has been made , but PRS advised that funding for its production has not been allocated and a date for its publication could not be given.

7.18 Video records of Watchhouse operations confirmed that staff did not advise detainees of their right to complain at any point during custody. In some videos, detainees demanding to make a complaint were ignored. Staff explained this by suggesting that many detainees are very angry or intoxicated when they arrive in the Watchhouse and frequently complain about the arresting officers or the way they are handled at the charge desk. Often detainees 'calmed down' after a period in detention, suggesting that they were no longer interested in complaining.

7.19 Review team observations confirmed that many detainees are angry or intoxicated on arrival in the Watchhouse. The demeanour of a detainee when seeking to complain may influence how the request is handled. However, the fact that a detainee is angry and/or intoxicated does not affect the right to complain and does not justify staff in ignoring the request.

7.20 For example, often detainees who are highly intoxicated want to make a complaint when they reach the Watchhouse charge counter. Often they are in no condition to communicate their concerns effectively. After discussion with Watchhouse sergeants and PRS, the review team suggested that all requests to complain made by a detainee should be noted in the Cell Management data base. When leaving the Watchhouse, on transfer to another custodial facility or on release, a detainee who has at any stage sought to complain should be reminded of that by the Watchhouse sergeant and provided with the opportunity to pursue the complaint. There is no reason why this approach should not be adopted with all detainees who indicate during detention their interest in making a complaint.

7.21 Staff in the Watchhouse reported that they had received very few complaints since 30 December 2006. The Watchhouse Manager could recall three Category 1 or 2 complaints that had been conciliated. However, no register of complaints is kept in the Watchhouse. No records are maintained in the Watchhouse to monitor the numbers of the complaints, the issues complained about or their outcome. The Watchhouse Manager may be personally aware, but once the Manager transfers that knowledge will be lost. No formal structures are in place to enable Watchhouse management to use complaint information to improve performance across the Watchhouse; or to inform governance and training requirements. Staff advised that they saw this as the role of PRS.

Watchhouse complaint issues and outcomes

7.22 This review was triggered by concerns raised following serious complaints about Watchhouse operations. The review team examined records of complaints about the Watchhouse for the period 2002-3 to 2006-7.

7.23 Obtaining accurate records of Watchhouse complaints proved difficult. PRS was unable to provide historical consolidated data on the number and outcome of complaints relating to the Watchhouse. In particular, it was not possible to obtain information about what action was taken in relation to complaints that had been dealt with through the conciliation process. For example, a conciliation may have resulted in an acknowledgement by the AFP of error, an apology and perhaps counselling of the member complained about or advice to all members regarding their responsibilities. The review team decided that it would not be an appropriate use of PRS' limited resources to collate this information manually. The discussion about complaints issues and outcomes below is based on information provided by the Ombudsman.

7.24 Table 1 provides a statistical summary from Ombudsman records of AFP, ACT Policing and Watchhouse complaints over this period. The Ombudsman has indicated that the data is not necessarily accurate because the Ombudsman complaint data base does not identify Watchhouse complaints separately. The summary has been prepared by searching the complaints database for key words relating to the Watchhouse. However, it is the best data on Watchhouse complaints available at this time.

7.25 Table 1 shows that over the last five years, ACT Policing complaints have accounted for well over half the complaints received about the AFP. Of these, between 7% and 10% annually have related to the Watchhouse. To 21 February 2007, ACT Policing complaints represent 62% of all complaints received about the AFP in 2006-2007. Of these, 12% related to the Watchhouse.

***Table 1**: Statistical Summary of AFP, ACT Policing and Watchhouse complaints*

Statistical Summary

	2002/03	2003/04	2004/05	2005/06	2006/07	
AFP complaints received	737	712	696	801	553	
ACT complaints received	513	503	443	353	343	*
Watchhouse complaints identified**	40	53	38	30	39	*
Watchhouse Issues identified**	87	112	101	75	61	*
Watchhouse complaints substantiated***	11	7	5	0	1	
Watchhouse issues substantiated***	5	3	2	0	1	

* Figures represent complaints received 1 July 2006 to 21 February 2007 and include Category 3 notifications

** Figures are not definitive. The Ombudsman's office usually distinguishes only if the complaint is about ACT Policing. These figures are based on searches of complaints including the word 'Watchhouse' in the narrative of the complaint or "Custody" in the Issue String. These searches returned 3000+ complaints, so further analysis was completed on the issue strings of the returned complaints. Searches were conducted on 500+ complaints considered likely to be complaints about the Watchhouse.

*** Figures represent complaints and issues closed 1 July 2002 to 21 February 2007. Figures indicate complaints or issues closed during the financial year. Figures do not include statistics relating to open cases as at 21 February 2007.

7.26 The Ombudsman has also provided, for Watchhouse complaints between 2002–03 and 2006–07, information about the issues complained about, and the complaint outcome. Most complaints related to failure to provide medical assistance, assault or excessive use of force, property matters, including failure to return all property, and failure to provide access to legal representation or telephone calls. A summary of substantiated issues relating to complaints received complaints is in Table 2.

7.27 The number of complaints about the Watchhouse is relatively small. However, some of the issues raised by the complaints are very serious and have given rise to allegations of assault on detainees by Watchhouse staff. It is also important to note that in many of the instances recently examined by PRS, the detainees concerned had not made a complaint. In light of the lack of advice given to detainees about their rights in custody, including their right to complain about their treatment, it is doubtful that the relatively low number of complaints is an accurate reflection of the level of detainee concern.

7.28 The review team examined the written and video records relating to a number of these complaints as well as selected video and other records of Watchhouse operations. Apart from incidents that gave rise to complaints, the examination identified a number of instances where the behaviour of staff fell below standards of best practice in delivery of care to detainees. Some of these have been covered earlier in the report. It is not clear why some of these detainees did not complain about their treatment. In some cases the detainees may have been too intoxicated to comprehend fully what was happening. Observations of the review team suggest that some detainees did not complain because they had reason to believe that their complaints would not be given serious consideration.

7.29 Feedback to the review team from interest groups suggests that timeliness of complaint resolution may deter some Watchhouse complainants. The review team acknowledges that there have been lengthy delays in the handling of AFP complaints. The pre-December 2006 requirement that the Ombudsman oversight handling of all complaints about the AFP may have contributed to these delays. The new CRAMS system is intended to improve handling times, with time limits established for resolution of complaints in different categories.

***Table 2**: Summary of substantiated issues in Watchhouse complaints 2002–03 to 2006–07*

Cause of complaint	Total
Adequacy of Practice and Procedures	2
Application of Law/Rule	1
Assault	5
Damage of Property	1
Delay	1
Use of Excessive Force	3
Fail to Provide Advice	1
Failure to Act	5
Neglect Of Duty	6
Unlawful Practice and Procedure	4
Unreasonable Practice and Procedure	3
Use of Weapon	1
Wrong Decision/Action	3
Grand Total	36

Ombudsman investigations

7.30 The Ombudsman has from time to time conducted investigations into aspects of Watchhouse operations or into AFP activities that affect the Watchhouse. These investigations have usually been undertaken in response to complaints to the Ombudsman that suggest there may be a systemic problem that requires attention. A list of Ombudsman investigations relevant to the Watchhouse undertaken over the last ten years is at Appendix 11.

7.31 The Ombudsman has made several recommendations for improvements to Watchhouse procedures or facilities as a result of these investigations. These have included recommendations relating to the handling of intoxicated persons, search procedures, and CCTV recording and monitoring of Watchhouse operations. The Ombudsman is currently undertaking an investigation into intoxicated persons in the

Watchhouse that will consider the use of the Sobering Up Shelter. The report of this investigation should be released later in the year.

Learning from experience

Role of PRS

7.32 PRS has a pivotal role in oversighting complaints management, investigating the more serious complaints, and utilising complaint information to improve performance across the AFP. However, the focus of PRS activities is very much on dealing with problems rather than working proactively to avoid them.

7.33 The review team was unable to identify many instances where PRS had adopted a proactive approach to complaints management. A significant amount of complaint and other data appears to be collected by PRS, but it does not appear to be used in a structured way to analyse or improve performance. For example, the review team was advised that PRS receives copies of all use of force reports. It appears these are simply held in PRS in case they are needed to investigate a complaint made regarding the incident covered by the report. PRS undertakes no analysis unless a complaint is made. For example, an increase in the number of reports relating to use of force in a particular location, or of a particular type of force, does not trigger a review of reports that might help identify gaps in AFP training or understanding of requirements. This kind of analysis of performance information can be helpful in identifying emerging problems and limiting the number of complaints.

7.34 The review team was concerned by the negative view many Watchhouse staff expressed about PRS. Staff acknowledged the value of an internal mechanism for investigating complaints against staff and monitoring staff compliance with legislative and procedural requirements. However, staff believed such a mechanism should also be a source of advice and support, particularly when they sought assistance in interpreting or understanding those requirements. Many members said they were not confident of receiving assistance from PRS. They felt PRS was more interested in catching them out than helping them to do the right thing.

