Inquiry into Custodial Arrangements in Police Lockups

Prepared by the WA Police Union

August 2013

Table of Contents

Prepared by Jane Baxter

Research Officer

15 August 2013

Background

In order to understand the context of the custodial arrangements under which WA Police Officers operate, three bodies of work are to be considered. The overarching document that influences and directs custodial arrangements in Police lockups is the recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). The Western Australia Police Building Code (in particular, the section entitled *Custodial Design Guidelines*) and the Western Australia Police *Lockup Management Procedures* are two Agency specific guidelines that have been shaped by the outcomes of the Royal Commission. It is with consideration for these three documents that our submission is composed.

There are 339 recommendations of the RCIADIC, yet only a small number of recommendations directly pertain to Police specific custodial arrangements. Within our submission, the following recommendations (in numerical order) are broadly considered and explored:

- Recommendation 124 - establishment of procedures for debriefing sessions following incidents of importance;
- Recommendation 127 - the delivery of medical services to persons in Police custody;
- Recommendation 133: recruit and in-service training with respect to identifying persons at risk/in distress;
- Recommendation 137 - instructions and training that specifically relate to monitoring a detainee in Police custody;
- Recommendations 139, 140 and 148 - design of cell for visual and audio surveillance;
- Recommendation 141 - supervision of a detained person;
- Recommendations 159 and 160 - measures relating to resuscitative equipment and training; and
- Recommendation 165 - eliminating aspects of a cell that may be capable of harming a detainee.

In 2000, the Government of Western Australia prepared its Implementation Report that detailed the progress of implementing the individual recommendations arising from the RCIADIC. WA Police was charged with noting which of the recommendations relating to Police Officers had been implemented, the extent to which each recommendation had been achieved and the success of each recommendation. In considering the aforementioned recommendations for our submission, each must be viewed in light of the Agency's perspective of what has been achieved and executed.

Arising from the RCIADIC, WA Police developed a set of *Custodial Design Guidelines* within its Police Building Code and the *Lockup Management Procedures* contained within the WA Police Manual. Within the background information about the *Custodial Design Guidelines*, the following has been noted:

> "In response to these concerns [being a number of deaths in custody in the 1980s] and the Royal Commission, the Australian Police Ministers' Council endorsed an indicative model for the design and operation of custodial facilities in all jurisdictions...
>
> Using this model, the Western Australia Police Service developed a set of standards, comprising the
>
> - Lockup Management Manual, and
> - Custodial Design Guidelines (previously the Safe Cell Guidelines).[1]"

The *Custodial Design Guidelines* is a 39-page, comprehensive document that outlines not only the "specialised technical requirements for the design of custodial facilities" but also "standardises the critical building components/elements required in a safe cell". The *Custodial Design Guidelines* expound a cell design philosophy (with an emphasis on "human interaction between detainees and personnel", a safe cell environment and a duty of care), design objectives and most predominantly, design criteria for custodial facilities (encapsulating building aspects such as communication systems, fire and emergency detection and planning, cell structure and built-in furniture).

The Police Manual's *Lockup Management Procedures* is a gazetted policy that outlines the administration and procedures for Police Officers in Police custodial facilities. The *Lockup Management Procedures* policy is 16 sections long and covers issues such as death/attempted self-harm and serious injury or illness, supervision, security of detainees and detainee's rights and services. Within the policy, there is only one specific reference to the recommendations of the RCIADIC.

The Australian Institute of Criminology (AIC), the national body charged with collecting and collating deaths-in-custody data, identifies a death in custody as a death occurring:

- within a Police institutional setting such as a cell, watch house or Police van; and

---

[1] *Western Australia Police Building Code: Custodial Design Guidelines*, obtained from the WA Police Intranet at: http://intranetportal/Home/AssetManagementDirectorate/BuildingManagementBranch/BuildingCode/tabid/3952/Default.aspx. The last revision of this document was made on 26 March 2013.

- in a custody-related operation (that is, a Police operation intended to arrest someone), such as sieges, raids and motor vehicle pursuits[2].

Given the focus of this submission is solely on Police lockups, it has been difficult for the Union to source specific data and statistics relating to deaths in Police custody that have *only* occurred in Police lockups and *only* in Western Australia. Nevertheless, the AIC has noted in its most recent monitoring report that despite a national fluctuation in the number of deaths from the decade 2000 -01 to 2010-11, "the number of deaths recorded in the last two years are at the lower end of historical levels[3]" (see Appendix A). The nature of deaths in Police custody has changed over the past 20 years, with the AIC citing that "[t]he most frequent Police custody death throughout the 1990s occurred in institutional settings such as a Police cell...[but since] 2000, deaths in motor vehicle pursuits... have become the most frequent type of Police custody death".

In order to assess the efficacy and implementation of the Royal Commission's recommendations, the *Custodial Design Guidelines* and the *Lockup Management Procedures* policy, an analysis of these documents in conjunction with broad statistics concerning deaths in Police custody is merely supplementary to an assessment of the status quo. Despite the immediacy of the timeframe for this inquiry, 462 WA Police Union Members were canvassed for information regarding their current (or most recent) work role that required them to provide custodial services. Members were asked for information about their watch house or station's lockup design, staffing and administration, access for detainees to medical and legal services, training and oversight mechanisms.

Data from both Sworn Police Officers and Police Auxiliary Officers was obtained. Just under 80 per cent of respondents indicated they were currently performing a job that required them to provide custodial services; of the near 21 per cent of respondents who were not currently involved in custodial duties, 74 per cent had recency (one to five years) with providing custodial care.

[2] Sourced from "Deaths in Custody in Australia to 30 June 2011: Twenty years of monitoring by the National Deaths in Custody Program since the Royal Commission into Aboriginal Deaths in Custody", prepared by Mathew Lyneham and Andy Chan from the Australian Institute of Criminology, 2013.
[3] ibid, p. xx.

Do current custodial arrangements at Police lockups comply with the recommendations of the Royal Commission into Aboriginal Deaths in Custody?

Not every recommendation that arose from the Royal Commission into Aboriginal Deaths in Custody is relevant to custodial duties or Police lockups and as such, this submission focuses largely on the following select recommendations from the Royal Commission. Whether WA Police has complied with the recommendations will be fleshed out as each subsequent reference term is discussed.

Recommendation 124 of the RCIADIC states that:

> "Police... should... establish procedures for the conduct of debriefing sessions following incidents of importance such as deaths, medical emergencies or actual or attempted suicides so that the operation of procedures, the actions of those involved and the application of specific situations can be discussed and assessed with a view to reducing risks in the future".

This proposal has been integrated into the *Lockup Management Procedures* at section LP-3.5 as the section clearly references the RCIADIC, and in fact, is the only reference to the Royal Commission in the entire policy. However, the procedure for debriefing is not at all elaborate and is simply a rehashing of the RCIADIC recommendation. The only difference is the addition outlining protocols for submitting a report should a Member identify a need to amend any procedures, orders or instructions. It is possible that a station or district's Standard Operating Procedures (SOPs) expands on the debriefing procedures, but given the feedback that was received from the Membership regarding debriefing sessions, it is unlikely that the policy exists in anything but its current Agency-wide gazetted form.

Recommendation 127 of the RCIADIC examines the delivery of medical services to persons in Police custody. The recommendation notes, in part, the following:

- "... a regular medical or nursing presence in all principal watch houses in capital cities and in such other major centres as have substantial numbers detained";
- "In other locations, the establishment of arrangements to have medical practitioners or trained nurses readily available to attend Police watch houses for the purpose of identifying those prisoners who are at risk...".

The *Lockup Management Procedures* policy refers extensively to the well being of the detainee, including the management of a self-harming prisoner and their medical treatment, but it is at section LP-4.2 that a link between policy and the RCIADIC recommendation can be drawn. LP-4.2 states that:

> "A 24/7 on call nursing service is provided by the Perth Watch House (PWH) where a Registered Nurse can be directed to attend the PWH or another agreed location, where Police are present, within the Metropolitan Region. This service is available by contacting the PWH Supervisor on [this number]."

There is no reference within the *Lockup Management Procedures* policy to a similar arrangement for Regional WA.

Recommendation 133 of the RCIADIC proposes that **all** Police Officers "should receive training at both recruit and in-service levels to enable them to identify persons in distress or at risk of death or injury through illness, injury or self-harm" and goes on to express that where a Police Officer "is dedicated wholly or substantially to cell guard duties, then such person should receive a more intensive and specialised training than would be appropriate for other Officers". In the 2000 Implementation Report, WA Police indicated that the recommendation had been achieved and that "custodial care is currently taught at recruit and in-service level"[4]. The WA Police Academy teaches all recruits (Sworn and Auxiliary) and transitional Officers a training module entitled "Duty of Care". The purpose of the program, which is scheduled to run for three hours and 20 minutes, is to "introduce trainees to WAPOL procedures and responsibilities with respect to managing persons in Police custody or under Police care/control"[5]. The "Duty of Care" module covers the following outcomes: WAPOL duty of care policy and guidelines; understanding the *Protective Custody Act 2000*; assessing detainees affected by drugs and/or alcohol; legislation and technique of a search of a person; and personal safety and understanding positional asphyxia.

Recommendations 159 and 160 of the RCIADIC refer to the necessity for Police watch houses to have resuscitation equipment of the safest and most effective type readily available and to have staff trained in the use of such equipment. The recommendations called for annual refresher courses in first aid for those Officers who routinely have the care of persons in custody. The WA Police Academy has indicated that all Officers, Sworn and Auxiliary, must undertake 'Life Support Training', which occurs once every two years and provides Officers with a rudimentary update on their first aid skills.

---

[4] p. 74.