7.35 By way of example, several Watchhouse staff referred to their uncertainty about the requirements for use of force reporting in the Watchhouse. They told the review team that they had sought clarification from PRS but it had not been provided. The review team is not suggesting that the responsibility for determining the content of the AFP's procedural framework rests with PRS. However, there would seem to be a role for PRS in advising staff in situations where the requirements are clear, or, if the requirements are unclear, drawing that lack of clarity to the attention of the appropriate area.

7.36 PRS could also take a more proactive role in identifying and remedying systemic problems that may give rise to complaints. While records indicate that PRS has undertaken research to identify systemic problems in the past, it seems no procedures are in place to ensure remedial action is taken. For example, in 2002, the then PRS Risk Analysis and Intelligence Team responded to the 'numerous' complaints made about the Watchhouse between 1 January 1999 and October 2001 by conducting an audit of Watchhouse operations. The audit identified three issues that were likely to have contributed to the number of complaints. They were:

- Detainees' limited understanding of their rights. No advice was provided to detainees when they arrived in the Watchhouse.

- Deficiencies in video coverage in the Watchhouse. Lack of coverage may have encouraged vexatious complaints and meant that it was sometimes difficult to determine what had occurred.

- High level of intoxication of some detainees. The level of intoxication may have affected detainee perceptions and resulted in complaints being made unnecessarily.

7.37 The audit made recommendations that are consistent with those made by the review team. They include that:

- Detainees should be given advice on their rights and obligations during custody.
- The CCTV video system should be upgraded.
- A single procedural guide should be developed for the Watchhouse. Practical guides in use in police custodial facilities in other jurisdictions were recommended as models.
- A specific training package for Watchhouse staff should be developed.

7.38 The review team attempted to determine what had occurred following the audit. There was no evidence of an implementation plan, or that any action was taken to address the recommendations. The review team was not able to determine where, within ACT Policing, responsibility for coordinating implementation of recommendations that cross several operational areas should rest. Staff suggested that training aspects, for example, would be the responsibility of Learning and Development; Performance and Planning should be responsible for procedures. In the absence of any coordinated approach, it is not surprising that the recommendations of the audit were not implemented.

A new approach to complaints

7.39 The review team observed that complaints are widely regarded by staff as a problem. This view is evidenced by anxiety about the role of PRS and 'being investigated', and by the secrecy that surrounded complaints and their outcomes in the past. Anxiety levels are exacerbated by staff perceptions that they lack advice on what they should be doing. Members are reluctant to express concern about procedures, to acknowledge that they could have done something better, or to learn from mistakes and the experiences of others. Rumours and misinformation thrive in such an environment.

7.40 No one likes complaints, but in all organisations, including the Watchhouse, complaints can provide invaluable feedback on performance. They can clarify staff understanding of appropriate procedures and behaviours. They can reassure staff that they are doing the right thing. Most importantly, they can ensure the interests of the public are protected as effectively as possible.

7.41 All staff in the Watchhouse face the same challenges in providing adequate care to detainees. However, the review team observed limited exchange of information between the sergeants and constables on different shifts about how to handle problems. For example, in response to a problem one Watchhouse sergeant had experienced, he sent an email reminding his colleagues about the requirements for dealing with Indigenous detainees. Review team observations suggest that this commendable action is very much the exception rather than the rule. There was no

evidence that the Watchhouse Manager, for example, routinely ensured all staff were aware of the issues raised by complaints. When staff turnover is so high, this sharing of information can help ensure lessons learned are not lost.

Review team opinion

7.42 A new approach to complaints is required that emphasises the opportunities complaints provide to improve outcomes for staff and for detainees. PRS has a role to play, but there needs to be an organisational acknowledgement, from the AFP and from ACT Policing of the importance of feedback from detainees and from staff.

7.43 The right to complain is integral to good administrative practice. However, the review team was not confident that arrangements for accepting and handling complaints about the Watchhouse are adequate. Detainees are not given appropriate advice about their right to complain and there is evidence that some staff are unwilling to take a request to complain seriously, especially if the detainee is intoxicated. Training is required to ensure that all staff understand their obligations in relation to complaints and have the skills required to manage detainees seeking to complain.

7.44 Improvements in record keeping and analysis of complaints about the Watchhouse are required. PRS is ideally placed to consolidate performance information derived from complaints and complaint outcomes across ACT Policing and the AFP. Data about complaints that are resolved quickly and do not require entry into CRAMS should be recorded consistently and be easily available in a form that facilitates analysis. Similarly the outcomes of conciliated complaints, including any action taken, such as an apology or explanation, should be consolidated. Regular performance reports are required to inform the ACT Policing executive about key issues raised, complaint outcomes, and trends. A mechanism is required to ensure that any recurring themes or recommendations arising from complaints can be brought to the attention of relevant operational areas, such as training or governance. Any recommendations must be accompanied by implementation plans, including feedback to the executive on progress in implementation.

7.45 Best practice in the Watchhouse requires an openness to questioning whether the procedures in place are delivering the best possible care to detainees. A more proactive role for PRS in supporting staff would assist. Some members interviewed by the review team recalled that PRS, or its predecessor, had formerly provided all staff with regular updates on complaint issues and changes to procedures of which staff should be aware. The information was presented in a newsletter format and was positively received by staff. Such updates can help ensure that all staff are aware of current performance issues and remind them of their obligations to comply with AFP and ACT Policing standards and values.

Recommendations

7.46 The review team recommends the following:

Recommendation 13

Appropriate and accessible materials should be developed to advise detainees about their right to complain about the AFP. This information should also be accessible to persons with language or understanding difficulties.

Recommendation 14

Complaint handling arrangements in the Watchhouse should be revised to ensure all staff have received training necessary to:

- Advise a detainee of the right to complain and how to go about making a complaint.

- Recognise when a detainee may require assistance in making a complaint; or when it would be appropriate to confirm whether the detainee wants to proceed with an intention to lodge a complaint.

- Distinguish between matters that can be resolved to the detainee's satisfaction by an explanation and do not require further consideration or entry into CRAMS.

- Record complaints appropriately within CRAMS.

Recommendation 15

PRS should take a more proactive approach to complaints management and the issues arising from complaints. This includes:

- Reviewing the recording of and reporting on complaint data to ensure that the performance of the Watchhouse can be monitored adequately. As a minimum, reports should be available on the number of complaints in each category, the issues raised, action taken and outcomes, and the time taken for resolution.

- Providing regular feedback to staff about complaint issues, informing staff about the recent legislative or procedural changes, and identifying areas where staff may benefit from reminders about their obligations and responsibilities.

- Developing a framework to ensure that any proposed actions or recommendations for performance improvements arising from complaints are implemented. This includes recommendations arising from individual complaints, as well as from audits or systemic reviews.

PART 8—OTHER ISSUES ARISING

8.1 During the course of the review, the issues discussed below came to the attention of the review team. Some relate primarily to the Watchhouse, others may be of interest in the broader operations of ACT Policing or the AFP. The review team has not made recommendations on these issues.

Alternative custodial models

8.2 The purpose of the review was to examine the operations of the Watchhouse and to recommend ways in which the management of detainees might be improved. The review team identified a number of deficiencies in Watchhouse procedures, staffing and management, and has made recommendations directed to enhancing outcomes within the current Watchhouse management framework. Implementation of these recommendations will improve the standard of care provided to detainees in the Watchhouse. However, it is worth considering whether continuing the Watchhouse under police management is the best use of policing resources and in the best interests of detainees.

8.3 ACT Policing resources are limited, and it must be acknowledged that police do not regard caring for persons in custody as central to a community policing role. There is ample evidence that many police look on custodial duties as much less important than prevention of crime and providing a safe community environment. This is reflected in the lack of procedural guidance and training provided to staff on caring for detainees, and the perception that Watchhouse duties are for police who perform poorly in other policing duties, or who need to be punished for some reason. Lack of interest in, and enthusiasm for, custodial duties is evident at all levels, and undoubtedly influences the way police tasked with custodial duties perform.

8.4 The review examined management structures for similar custodial operations in other jurisdictions. Of particular interest to the review team were facilities where responsibility for detainees after charging was handed to staff responsible solely for their care in custody. These staff were not sworn police but were specifically and comprehensively trained to care for persons in a custodial environment.

8.5 The advantages the review team observed in having a dedicated, trained custodial workforce include:

- Standard operating procedures for the facility that
  - provided comprehensive instruction on all aspects of custodial care within that facility;
  - were regularly reviewed and updated to accommodate changes in legislation or best practice standards.

- Tailored pre-employment and in-service training in all aspects of detainee care, including
  - sound understanding of staff duty of care to ensure detainee safety, health and well-being; and
  - use of force in a custodial setting.

- Strong staff morale. This stemmed from staff confidence
  - in the value of the work being undertaken

- possession of the skills and experience necessary to perform their duties to a high standard.

- Strong reporting and accountability structures that provided performance information to identify any problems in delivery of custodial services; and to remedy them.

- Ready access to backup staff when required to manage busy periods.