[5] As noted on the lesson plan document, accessed from the WA Police Academy.

Regular training in restraint techniques, including the application of restraint equipment was recommended (recommendation 163) and the 2000 Implementation Report noted that "District Officers have responsibilities, which include monitoring records to ensure all Police Officers within a region maintain currency in their various qualifications"[6]. The WA Police Academy has confirmed that Auxiliary Officers receive approximately 18 hours of rigorous 'Confined Space Extraction' training at the recruit level and transitional Officers receive approximately eight hours of similar training. Police Officers do not receive this training; instead they receive only a foundation level of weapon retention training that is refreshed when they are required to perform their annual 'Critical Skills Training'.

Recommendations 137 and 141 of the RCIADIC specifically identify the means of monitoring a detainee in a Police lockup by noting how, when and why to check a person detained in a cell and by whom the check is to be conducted. The 2000 Implementation Report has noted that WA Police has implemented these initiatives and that not only is it "procedure for a Member to regularly visit each prisoner to ensure the safety and welfare of that prisoner" but in "instances where a detainee must be held and [24 hour supervision] is not available he/she must be transported to a 24 hour centre"[7]. In reviewing the *Lockup Management Procedures*, the policy refers to surveillance of a detainee until release or discharge and a brief overview of how to conduct a cell check for the health, safety and welfare of a detainee (see Appendix B for the full policy details). Most notable is that the policy does not strictly apply the steps outlined in recommendation 137, specifically, those procedures outlined in part b and part c.

Recommendations 139, 140, 148 and 165 relate to the design of a Police custodial cell to maximise visual and audio surveillance and to minimise the risk of harm or injury to a detainee. In the 2000 Implementation Report, WA Police not only noted that "a large number of Police stations had cell upgrades in relation to alarms" and that "all new Police stations have been fitted with modern alarm equipment", but that WA Police "continually monitors the application of the Custodial Design Guidelines, and where appropriate will alter or add to them as circumstances dictate a process of ongoing improvement"[8].

The relevant Agency document that oversees cell design is a section within the WA Police Building Code entitled *Custodial Design Guidelines*. This document was developed as a result of

[6] p. 97.
[7] pp. 81-83.
[8] Recommendation 139, p. 82 and recommendation 165, p. 98, respectively.

recommendation 332, which stipulated that standard guidelines for Police custodial facilities would be formulated at a National level by Australia's Police Ministers before being implemented on a jurisdictional level.

What is the state of access to medical and legal services for detainees?

The provision of medical services

Contained within the *Lockup Management Procedures* are details regarding the provision of medical needs. The Member in charge of a lockup shall, according to the policy, both "arrange any medical attention necessary for the health, safety and welfare of a detainee" and "record this information on the detainee's running sheet, Custody and in the occurrence book". The policy also recognises the importance of the Aboriginal Medical Service (AMS) and directs Police Officers to utilise the AMS for Aboriginal detainees, where the service is available. Guidelines specify what Police Officers must do with regards to medical treatment for detainees and how to administer medication. Throughout the document, Officers are reminded of their duty of care. The *Lockup Management Procedures* provide for a 24/7 on call nursing service run through the Perth Watch House, and this nursing service can also be directed to attend other agreed Metropolitan locations.

From the above, it can be seen that WA Police has endeavoured to enshrine recommendation 127 in policy and there can be no doubt that the health and well being of detainees is essential to those Officers providing custodial care. However, more often than not, Officers are providing medical assistance to detainees beyond their expertise, capabilities and responsibilities. When Members were asked if they had ever utilised any medical assistance for a detainee apparently in need of medical treatment, 75.3 per cent indicated they had and 188 Members provided extra detail about the assistance rendered. Our Members indicated they had assisted detainees experiencing asthma attacks, seizures, suspected heart attacks, attempted self-harm, drug overdoses, alcohol poisoning and diabetes. Oftentimes, the detainee was attended to at the lockup facility or transported to hospital by St John Ambulance (SJA) but on many occasions, the detainee was transported from the lockup to the nearest hospital by Police van.

Members spoke about the pervasiveness of self-harm in lockups and watch houses, with one Member noting the prevalence of "detainee's smashing their heads against the glass of the cell doors in an effort to be let out". Numerous Members observed the disturbing frequency of detainees feigning illness to escape being held in a lockup (for example, one Member "called SJA for a detainee who appeared to be convulsing; SJA believed detainee was faking") and even more Members reiterated that waiting with a detainee at hospital was extraordinarily taxing on their time and, in the end, the Agency's bottom line. One Member summarised this by saying that although they understood that it was necessary to seek medical assistance for the detainee by taking them to

the hospital, doing so was "very time consuming and ties up [both] Police and hospital staff". Another Member noted that it "tied up a lot of Police resources whilst Officers sat in an Emergency Department (ED)", often for anywhere between two and six hours at a time and this was reiterated by one Member who stated that sitting in an ED for hours at a time "depletes frontline resources and poses a risk to other Officers on patrol requiring back up".