8.6 The review team noted that in 1998 responsibility for custody of detainees in the ACT court cells passed from ACT Policing to ACT Corrective Services. ACT Corrective Services is also responsible for the staffing of the Belconnen Remand Centre and will staff the new ACT prison when it is completed in 2008. It may be appropriate to consider whether it might now be timely to transfer responsibility for custody of detainees in the Watchhouse to ACT Corrective Services.

8.7 The review team considered the emotional nexus between police who have arrested a detainee and the police who subsequently process and care for the detainee in the Watchhouse. In our view, this nexus was at times so strong that it influenced adversely the behaviour of Watchhouse staff. This is not in the best interests of detainees.

Recommendation 16

ACT Policing should consider examining the feasibility of alternative custodial models, including staffing the Watchhouse with both sworn and unsworn members or drawing on other agencies such as Corrective Services.

Streamlined charging

8.8 The review team noted that with the introduction of electronic 'on line' charging several years ago, lodging and charging of detainees once they entered the Watchhouse was smooth and efficient. However, procedures around entry to the Watchhouse should be revised to ensure that detainees are not held unnecessary in police vehicles while any Watchhouse charging backlog is cleared. The single charge counter in the Watchhouse limits the rate at which detainees can be charged. For every detainee charged, the arresting officers will be away from their patrol or beat preparing the documentation required for charging.

8.9 Faster processing of detainees could be achieved with an additional charge desk during busy periods, either within the Watchhouse or in another station. Tuggeranong station was built to accommodate a charge counter, and could be staffed to provide full charge, bail and custodial facilities. Costs associated with operating a separate facility would be higher than those required for staffing a second charge desk in the Watchhouse.

8.10 A 'fast track' charge system used in the Brisbane Watchhouse to reduce the time arresting officers are away from patrol or beat duties might be adapted for use in the ACT. The 'fast track' system operates only at peak times. A detainee is brought into the Brisbane Watchhouse by the arresting officers and placed in a holding cell, as usual. However, the arresting officers then provide an oral briefing to a designated Watchhouse staff member who is tasked solely with preparation of the documentation required to support charging of the detainee. This frees up arresting officers to go back on patrol or beat. The documentation is prepared and checked

with the arresting officers before being considered by the charge sergeant.

Integrity of video records in Belconnen, Gungahlin, Woden and Tuggeranong Police Stations

8.11 The review team noted concerns about management of the CCTV records in the Watchhouse and has made recommendations for improvements. Similar concerns exist in relation to the integrity of video records in the Belconnen and Gungahlin Police Stations. For example, at Belconnen, used tapes were labelled and housed in a locked room, and the key to the room was held on the desk of the OIC of Belconnen Station, easily accessible to all staff. In Gungahlin, staff on duty during the review team's visit demonstrated little understanding of how to use the video recording system. They could not explain the procedures for safe itemising, storing and archiving of records.

8.12 Few persons are detained in the holding cells in police stations around the ACT—Gungahlin staff reported their holding cell had been used once in the previous 12 months. Nevertheless, all staff should understand the procedures for operating the video recording systems in their stations and for maintaining the integrity of any records created. ACT Policing may wish to consider the development and implementation of standardised procedures for handling video recordings across the ACT.

Improving use of force reports

8.13 The review involved the scrutiny of procedures for use of force reporting in the AFP and in other jurisdictions. Beyond the recommendations arising from consideration of use of force in the Watchhouse (see Part 4), the review team noted other aspects of the reporting process might be improved across the AFP.

8.14 Currently, where more than one member has been involved in an incident where force was used, only one report is prepared, usually by the member who took the lead in the incident. There appears to be no process in place to enable the accuracy of the report to be checked against the recollections of other members present during the incident. In fact, the review team was advised by Watchhouse staff that when they have been present at an incident involving use of force, they have rarely been asked to comment on a report of the incident completed by another member.

8.15 In other jurisdictions, it is not uncommon for a separate use of force report to be completed by every person present at the incident, regardless of whether every person used force. Each person must complete his or her report independently and without consulting others present during the incident. The review team was advised that this process gave supervisors a degree of confidence that they were receiving an accurate account of what occurred.

8.16 Other jurisdictions also appeared to have clearer and more rigorously enforced procedures governing completion of use of force reports than those within the AFP. For example, some Watchhouse staff report they are still unclear about when a use of force report should be completed; and there is limited assessment of the accuracy of reports by Watchhouse management. By comparison, reports in relation to use of force by court cells staff are closely scrutinised by management and disciplinary action taken when staff do not comply with reporting requirements.

Cultural issues in ACT Policing

8.17 Good administration requires commitment at all levels, and particularly at senior levels. The review revealed evidence of a lack of commitment to follow through on a task to the point of completion, particularly among some of the senior staff responsible for providing leadership. In relation to the Watchhouse, their actions suggested that they saw leadership solely in terms of ensuring staff adhered to current practice. They appeared to see no need to explore whether practice was appropriate to deliver the outcomes required in the Watchhouse. The review team saw no acknowledgement of, or attempt to, address the poor morale in the Watchhouse.

8.18 During the course of the review, many Watchhouse staff raised with the review team their misgivings about aspects of Watchhouse operations. They identified a number of the deficiencies covered in this report, and some proposed innovative and sensible ways to address them. The review team was concerned that staff routinely reported having raised these issues, and the proposed solutions, with senior staff with limited or no success. An example is the draft Watchhouse Manual.

8.19 The staff responsible for drafting the Manual were aware of the need for practical, day-to-day guidance on caring for detainees. Watchhouse management was aware of the need and aware that staff decided to start drafting their own Manual in April 2006. But the members who initiated work on the Manual have largely moved on. Some other sergeants have picked up the drafting, as other commitments and interests have allowed. No one in Watchhouse management took responsibility for moving the project forward until this review commenced. The Manual is still in draft and still incomplete.

8.20 While the review was in progress, the review team drew to the attention of Watchhouse management issues that the team believed needed to be given priority, preferably before completion of the review. Although the response from ACT Policing executive was commendable, the response from Watchhouse management was disappointing. Some issues were addressed, some were not. Of those that were pursued, some were given a cursory examination and taken no further, despite repeated requests for advice on progress. In other cases, the issue was acknowledged and preliminary action taken. But the action was not always followed up and progress on many issues appears to have languished.

8.21 An apparent lack of commitment to achieving organisational objectives was evident well beyond the Watchhouse. For example, accurate and comprehensive procedural guidance is essential to consistently high standards of administrative practice across the AFP. Almost all the AFP and ACT Policing governance documentation considered by the review team had areas that were out of date or wrong. The review team was advised that new guidelines have recently been issued to facilitate updating of the governance framework. However, we were advised that a lack of staff to undertake this work has limited the updating of governance documentation in the past. Implementation of the new guidelines will require an appropriate staffing commitment.

Appendices (*Not reproduced in printed report)*

Appendix 1—Photographs

a. Sally port

b. Watchhouse charge counter

c. Watchhouse workroom with CCTV monitors

d. Holding cells

e. Single cell

f. Group cell

g. Common area outside female cells

h. Toilet and bubbler (in all cells except drug evidence and padded cells)

i. Toilet in padded cell

Appendix 2—List of Acronyms

ACLEI	Australian Commission for Law Enforcement Integrity
ACT	Australian Capital Territory
AFP	Australian Federal Police
AJC	Aboriginal Justice Centre
ALS	Aboriginal Legal Service (ACT & NSW)
CATT	Crisis Assessment and Treatment Team
CCTV	Closed Circuit Television
CFACTS	Clinical Forensic ACT Service
CMT	Complaint Management Team
CO	Commissioner's Order
COMB	Commonwealth Ombudsman
CRAMS	Complaint Reporting Management System
DCPO-R	Deputy Chief Police Officer — Response
DHCS	Disability, Housing and Community Services (ACT)
DVD	Digital Video Disc
DVR	Digital Video Recorder
LEO	Law Enforcement Ombudsman
MOU	Memorandum of Understanding
NESB	Non-English Speaking Background
OC	Oleoresin Capsicum
OH&S	Occupational Health & Safety
OIC	Officer in Charge
OSA	Operational Safety Assessment
OSC	Operational Safety Committee
PROMIS	Police Realtime Online Management Information System
PRS	Professional Standards
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
SEALS	South Eastern Aboriginal Legal Service

Appendix 3—Comparative summary of State/Territory police custodial arrangements

	A.C.T. (City)	N.S.W. (Queanbeyan)	Victoria (Wodonga)	Tasmania (Hobart)	S.A. (Adelaide)	W.A. (Perth)	N.T. (Darwin)	Qld. (Brisbane)
No. of cells:	28	5	7	Remand Centre	45	17	15	62
Staffed by:	Police only.	Police & Corrective Services. Police undertake pre-charge detention and charge duties. When a detainee is charged and bail refused, the detainee is transferred into the custody of Corrective services (co-located in the Queanbeyan W/House).	Police only.	Corrective Services. Charge room only in Police Station. Hobart Remand Centre is located next door to Hobart Police Station, whereby both pre & post-charge detainees are transferred into the custody of Corrective Services.	Police only.	Police only.	Police and Police Auxiliaries. *NB: "The aim of the Police Auxiliary scheme is to employ Police Auxiliaries for Police Duties of a less complex nature."*	Police & Civilians. Police perform custodial and judicial function. Police are assisted with the custodial function by unsworn Assistant W/House Officers.