In Regional WA, Officers appear to be more pressed in the provision of medical services than their Metropolitan counterparts. In remote areas, Officers have no choice but to convey the detainee to the nearest hospital themselves. One Member in particular noted how difficult it was to accommodate any absence of staff at small, regional, remote locations, especially when a trip to the nearest hospital could take hours. Some Members noted instances where there were locum doctors and nurses available to attend lockups and watch houses but the availability of this service varied tremendously around the state. Currently, there is no 24/7 on-call nursing service for any other major 24/7 station in WA outside of Perth and 52.7 per cent of respondents to our survey were not aware that the 24/7 on-call nursing service run through the PWH even existed.

From this information, it appears that recommendation 127 of the RCIADIC has been implemented only to the extent that it is enshrined, in some way, in WA Police policy. Whilst the PWH retains access to a 24/7 on-call nursing service, no other major centres in WA have access to a similar arrangement. Officers at the PWH have indicated that a Registered Nurse, hired by an external agency, is present at the PWH during notable busy or 'peak' times. However, it has been suggested that a nurse should be stationed at the PWH at all times, and not just on certain weeknights and weekends. In Regional WA, whilst some stations have a degree of access to remote area nursing staff, other stations do not, which contravenes part b of recommendation 127 of the RCIADIC.

The provision of legal services

The *Lockup Management Procedures* also requires that it is the responsibility of the Officer preferring the charge to notify the Aboriginal Legal Service (ALS) whenever an Aboriginal person is charged and the individual approves. ALS office locations are listed within the *Lockup Management Procedures* and at section LP-14.9, an Officer is directed to "assist and facilitate the visit to any lockup of officers from the Aboriginal Legal Service or field liaison officers during reasonable hours". Stations and lockups are encouraged to display advertising cards or notices from the ALS.

A majority of the respondents to the survey (85.7 per cent) indicated that any time an Aboriginal person was detained and charged, and the detainee approved, the ALS was notified, as per

recommendations 223 and 224 of the RCIADIC. Respondents were given the opportunity to provide details when answering this question. Most Members noted that they alerted the ALS by sending them the required forms that would be generated during the paperwork process by faxing the ALS District Office and a phone call would be made if notification was required after business hours.

However, a number of Officers noted their concerns about representatives from the ALS, largely their availability after normal business hours. Several Members indicated when they attempted to contact the ALS after hours (and there did not seem to be a difference between Regional and Metropolitan WA), they would rarely, if ever, have their calls returned or faxes acknowledged. One respondent said that they were only able to fax the ALS outside of business hours as

> "...there are no after hours contact numbers for ALS, or any lawyers [where I am stationed] in Regional WA. It is below these people to be required to attend a lockup after hours. If contact is made, their standard response is to advise the person detained to not make any comment to Police and that they will deal with their issues in the morning".

A Member based in the Kimberley District also noted the difficulty in contacting an ALS representative and said "I have rung the ALS after hours number on over 20 occasions and not once has someone picked up the phone. Once I got a call back five hours later. Very poor service from the ALS when you are trying to afford someone their legal rights under the [*Criminal Investigation Act 2006*]". One Member attempted to provide an explanation as to why not every Officer was in the habit of contacting the ALS upon detaining an Aboriginal person by observing that

> "I believe the complete lack of interest shown by ALS in this sort of notification when we have someone in custody is probably discouraging many Officers from contacting them further".

Sufficiency of welfare services

Respondents to the survey were asked "Do you believe that sufficient welfare services are provided to detainees?" and even though 78.2 per cent believed that welfare services were sufficient, the 74 respondents who elaborated further appeared to disagree with the majority. Several Members noted the quality of the food:

- "the food choice is disgusting. There is no option for vegetarians, no fresh food at all";
- "meals provided for detainees is a pie or sausage roll... I do not believe this is sufficient for three meals a day"; and
- "no meals readily available and no provisions to obtain them. Officers expected to purchase prisoner meals out of their own pockets".

Others noted the inadequacy of staffing levels at welfare providers:

- "[welfare services are] available, the staff to enact it isn't";
- "the Aboriginal Visitors Service is a good service but is very infrequent and not reliable";
- "[welfare staff are not available] when you really need them, generally out of office hours"; and
- "Crisis Care are often unable to provide emergency accommodation, especially for males who are released on bail and have nowhere to stay".

A lack of access to mental health providers was noted by several as particularly concerning:

- "[detainees who have mental health problems] should be in a secure unit of a hospital, not in a Police lockup";
- "PWH and district lockups should be able to have sufficient medical facilities and staff to monitor [mental health detainees]";
- "nursing staff and mental health professionals should be provided to better assess prisoners"; and
- "[lockups] should have drug and alcohol abuse info [and] access to counsellors".

What can be said about the adequacy of Police lockup design, staffing and administration?

The Royal Commission recommendations do not specify much in terms of Police lockup design, staffing and administration, instead entrusting the Australian Police Ministers' Council to "formulate and adopt standard guidelines for Police custodial facilities throughout Australia" (recommendation 332). Any reference to Police lockup design, staffing and administration in the RCIADIC can be found within the section entitled "Custodial Health and Safety", spanning recommendations 122 to 167. Within these recommendations, the Royal Commission broadly notes:

- The arrangement of a medical presence or availability of medical staff to assist with those detainees who have been identified at risk through illness, injury or self-harm;
- Procedures for regular and routine health and safety checks;
- The provision of electronic surveillance equipment to supplement checks made in person;
- That Police cells be designed to maximise direct visual surveillance and be designed to emphasise and facilitate personal interaction between detainees and their custodial officers and/or visitors;
- That all cells be equipped with an alarm or intercom system which gives direct communication to custodians;
- That Police authorities should carefully scrutinise equipment and facilities provided at custodial institutions to reduce and eliminate the potential for a detainee to cause self-harm (including screening hanging points in cells); and
- That all custodial staff be adequately trained and refreshed in resuscitative techniques, restraint techniques and being able to identify those at risk of death or injury.

Police Lockup Design

The *Custodial Design Guidelines* take a very scientific view on the design of Police lockups. The guidelines specify technical aspects that all safe cells must adhere to, including:

- Communication systems such as cell alarms and audio monitoring that is to be manned in some capacity 24 hours a day, a push button cell alarm to enable a detainee to call for assistance, a cell intercom;
- CCTV that produces a clear picture on the monitor with good contrast in full colour under a variety of lighting conditions;

- Fire protection criteria including smoke detectors and alarms, fire evacuation and emergency plans, fire hoses and extinguishers;
- Built-in furniture specifications;
- Specialised activity space details such as the size and design of the sally port and the width of cell block corridors; and
- Safe cell structure specifying the requirements for walls, floors, climate control, finishes and power sources.

Given the age of Police lockups around the state (varying from less than 12 months to 147 years old), there exists a great disparity between lockup design from station to station. When asked if cells had been designed to emphasise interaction between detainees and personnel, 51.3 per cent of respondents believed the design and layout of the cell did *not* maximise direct visual surveillance, which not only goes against recommendations 139 and 148 of the RCIADIC but contradicts a 13 year old undertaking from the Agency that the design and re-design of cells were a "process of ongoing improvement"[9]. Our concern is not just for the well being of the detainee, but largely for our Members, who are not only tasked with a legal duty of care but who face uncertain and often volatile situations upon entering a cell. When an Officer does not have complete and unhindered vision of a detainee, that Officer is never fully cognisant of the actions and behaviours of a prisoner. This is not only dangerous for an at risk or aggressive detainee but it also means that an Officer must be continually checking their prisoner, which is time consuming and resource intensive if there is more than one detainee.

Respondents to the survey were also asked to consider their current (or most recent) tenure at a Police lockup facility and complete a matrix about the station's cell features (features which are identified in the *Custodial Design Guidelines* as necessary for every cell). The full response can be viewed at Appendix C, but the following is vital to note:

- 12.2 per cent of respondents noted the cell did not have a push button cell alarm enabling a detainee to call for assistance;
- 7.5 per cent of respondents noted the cell did not have CCTV;
- 31.1 per cent of respondents noted that the cell did not have CCTV that produced a clear picture on the monitor with good contrast in full colour; and
- 13.2 per cent of respondents noted that there were no duress alarms installed along cell block corridors.

[9] As noted in the 2000 Implementation Report.

The ramifications poor cell design has on our Members is enormous. Given the onus of a legal duty of care that Officers are tasked with, it is absolutely vital that they are able to undertake their duties in an environment that is conducive to constant surveillance, audio access to detainees and other Officers and is safe for both detainees and Officers. The outmoded and hazardous design and layout of many of WA Police's cells not only demonstrates a non-compliance with recommendations 139 and 140 of the RCIADIC but also a lack of adherence to the overarching Agency policy (the *Custodial Design Guidelines*) that was formulated arising from recommendation 332.

Members were asked if they believed if the references to custodial facilities in the WA Police Building Code were adequate. Approximately 58 per cent responded yes, whilst 42.1 per cent of respondents indicated that the Building Code was not adequate. Members were given the opportunity to make suggestions about what is currently missing from the Building Code that should be a requirement and the following was noted:

- "No easy movement of detainee by stretcher";
- More audio facilities, including communication devices to be situated on an Officer's work desk;
- "Cleaners at every station to clean the cells straight after incidents";
- "Fixed, unmoveable beds/mattresses";
- Proximity of cells within the station, including the proximity of the padded cell to the other holding cells;
- Driveways leading to sally ports need to be designed differently to avoid conflict of pathways with other vehicles entering/departing;
- Larger monitors to display CCTV from cells – currently monitor is divided into four screens and are high up away from the communal work area, making visibility of the prisoner difficult;
- "Doors to cells should have security hatches with spit screens to enable the passage of food/water into the cells without the Officer having to open the door";
- "Lockups were not made to comply with the provisions of the CIA in relation to uncharged suspects and this is a huge issue that needs to be addressed ASAP"; and
- Penalties for a lack of enforcement with the Building Code.