	A.C.T. (City)	N.S.W. (Queanbeyan)	Victoria (Wodonga)	Tasmania (Hobart)	S.A. (Adelaide)	W.A. (Perth)	N.T. (Darwin)	Qld. (Brisbane)
Types of detainee:	Pre-charge. Post-charge (pending transfer to Court on day of sitting). Intoxicated.	Pre-charge. Post-charge.	Pre-charge. Post-charge. *NB: Prisoners can be held up to 14 days.*	Pre-charge. Post-charge.	Pre-charge. Post-charge. Corrections Prisoners.	Pre-charge. Post-charge. 12 x 'Trusty Prisoners'. *NB: 8,400 detainees per annum (average 23 daily).* On Thursday, Friday and Saturday nights, may have up to 40 detainees lodged.	Pre-charge. Post-charge.	Pre-charge. Post-charge. *NB: Average number of detainees in custody is 50–60.*

	A.C.T. (City)	N.S.W. (Queanbeyan)	Victoria (Wodonga)	Tasmania (Hobart)	S.A. (Adelaide)	W.A. (Perth)	N.T. (Darwin)	Qld. (Brisbane)
No. of staff (per shift):	3 x Police: • 1 x Sgt • 2 x Const.	1 x Police: • Custody Manager (Sgt or S/C) 2 x Corrective Services.	2 x Police: • 1 x S/c (W/H Keeper) • 1 x Const. Both members perform W/House and front office duties simultaneously	1 x Police Custody Officer (Sergeant) Performs a judicial function and transfer role only.	4 x Police: • 1 x W/H Sgt • 1 x Senior Cell Guard • 2 x Cell Guards.	11 x Police: • 2 x Sgt • 9 x Const.	3 x Police: • 1 x W/H C'mndr (Snr. Sgt) • 2 x Police Auxiliaries.	6 x Police; & 6 x W/House Assistants: • 1 x Duty Snr Sgt • 1 x Charge Sgt • 4 x Const. • 6 x W/H Assistants
Surge capacity:	No. Overtime utilised on New Years Eve to roster an extra W/House team.	Not specified.	No.	Not specified.	Not specified.	Yes. Back-up team deployed for peak periods (6pm–2am Thu, Fri & Sat). Surge includes a Nurse and a Justice of the Peace.	Yes. During 'high demand' shifts, an additional member may be rostered. Special events where an Operational Order is promulgated may include rostering of	Yes. Extra members are deployed on Fri & Sat evenings.

	A.C.T. (City)	N.S.W. (Queanbeyan)	Victoria (Wodonga)	Tasmania (Hobart)	S.A. (Adelaide)	W.A. (Perth)	N.T. (Darwin)	Qld. (Brisbane)
							additional W/House staff.	
Dedicated W/House Manager	Yes (Sgt)	No. Police Custody Manager reports to the shift Sgt and Duty Officer.	No. The W/House Keeper reports to the shift Sgt, who reports to Station Manager.	No. Inspector in charge of the Division is responsible for oversight of the Charge Room.	No. W/H Sgt reports to the Adelaide Operations Snr Sgt.	Yes (Snr. Sgt) W/House OIC is supported by an Admin Officer (S/C).	No. W/House C'mndr reports directly to the shift Duty Supt.	Yes • W/H Insp. • OIC (Snr. Sgt) • 2 x AO3 Admin; & • 1 x AO2 Admin Officer.
Rostered shifts:	8 hours	Police • 12 hours Corrective Services • 8 hours.	8 hours	8, 9 & 10 hours	8 hours	12 & 8 hours	8 & 10 hours	8 hours
Staff deployment periods:	Sergeant • 12 months Constable	Police Custody Manager is rostered from patrol on a shift-by-shift basis.	Rostered daily from station resources.	Hobart Uniform Branch is responsible for operation of the Hobart	Sergeant • 6 months Cell Guards	Sergeants • not less than 12 months; If an Officer	No specific period of deployment.	For substantive Police Officers, generally no more than 2

	A.C.T. (City)	N.S.W. (Queanbeyan)	Victoria (Wodonga)	Tasmania (Hobart)	S.A. (Adelaide)	W.A. (Perth)	N.T. (Darwin)	Qld. (Brisbane)
	• 20 weeks	Corrective Services are deployed to W/House & Court cells for indefinite period.		Charge Room. Uniform Branch Sergeants alternate between patrol and charge duties on a daily basis.	and Senior Cell Guard are drawn from patrol resources.	serves in the W/House for 24 months or more, this is regarded as 'country service'. Probationary Constables 15 week rotation.		years. Probationary Constables must complete a 2 week rotation.
CCTV	Digital CCTV of entire W/House; • 54 cameras. All W/House footage is transferred from hard drive onto digital tape. Digital tapes are archived for 10 years.	CCTV of entire Watchhouse, but only the Admission and dock (pre-charge) area are recorded.	Digital CCTV recording is stored for one week on a hard-drive —unless specifically copied for evidentiary purposes.	Not specified.	CCTV video recordings are archived.	CCTV throughout all cells and W/House: • Only the admission area is digitally recorded • 91 days overwrite.	Digital CCTV recording.	CCTV throughout Watchhouse. Majority of cameras record 1 frame per 3 seconds. 'At Risk' cameras record 4 frames per second. CCTV recordings are archived for 186 days.

	A.C.T. (City)	N.S.W. (Queanbeyan)	Victoria (Wodonga)	Tasmania (Hobart)	S.A. (Adelaide)	W.A. (Perth)	N.T. (Darwin)	Qld. (Brisbane)
Training	No formal training. On-the-job.	Police Custody Manager training is a one day workshop. Corrective Services basic (recruit) training is 3 months.	No formal training. On the job.	No formal training. On the job & read procedures. Recent review highlighted a lack of training.	Not specified.	One training day, every 5 weeks. Courses: • basic fire extinguish • St John's Senior First Aid • Life Support • Confined space & cell extraction • Certificate III & IV in Custodial Services.	Initial induction training (position specific) is 5 weeks.	Formal training program for Assistant W/House officers. Sworn officers receive induction package prior to their deployment in the W/House.

Appendix 4—Comparative summary of ACT Policing cells

	City	*Tuggeranong*	Woden	Belconnen	Gungahlin
Number of cells	28	5	5	2	1
Provision of natural light	Yes • Outside group cells • In male, female & intoxicated persons common areas.	No	Partly from skylight	No	No
Cell quality	Good	Good	Good	Poor • Old scuffed paintwork • Poor air circulation (air-conditioning does not work).	Good
Toilet in cell	Yes (except drug evidence cell)	Yes	Yes	No	Yes
Bubbler in cell	Yes (except padded & drug evidence cells)	Yes	Yes	No	Yes
Bedding	Mattress & blankets	Blankets, but no mattress.	Blankets, but no mattress.	Blankets, but no mattress.	Mattress & blankets

	City	Tuggeranong	Woden	Belconnen	Gungahlin
CCTV	Digital recording of all cells and public areas. All recordings downloaded and archived for 10 years.	VCR—responsibility of Arresting Officer to record. Tape is exhibited after use.	Digital recording activated by 'movement'. CCTV overwrites itself after a period of one month. CCTV is not routinely downloaded. To download footage onto a disc, a DKS technician is required.	VCR—responsibility of Arresting Officer to record. Tape is exhibited after use.	VCR—responsibility of Arresting Officer to record. Tape is exhibited after use.
Monitoring	Operates 24/7. Detainees monitored by: • 1 x W/H Sgt; • 2 x Const.	CCTV monitors in front office and staff muster room. Detainee is monitored by both front-office members and Arresting Officer/s.	Arresting Officers seated immediately outside cell.	CCTV monitor in front office. Detainee is monitored by front-office members and. Arresting Officer/s.	CCTV monitor in front office. Detainee is monitored by front-office member (during 10am—6pm), and Arresting Officer/s.
Charge counter	Yes.	Yes	No	No	No
OC decontamination shower and eye wash.	OC decontamination shower and eye wash in sally port.	Showering facilities inside Watchhouse.	Eye-wash in sally port. Showering facilities inside Watchhouse.	No	No
Non-contact Visitors Room	Yes (2)	Yes (1)	No.	No.	No.