A number of respondents noted their concerns about a lack of compliance with Section 139 of the *Criminal Investigation Act 2006* (CIA). The survey asked Members if their station or watch house had a holding room for suspects (in accordance with section 139(3) of the CIA) and although 48.1 per

cent indicated that they believed it did, it was evident in the feedback that the notable absence of suitable holding rooms in stations and watch houses was cause for great concern. Currently, no Police station or watch house in the state of WA has a CIA compliant holding room and as such, Officers are forced to utilise other areas within the station to detain an arrested suspect. One Member noted that "arrested suspects are being put in interview rooms and breath [analysis] rooms with one Officer [which means] statements can't be taken in these rooms", suspects are moved around from room to room and the station must operate less one Officer as that Officer guards the suspect. Other Members observed that their Officer in Charge's (OICs) office would be utilised as a holding room; several Detectives indicated their interview rooms became something more like common rooms for arrested suspects; at the Mandurah Police Station, it was noted that the holding area is adjacent to the general office space and within close proximity to Police computers and office products that could be used as weapons. One Member expressed that "it is neither safe nor satisfactory to hold potentially violent, aggressive or potential escape risks in office areas". This was reiterated by another Member who noted that "there is nothing to prevent an arrested suspect that is about to be interviewed from assaulting an Officer, having free run of the station and damaging property... taking anything that could be used as a weapon and either walking out the back door or jumping the front counter".

Police Lockup Staffing

Neither the Royal Commission recommendations, the *Custodial Design Guidelines* nor the *Lockup Management Procedures* make instructions with respect to staffing at Police lockups. Despite the advice of the Royal Commission to the Police to ensure that its human resources are adequately and appropriately trained in cultural awareness, resuscitative techniques and risk assessment, the recommendations of the RCIADIC never propose an Officer to detainee ratio. Recommendation 141 does note that:

> "...no person should be detained in a Police cell unless a Police Officer is in attendance at the watch house and is able to perform duties of care and supervision of the detainee".

The *Lockup Management Procedures* do not stipulate a minimum station or watch house staffing requirement for custodial care duties to be adequately performed and nowhere else in the Police Manual is there a mention of this.

The Union has been aware for a number of years of an obvious lack of uniformity regarding custodial care protocols throughout the state. We know that whilst some OICs ensure that two staff are always present to carry out the custodial care of persons detained in Police custody, there are others who seem to be willing to compromise the safety and welfare of both detainees and Officers by

rostering only one Officer to custodial duties, particularly on night shift with the expectation that another Officer could be recalled to duty if necessary. The survey reinforced this understanding: Members were asked if they had ever been directed or have had to perform single officer custodial care duties and an overwhelming 84.2 per cent of respondents indicated in the positive. When asked how often, 58.7 per cent of respondents indicated they had been directed to do so on more than 20 occasions. One Member elaborated by saying that:

> "It is not safe for one person to conduct custodial duties, however, this happens on every single shift in our regional station. Officers have to lock themselves in the lockup area with detainees whilst conducting physical cell checks. This one Officer also has to be VKI and POC for the region".

Another Member noted that:

> "At my current location, it is normal and daily practice for one Officer to be responsible for up to 10 detainees, whilst also manning the station by himself, conducting CAD dispatch for the region, phones, radio, counter and office duties... Due to the lockup design, staff have to lock themselves in with detainees when conducting cell checks, providing meals, etc [which poses an enormous safety risk]".

One respondent wrote that they actually crossed their fingers and prayed that no one actually attempted to kill themselves whilst they were a single Officer on duty at a station "multi-tasking".

The examples provided by Members who perform single Officer custodial duties are deeply concerning:

- "At times, I have eight prisoners to deal with [on my own]... I have to try and take out one at a time and shut the door whilst keeping an eye on the one I'm transferring to a cell";
- "On my arrival at my current station, I was told I was on lockup duty. Before even reading the station's lockup manual, I was instructed to sign a lockup handover summary stating that I was aware of all of the particular stations' lockup procedures and policies, making me responsible for an incident should anything occur. I then commenced my 10 hour shift as a single Officer within the lockup";
- "It was routine [when I worked in Halls Creek] for one Officer custodial care to be rostered overnight with an in-house policy for one Officer to care for up to five detainees; six or more required a second officer to work overtime. But then at 0600 hours both Officers would go home and one early start day shift Officer would manage on their own until 0800 hours. Depending on when the AIMS truck was passing through

on its overnight run from Kununurra to Broome, this two hour window could [see the station] contain as many as 30 detainees... My OIC also routinely expected two night shift custodial Officers to leave the station/lockup totally unattended to attend to tasking, on occasions for up to two hours"; and

- "My current station has only two staff so it always necessitates that one Officer remains with the detainee; this is obviously an OSH issue however the risk is accepted by the OIC/staff in order to 'get the job done' ".