Appendix 5—Statistical breakdown of persons in custody at the City Watchhouse 2002 to 2007

Number of persons taken into custody in the City Watch House by reason for custody

Reason for custody	Financial year				
	2002-03	2003-04	2004-05	2005-06	2006-07*
Arrested	2911	2894	2526	2972	2073
Immigration	25	59	35	0	0
Intoxicated	696	844	1102	1563	1098
Intoxicated then charged	9	12	25	23	17
Parole Hearing	0	5	2	1	0
Serving/Sentenced prisoner	2	7	4	2	1
Total in custody	**3643**	**3821**	**3694**	**4561**	**3189**

Source: PROMIS database as at 01 March 2007

* 01 July 2006 to 28 February 2007

Number of persons taken into custody in the City Watch House by gender

Gender	Financial year				
	2002-03	2003-04	2004-05	2005-06	2006-07*
Male	3067	3096	3121	3870	2713
Female	574	723	573	691	475
Not specified	2	2	0	0	1
Total in custody	**3643**	**3821**	**3694**	**4561**	**3189**

Source: PROMIS database as at 01 March 2007

* 01 July 2006 to 28 February 2007

Number of persons taken into custody in the City Watch House by Indigenous status

Indigenous status	Financial year				
	2002-03	2003-04	2004-05	2005-06	2006-07*
Aboriginal	376	336	409	495	317
Torres Strait Islander	7	13	29	27	12
Aboriginal and Torres Strait Islander	0	0	0	0	0
Non-Indigenous	3260	3472	3256	4039	2860
Total in custody	**3643**	**3821**	**3694**	**4561**	**3189**

Source: PROMIS database as at 01 March 2007

* 01 July 2006 to 28 February 2007

Number of persons taken into custody in the City Watch House by age status

Age status	Financial year				
	2002-03	2003-04	2004-05	2005-06	2006-07*
Adult	3237	3402	3332	4044	2844
Juvenile	406	419	362	517	345
Total in custody	**3643**	**3821**	**3694**	**4561**	**3189**

Source: PROMIS database as at 01 March 2007

* 01 July 2006 to 28 February 2007

Number of persons taken into custody in the City Watch House by time in custody

Time in custody	Financial year				
	2002-03	2003-04	2004-05	2005-06	2006-07*
Less than 2 hours	396	340	271	233	183
2 to 4 hours	580	590	521	548	347
4 to 6 hours	532	518	475	482	266
6 to 8 hours	700	848	952	1044	755
8 to 10 hours	255	298	467	959	768
10 to 12 hours	231	209	197	310	228
12 to 24 hours	847	907	723	891	572
24 to 48 hours	86	97	72	72	62
48 to 72 hours	1	0	1	3	1
72 hours and above	2	2	0	1	0
Release time and date not specified	13	12	15	18	7
Total in custody	**3643**	**3821**	**3694**	**4561**	**3189**

Source: PROMIS database as at 01 March 2007

* 01 July 2006 to 28 February 2007

Appendix 6—Detainee assessment questionnaire

Are you taking any tablets, drugs or medication?

Are you an epileptic?

Are you a diabetic?

Are you an asthmatic?

Are you being treated for heart disease?

Are you ill in any way?

Have you been injured recently?

Have you been held in custody before?

Have you ever tried seriously to hurt yourself?

How much alcohol have you consumed?

How would that amount of alcohol usually affect you?

Do you have any concerns in relation to your level of intoxication?

Have you consumed any recreational drugs?
The reason I am required to ask you this question is for our information only, so that we are able to better monitor your welfare whilst you are in our custody.

Are you an Aboriginal or Torres Strait Islander?
If yes, ensure aboriginal legal service is notified by phone and facsimile. Record the results in the comments section.

Are you under 18 years of age?
If yes, enter their age in the comments section.

If under 18 years of age, has a parent or guardian been advised of your arrest?
If not, what attempt has been made to do so? (what is their phone number etc?)

Appendix 7—Visual assessment checklist

Any obvious pain, injury or illness?

Any suicide signs?

Any obvious sign of infection?

Asked for medication?

Appears to be under the influence of alcohol or drugs?

Visible signs of alcohol / drug withdrawal?

Carrying medication or street drugs?

Show agitation or aggressiveness?

Appearance of despondency?

Carrying neck or wrist scars which suggest previous self-injury?

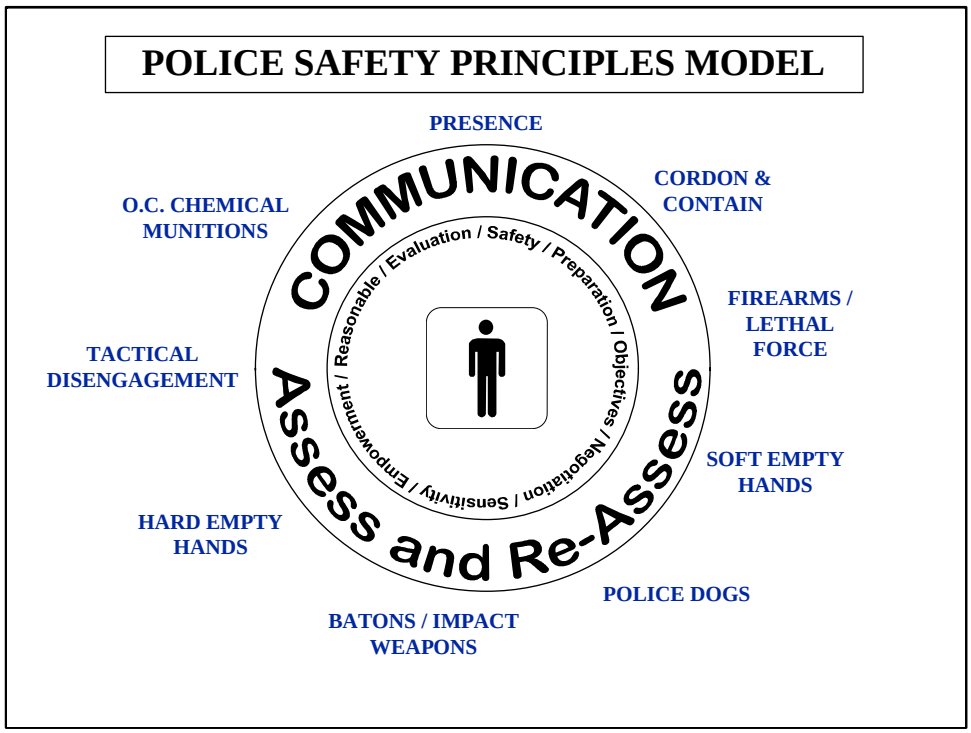
Has made threats or has history of self-injury in custody?

Appears irrational or mentally disturbed?

Any medical conditions that police should be aware of?
More remarks?

If anyone should call here whilst you are in custody saying that they are a friend of yours, a member of your family or a legal practitioner acting on your behalf, do you have any objections to them being told you are here?

Appendix 8—Australian Federal Police Safety Principles Model



Reasonable

. Any application of force must be reasonable, necessary & proportionate to the threat or resistance offered.

Evaluation

. Prior intel gathering and evaluation may reduce the need for later use of force

. Conduct risk assessments

Safety

. The primary consideration must be the safety of all persons involved

Preparation

. Mental and physical

. Planning is critical

. Consider limitations and parity/disparity

Objectives

. Should be continually re-assessed

. Do not lose sight of aims & objectives merely because of confrontation

Negotiation

. Negotiation is the primary preferred means of confrontation management

. Communication should be active and ongoing wherever possible

. Cordon and containment options are preferred - forced entries are to be avoided

Sensitivity

. Adoption of communication strategies for dealing with the mentally ill

. Acceptance and accommodation of cultural diversity in interactions

. Sensitivity to the persons and issues involved

Empowerment

. Acceptance of responsibility and accountability

. Allocation of appropriate resources

. Effective command and control - assertive communication style

Appendix 9—Table of State/Territory police jurisdictions using OC foam

	Jurisdiction					
	NSW	QLD	VIC	SA	WA	NT
Use of foam	No	Yes	Yes	No	No	Yes
Watchhouse	No	Yes	Yes*	No	No	Yes

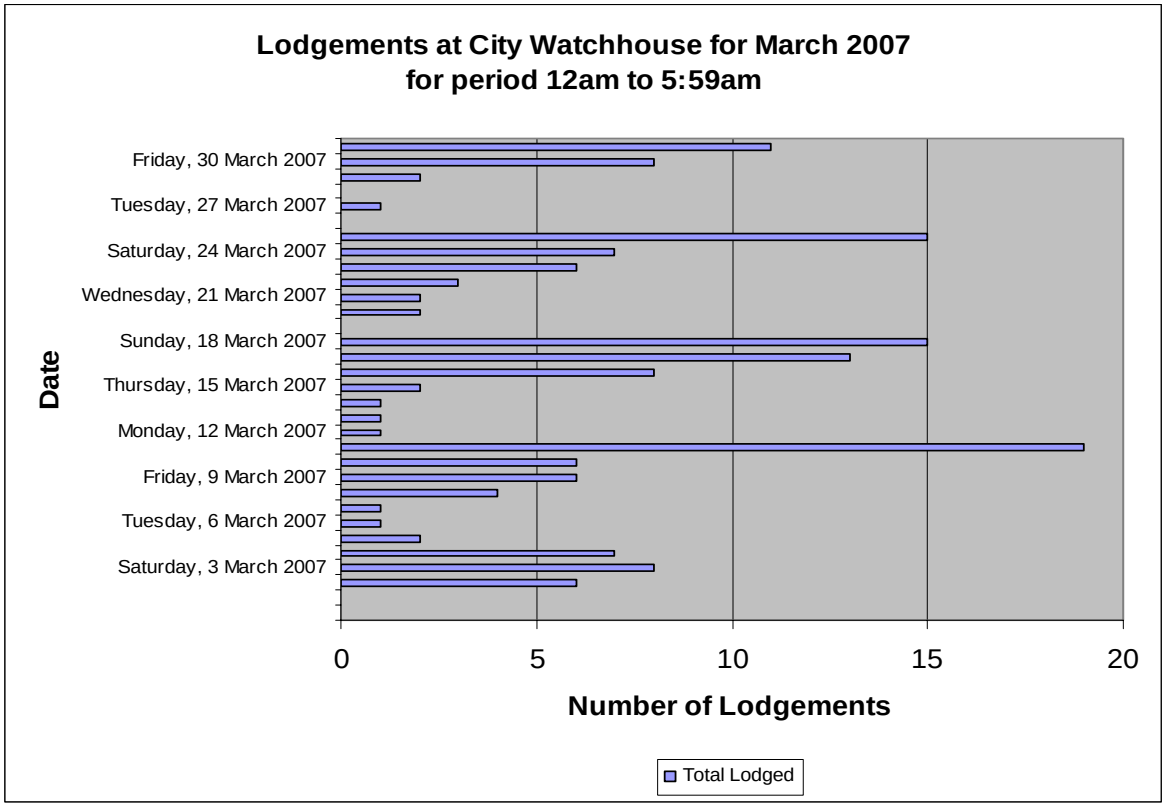
* *The Watchhouse does not have any OC per se, but usual practice is for either a Sergeant or Leading Senior Constable of the Watchhouse to sign a canister of 10% Foam out and for that canister to be stored in the Watchhouse during night shift for the use of that member.*

Appendix 10—Breakdown, by day, of numbers of persons lodged in custody over one month

Number of persons lodged in the City Watch House

Arrested between 12am and 5.59am

Date lodged in custody 2007	Lodgement reason				Total Lodged
	Arrested	Immigration	Intoxicated	Serving/Sentenced prisoner	
Thursday, 1 March	0	0	0	0	**0**
Friday, 2 March	2	0	4	0	**6**
Saturday, 3 March	3	0	5	0	**8**
Sunday, 4 March	1	0	6	0	**7**
Monday, 5 March	1	0	1	0	**2**
Tuesday, 6 March	1	0	0	0	**1**
Wednesday, 7 March	0	0	1	0	**1**
Thursday, 8 March	0	0	4	0	**4**
Friday, 9 March	4	0	2	0	**6**
Saturday, 10 March	2	0	4	0	**6**
Sunday, 11 March	5	0	14	0	**19**
Monday, 12 March	1	0	0	0	**1**
Tuesday, 13 March	0	0	1	0	**1**
Wednesday, 14 March	0	0	1	0	**1**
Thursday, 15 March	1	0	1	0	**2**
Friday, 16 March	1	0	7	0	**8**
Saturday, 17 March	7	0	6	0	**13**
Sunday, 18 March	5	0	10	0	**15**
Monday, 19 March	0	0	0	0	**0**
Tuesday, 20 March	2	0	0	0	**2**
Wednesday, 21 March	0	0	2	0	**2**
Thursday, 22 March	2	0	1	0	**3**
Friday, 23 March	2	0	4	0	**6**
Saturday, 24 March	2	0	5	0	**7**
Sunday, 25 March	5	0	10	0	**15**
Monday, 26 March	0	0	0	0	**0**
Tuesday, 27 March	1	0	0	0	**1**
Wednesday, 28 March	0	0	0	0	**0**
Thursday, 29 March	1	0	1	0	**2**
Friday, 30 March	5	0	3	0	**8**
Saturday, 31 March	6	0	5	0	**11**
Total	**60**	**0**	**98**	**0**	**158**

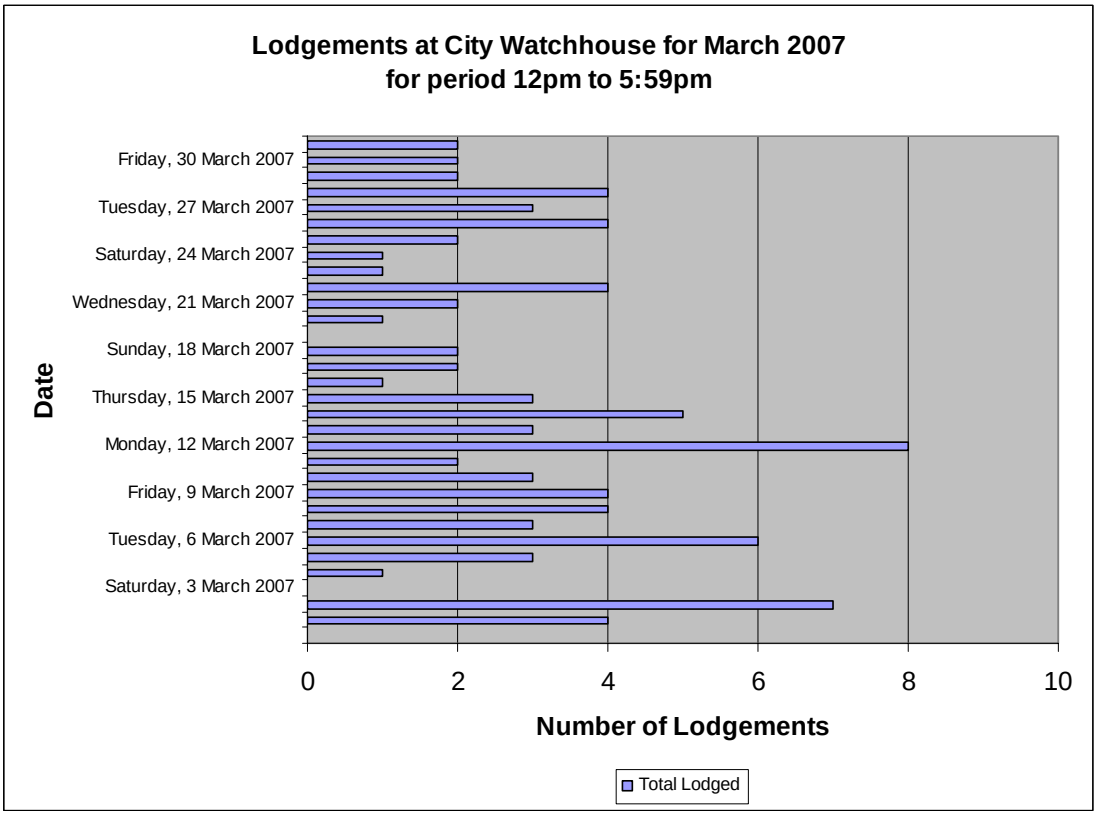

Lodgements at City Watchhouse for March 2007
for period 12am to 5:59am
Friday, 30 March 2007
Tuesday, 27 March 2007
Saturday, 24 March 2007
Wednesday, 21 March 2007
Sunday, 18 March 2007
Thursday, 15 March 2007
Monday, 12 March 2007
Friday, 9 March 2007
Tuesday, 6 March 2007
Saturday, 3 March 2007
Date
0
5
10
15
20
Number of Lodgements
Total Lodged

Arrested between 6am and 11.59am

Date lodged in custody 2007	Lodgement reason				Total Lodged
	Arrested	Immigration	Intoxicated	Serving/sentenced prisoner	
Thursday, 1 March	4	0	0	0	**4**
Friday, 2 March	0	0	0	0	**0**
Saturday, 3 March	1	0	2	0	**3**
Sunday, 4 March	1	0	0	0	**1**
Monday, 5 March	3	0	0	0	**3**
Tuesday, 6 March	2	0	0	0	**2**
Wednesday, 7 March	1	0	0	0	**1**
Thursday, 8 March	1	0	0	0	**1**
Friday, 9 March 2007	1	0	0	0	**1**
Saturday, 10 March	1	0	1	0	**2**
Sunday, 11 March	2	0	0	0	**2**
Monday, 12 March	1	0	0	0	**1**
Tuesday, 13 March	2	0	0	0	**2**
Wednesday, 14 March	2	0	0	0	**2**
Thursday, 15 March	3	0	1	0	**4**
Friday, 16 March 2007	1	0	1	0	**2**
Saturday, 17 March	0	0	1	0	**1**
Sunday, 18 March	0	0	0	0	**0**
Monday, 19 March	2	0	0	0	**2**
Tuesday, 20 March	0	0	0	0	**0**
Wednesday, 21 March	5	0	0	0	**5**
Thursday, 22 March	2	0	0	0	**2**
Friday, 23 March	0	0	0	0	**0**
Saturday, 24 March	2	0	0	0	**2**
Sunday, 25 March	0	0	1	0	**1**
Monday, 26 March	3	0	0	0	**3**
Tuesday, 27 March	1	0	0	0	**1**
Wednesday, 28 March	2	0	0	0	**2**
Thursday, 29 March	3	0	0	0	**3**
Friday, 30 March	1	0	0	0	**1**
Saturday, 31 March	2	0	0	0	**2**
Total	**49**	**0**	**7**	**0**	**56**