Members were also asked if custodial care duties could be adequately performed by a single Officer. More than 82 per cent of respondents indicated that custodial duties could **not** be sufficiently performed by a single Officer for the following reasons:

- The risk of single Officer custodial care duties to the Officer is serious and elevated should an emergency (self-harm, assault, medical emergency) present itself, especially in smaller outstations;
- Single Officer custodial care duties make an irony of the Agency's Single Officer Patrols policy, which dictates that no Officer is "to be rostered, directed or encouraged to patrol alone"[10];
- One person cannot adequately handle custodial care duties on top of answering phones, attending the front counter, CAD supervision, paperwork et cetera;
- To be charged with sole custodial care duties requires a great deal of patience and concentration, especially when dealing with an at risk person, and without assistance, fatigue issues could become a concern;
- Two or more Officers performing custodial care duties in unison prevents allegations made by any persons in custody as a second Officer can assist with corroborations, especially when dealing with persons of the opposite sex; and
- Single Officer custodial care duties mean that there is never the certainty of continuous detainee health and safety checks as the Officer can be interrupted from care duties and detainee(s) left unattended for lengthy periods of time.

One Member who believed that custodial care duties could not be adequately performed by a sole Officer proffered arguments for increased supervision for both the detainee and Police by saying that "it takes two people to give quality first aid, and two people attending the detainee decreases the risk of assault to the Police Officer".

[10] As per the WA Police Operational Manual, Policy **PA – 1.2.2 Single Officer Patrols**.

Most Officers cited a lack of staff resources (most specifically, insufficient staff numbers), gruelling workloads and withering district office budgets as to why many Officers were tasked to perform single Officer custodial care duties. One Officer described the workload to be performed by a single Officer in custodial duties as "extremely time consuming" and at the same time, they "felt like [they were] being set up to fail". This mentality is fostered by the fact that the Agency does not have clear and defined protocols about custodial care staffing beyond the management of detainees instructions in the *Lockup Management Procedures*. Even though the *Lockup Management Procedures* has incorporated aspects of recommendation 137 and 141 of the RCIADIC, full compliance with these recommendations as well as the policy fails to be achieved when Officers carrying our custodial care are forced to do so alone and, more often than not, whilst they must continue with their usual work duties.

The Union has frequently raised this concern with the Agency over a number of years, and reminded it of their Occupational Safety and Health (OS&H) obligations, particularly Regulation 3.3 of the OS&H Regulations that states:

> "If an employee is isolated from other persons because of the time, location or nature of the work then the employer must ensure that –
>
> (a) there is a means of communication available which will enable the employee to call for help in the event of an emergency; and
>
> (b) there is a procedure for regular contact to be made with the employee and the employee is trained in the procedure."

The Union is of the strict view that compliance with the above regulation must be provided to Members who are serving at isolated Police stations and are forced by management to carry out custodial care duties alone. This, coupled with the inability to regularly check on the safety and welfare of a prisoner, or a group of prisoners, could prove disastrous for our Members.

The staffing of Officers providing custodial care at Police stations and lockups may be a factor that contributes to the number of assaults on Officers in Police lockups. Approximately 65 per cent of the survey respondents indicated they had been assaulted by a detainee or suspect in a lockup or watch house whilst undertaking custodial duties. Only 25 per cent believed that the design and layout of the cell was a factor in the assault occurring. In statistics obtained from WA Police, assaults on Police Officers from 2008 until 2013 (YTD) fluctuated in total but remained fairly constant within each district (see Appendix D). We can see that from January 2008 until July 2013, there were a total of 226 assaults on Police Officers in Metropolitan WA and a total of 215 assaults on Police Officers in

Regional WA. Without knowing the variables such as the number of custodial staff working, rank of custodial staff involved (which would allude to experience and training), day and time the assault occurred, status of the detainee (gender, age, medical history), number of station cells and the number of already occupied cells, workload of Officers at the time of the assault and the cell design and layout, we are not necessarily at liberty to make assertions about the factors resulting in these assaults. However, the fact our Members have been subjected to a total of 441 assaults over the last five and a half years in Police stations, lockups and watch houses alone, is indicative that a problem exists with Officer safety and wellbeing in Police lockups and watch houses whilst undertaking custodial care duties.