Arrested between 12pm and 5.59pm

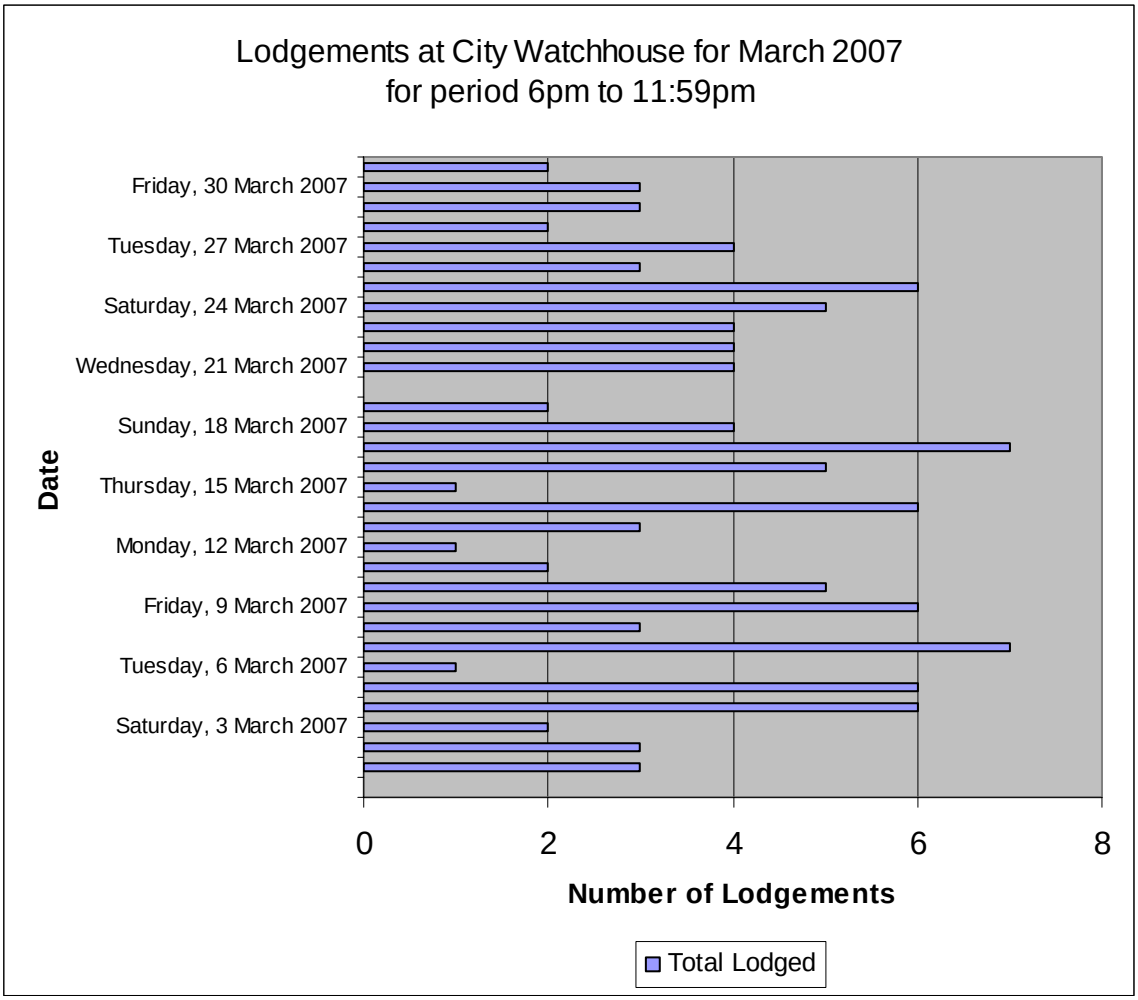
Date lodged in custody 2007	Lodgement reason				Total Lodged
	Arrested	Immigration	Intoxicated	Serving/sentenced prisoner	
Thursday, 1 March	3	0	1	0	**4**
Friday, 2 March	6	0	1	0	**7**
Saturday, 3 March	0	0	0	0	**0**
Sunday, 4 March	1	0	0	0	**1**
Monday, 5 March	2	0	1	0	**3**
Tuesday, 6 March	6	0	0	0	**6**
Wednesday, 7 March	3	0	0	0	**3**
Thursday, 8 March	4	0	0	0	**4**
Friday, 9 March	2	0	2	0	**4**
Saturday, 10 March	3	0	0	0	**3**
Sunday, 11 March	2	0	0	0	**2**
Monday, 12 March	8	0	0	0	**8**
Tuesday, 13 March	3	0	0	0	**3**
Wednesday, 14 March	5	0	0	0	**5**
Thursday, 15 March	3	0	0	0	**3**
Friday, 16 March	1	0	0	0	**1**
Saturday, 17 March	1	0	1	0	**2**
Sunday, 18 March	1	0	1	0	**2**
Monday, 19 March	0	0	0	0	**0**
Tuesday, 20 March	1	0	0	0	**1**
Wednesday, 21 March	2	0	0	0	**2**
Thursday, 22 March	4	0	0	0	**4**
Friday, 23 March	1	0	0	0	**1**
Saturday, 24 March	0	0	1	0	**1**
Sunday, 25 March	1	0	1	0	**2**
Monday, 26 March	1	1	2	0	**4**
Tuesday, 27 March	3	0	0	0	**3**
Wednesday, 28 March	3	0	1	0	**4**
Thursday, 29 March	2	0	0	0	**2**
Friday, 30 March	2	0	0	0	**2**
Saturday, 31 March	2	0	0	0	**2**
Total	**76**	**1**	**12**	**0**	**89**

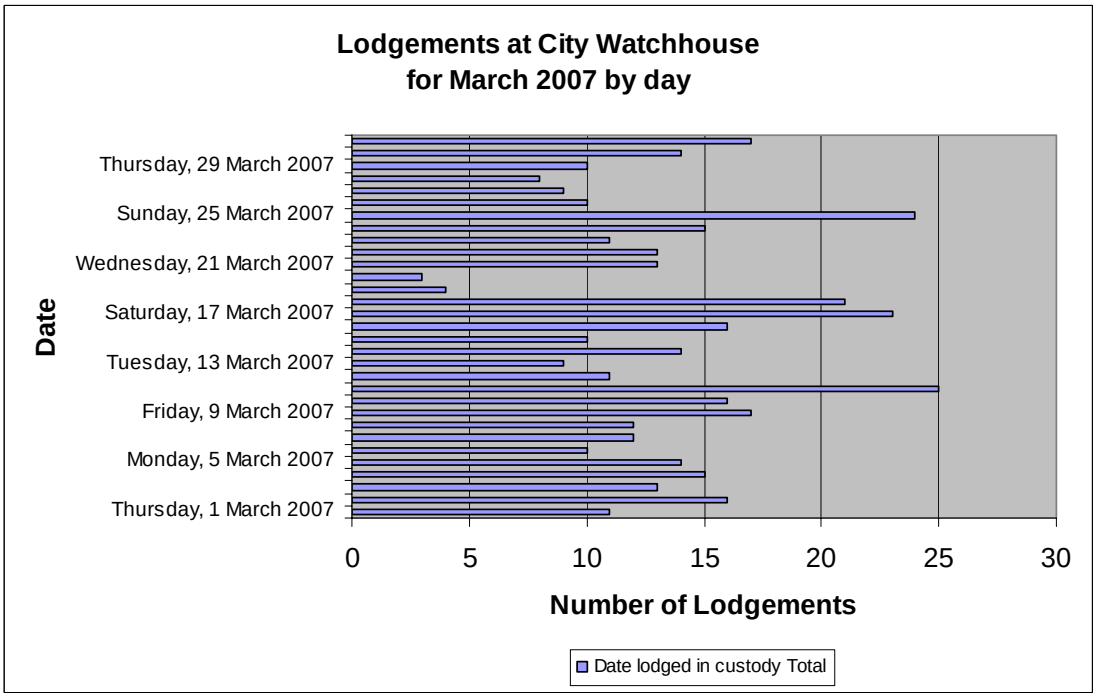

Lodgements at City Watchhouse for March 2007
for period 12pm to 5:59pm
Date
Friday, 30 March 2007
Tuesday, 27 March 2007
Saturday, 24 March 2007
Wednesday, 21 March 2007
Sunday, 18 March 2007
Thursday, 15 March 2007
Monday, 12 March 2007
Friday, 9 March 2007
Tuesday, 6 March 2007
Saturday, 3 March 2007
0
2
4
6
8
10
Number of Lodgements
Total Lodged

Arrested between 6pm and 11.59pm

Date lodged in custody 2007	Lodgement reason				Total Lodged
	Arrested	Immigration	Intoxicated	Serving/sentenced prisoner	
Thursday, 1 March	3	0	0	0	**3**
Friday, 2 March	3	0	0	0	**3**
Saturday, 3 March	1	0	1	0	**2**
Sunday, 4 March	6	0	0	0	**6**
Monday, 5 March	6	0	0	0	**6**
Tuesday, 6 March	1	0	0	0	**1**
Wednesday, 7 March	7	0	0	0	**7**
Thursday, 8 March	2	0	1	0	**3**
Friday, 9 March	4	0	2	0	**6**
Saturday, 10 March	5	0	0	0	**5**
Sunday, 11 March	2	0	0	0	**2**
Monday, 12 March	0	0	1	0	**1**
Tuesday, 13 March	2	0	1	0	**3**
Wednesday, 14 March	5	0	1	0	**6**
Thursday, 15 March	1	0	0	0	**1**
Friday, 16 March	5	0	0	0	**5**
Saturday, 17 March	3	0	4	0	**7**
Sunday, 18 March	2	0	2	0	**4**
Monday, 19 March	2	0	0	0	**2**
Tuesday, 20 March	0	0	0	0	**0**
Wednesday, 21 March	4	0	0	0	**4**
Thursday, 22 March	2	0	1	1	**4**
Friday, 23 March	2	0	2	0	**4**
Saturday, 24 March	4	0	1	0	**5**
Sunday, 25 March	5	0	1	0	**6**
Monday, 26 March	3	0	0	0	**3**
Tuesday, 27 March	4	0	0	0	**4**
Wednesday, 28 March	2	0	0	0	**2**
Thursday, 29 March	3	0	0	0	**3**
Friday, 30 March	1	0	2	0	**3**
Saturday, 31 March	0	0	2	0	**2**
Total	**90**	**0**	**22**	**1**	**113**

Source: PROMIS database as at 14 May 2007


Lodgements at City Watchhouse for March 2007
for period 6pm to 11:59pm
Friday, 30 March 2007
Tuesday, 27 March 2007
Saturday, 24 March 2007
Wednesday, 21 March 2007
Sunday, 18 March 2007
Thursday, 15 March 2007
Monday, 12 March 2007
Friday, 9 March 2007
Tuesday, 6 March 2007
Saturday, 3 March 2007
Date
0
2
4
6
8
Number of Lodgements
Total Lodged


Lodgements at City Watchhouse
for March 2007 by day
Thursday, 29 March 2007
Sunday, 25 March 2007
Wednesday, 21 March 2007
Saturday, 17 March 2007
Tuesday, 13 March 2007
Friday, 9 March 2007
Monday, 5 March 2007
Thursday, 1 March 2007
Date
0
5
10
15
20
25
30
Number of Lodgements
Date lodged in custody Total

Appendix 11—Ombudsman own motion investigations relating to the Watchhouse since 1997

- Own Initiative Investigation: Policing of Domestic Violence in the ACT (2001).
- Own Initiative Investigation: Review of the AFP's Use of Powers Under the *Intoxicated Persons (Care and Protection Act) 1994* (2001).
- Investigation into the Use of Police Powers under the *Intoxicated Persons (Care and Protection) Act 1994* (1998).
- Own Motion Investigation: Allegations of Unlawful Arrest, Unlawful use of Force, Wrongful Detention and Interview (1998).
- Investigation into the Detention of a Male Person by the Australian Federal Police under the Provisions of the *Intoxicated Persons (Care and Protection) Act 1994* (1997).
- Own Motion Investigation: Personal Searches Conducted by the Australian Federal Police (1997).
- Own Motion Investigation: The Interaction Between the Australian Federal Police and Youth in the ACT (1997).

Appendix 12—List of those invited to provide submissions

*Note: **Bold** indicates the receipt of a response from the individual/organisations.*

1. Aboriginal Legal Service (ACT & NSW)
2. Aboriginal and Torres Strait Islander Consultative Committee
3. **ACT Aboriginal Justice Centre Inc.**
4. **ACT Ambulance Service**
5. **ACT Corrective Services**
6. **ACT Department of Justice & Community Safety**
7. **ACT Department of Disability, Housing and Community Services**
8. ACT Disability Advisory Council
9. ACT Disability, Aged & Carer Advocacy Service
10. ACT Domestic Violence Prevention Council
11. **ACT Health**
12. **ACT Human Rights Commission**
13. ACT Law Society
14. **ACT Magistrates Court and Tribunals**
15. ACT Multicultural Community Council
16. ACT Office of Multicultural, Aboriginal and Torres Strait Islander Affairs
17. ACT Victims of Crime Coordinator
18. ACT Supreme Court
19. Advocacy for Inclusion
20. Alcohol & Drug Program (ACT Health)
21. **Australian Federal Police Association**
22. **Australian Institute of Criminology**
23. Belconnen Remand Centre
24. Canberra Rape Crisis Centre
25. **Canberra Multicultural Community Forum**
26. Centacare Australia Ltd. (ACT)
27. Citizen Advocacy ACT Inc.
28. **Civil Liberties Australia (ACT)**
29. **Commonwealth Director of Public Prosecutions**
30. **Corrections Health ACT**
31. Director of Public Prosecutions (ACT)
32. Disability ACT
33. **Domestic Violence Crisis Service**
34. Gugan Gulwan Youth Aboriginal Corporation
35. Legal Aid Commission (ACT)
36. **Mental Health ACT**
37. Mental Health Foundation ACT Inc.
38. Ministerial Muslim Advisory Council
39. **National Indigenous Human Rights Congress**
40. Office for Children, Youth and Family Support (ACT)
41. **People with Disabilities ACT**
42. Police Consultative Board
43. Prisoners Aid ACT
44. **Professor David Biles**
45. **Public Advocate of the ACT**
46. Public Trustee (ACT)
47. Quamby Youth Detention Centre
48. Victims of Crime Assistance League (VOCAL)
49. **Victoria Institute of Forensic Medicine**
50. Welfare Rights and Legal Centre
51. Winnunga Nimmityjah Aboriginal Health Services
52. Women's Legal Centre

Appendix 13—Relevant legislation and governance instruments

Legislation

Bail Act 1992 (ACT)
Crime Prevention Powers Act 1998 (ACT)
Crimes Act 1900 (ACT)
Crimes Act 1914 (Cth)
Crimes Amendment (Forensic Procedures) Act 2001 (Cth.)
Crimes (Forensic Procedures) Act 2000 (ACT)
Criminal Code 2002 (ACT)
Criminal Code Act 1995 (Cth)
Children and Young People Act 1999 (ACT)
Domestic Violence and Protection Orders Act 2001 (ACT)
Drugs of Dependence Act 1989 (ACT)
Evidence Act 1971 (ACT)
Evidence Act 1995 (Cth)
Firearms Act 1996 (ACT)
Human Rights Act 2004 (ACT)
Intoxicated People (Care and Protection) Act 1994 (ACT)
Liquor Act 1975 (ACT)
Mental Health (Treatment and Care) Act 1994 (ACT)
Privacy Act 1988 (Cth)
Prohibited Weapons Act 1996 (ACT)
Public Order (Protection of Persons and Property) Act 1971 (Cth)
Road Transport (Alcohol and Drugs) Act 1977 (ACT)
Road Transport (General) Act 1999 (ACT)
Service and Execution of Process Act 1992 (Cth)

Commissioner's Orders

Commissioner's Order 2—Professional Standards
Commissioner's Order 3—Use of Force

AFP National Guidelines

ACT Policing Property, Exhibit and Drug Handling
Complaint Management
Emergency Procedures
First Aid in the Workplace
Health and Safety
Police Custodial Facilities and People in Custody
Professional Reporting
Reporting Obligations
Uniform and Standards of Dress
Workplace Harassment

Practical Guides

Aboriginal Interview Friends and Interpreters—Section 23J of the Crimes Act 1914
Infection Control for Communicable Diseases
Infectious Disease Control: Police

ACT Policing Practical Guides

Bail—ACT
Breach of the Peace (Best Practice Guide)
Briefs of Evidence—ACT
Cautions and Diversionary Programs—ACT
Child Abuse and Sexual Offences—ACT
Children and Young People—ACT
Drug Search Procedure—ACT
Extraditions—ACT
Family Violence Incidents—ACT
Identification Evidence—ACT
Identification of Suspected and Arrested Persons—ACT
Interpreters and Translators—ACT
Management of Major Incidents—ACT
Oleoresin Capsicum (OC) Spray—ACT
Persons Suffering from Mental Illness or Mental Dysfunction—ACT (Best Practice Guide)
Persons in Custody—ACT
Sobering Up Facility—ACT
Video / Audio Recording of Interviews—ACT (Best Practice Guide)
Warrants—ACT

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Commonwealth Ombudsman, *Own Motion Investigation: Allegations of Unlawful Arrest, Unlawful Use of Force, Wrongful Detention and Interview* (Canberra: COMB, 1998)

Commonwealth Ombudsman, *Investigation into the Detention of a Male Person by the Australian Federal Police Under the Provisions of the Intoxicated Persons (Care and Protection) Act 1994* (Canberra: COMB, 1997)

Commonwealth Ombudsman, *Own Motion Investigation into Personal Searches Conducted by the Australian Federal Police* (Canberra: COMB, 1997)

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