Despite the perceptions that the PWH is now the best resourced and most modern WA Police custodial facility, the PWH is similarly besieged by a lack of appropriate staffing levels. A PWH Shift Supervisor has described the backlog of detainees, which is created by an insufficient number of staff to process incoming prisoners, as fostering an environment that is "under severe and constant pressure", has "volatile conditions" to work in and is rife with fatigue and OSH issues. In an email that was forwarded to the Union, written by a Shift Sergeant, it was noted that on 8 August 2013 the PWH received 18 detainees between the hours of 11.40pm and 3.30am (equivalent to one detainee approximately every 15 minutes). The influx of detainees was so great for the PWH to handle, the Shift Sergeant was forced to advise the Police Operations Centre that the PWH was closed for an hour and a half, between 3.15am and 4.50am. The Shift Sergeant indicated that none of her staff took their designated meal/rest breaks during this shift and the Police Officers who brought the detainees to the PWH were forced to wait extraordinary lengths of time to see their detainee through custody processing.

Such a large numbers of prisoners to be processed at the PWH is not unusual. In a document provided by staff from the PWH, it can be seen that incoming detainee figures over the last two years has increased dramatically (see Appendix E). The Union is greatly concerned that the welfare of the PWH staff is jeopardised and the level of care that can be provided to detainees is significantly reduced with an overwhelming detainee to Officer ratio.

The question has been posed as to who should be responsible for providing custodial care duties within WA Police given that there are currently three groups of employees who are tasked to this duty. Police Officers, Police Auxiliary Officers and Custody Officers across Metropolitan and Regional WA are employed by WA Police to provide custodial care in Police lockups and watch houses. In our

Member survey, we asked respondents if they believed custodial duties should be outsourced (that is, performed by an agency external to WA Police). Whilst 15 per cent were unsure, an overwhelming 62.6 per cent believed custodial duties should be outsourced. Some of the reasons proffered for why these duties should be performed by another agency were:

- "To allow Police to provide more essential services to the community whilst relying on custodial 'specialists' to deal with detainees";
- "To enable staff to be released/attend to core frontline operational Policing duties";
- To separate Police investigating a matter from the suspect/person of interest;
- The "Department of Corrective Services... [is] better trained and qualified to deal with detainee issues" as "good custody requires trained and specialised Officers whose sole duties are custody"; and
- "Independence and outside accountability", so that criticism and oversight on Members' actions is reduced.

The majority of respondents indicated that Police Auxiliary Officers were best suited to undertake custodial duties. Members believed that Auxiliary Officers performed custodial duties in a "professional and efficient manner" and Police Officers described "loving" having Auxiliary Officers employed to assist them with custodial duties as the Sworn Officers felt it freed them up to undertake other Policing duties. Police Auxiliary Officers were noted as doing a "wonderful job" and they "would be appreciated at any station". Police Officers believed that Auxiliary Officers were the best employee for the job because being employed by WA Police would ensure they were cognisant of the Police environment and could be trained by Officers who know and understand the nature of the work. However, most Officers noted that there is currently a severe shortage of Auxiliary Officers and that the retention rate of Auxiliary Officers is very low, which is largely attributable to poor work conditions, low wages and a lack of job progression.

Police Lockup Administration

Recommendation 159 of the RCIADIC required that all Police watch houses be administered with resuscitation equipment of the "safest and most effective type readily available in the event of an emergency and staff who are trained in the use of such equipment". Even though the Agency has indicated in the 2000 Implementation Report that this was achieved, 33.9 per cent of respondents to our survey indicated their station *did not* have the necessary resuscitation equipment at their custodial facility. One Member documented the following:

> "I have worked in a non-compliant lockup where I had a person die in my cells. Police Internal Affairs were there within four hours from Perth, but they were not able to comment on how many years the station had been asking for a defibrillator and cell upgrades".

Even though Life Support Training is a necessary requirement for Officers to possess, the fact that 31.6 per cent of survey respondents did not believe custodial staff were adequately trained to use resuscitative equipment indicates that the training Officers are receiving is potentially inadequate for the environment they face. Are five hour 'refresher' courses run every two years sufficient to ensure that Officers tasked with custodial care can provide basic first aid care, given the gamut of medical conditions they face? Policies, Agency documents and Government-wide recommendations can dictate best practices for detainee access to medical services. However, if Officers aren't provided with the tools to ensure that these initiatives are put into practice, not only are the implications for prisoners serious but the repercussions for our Members are enormous as they are ultimately charged with a detainee's duty of care.

Recommendation 163 of the Royal Commission requires that Police Officers receive regular training in restraint techniques, including the application of restraint equipment. When queried, only 35.4 per cent of respondents indicated they were provided with regular restraint technique training. The general consensus amongst all Officers was that they had to make do with the restraint equipment that was available in the station and rely on experience and learned skills when dealing with non-compliant detainees who required restraining. As Auxiliary Officers are the only group of employees provided with specific restraint technique training, yet all operational Police Officers face the possibility of undertaking custodial duties (the likelihood of which is especially so when the station is smaller and based in Regional WA), it appears that the Agency does not believe that restraint technique training is necessary for all of its employees. Given the propensity for violent, non-compliant and aggressive prisoners, it is not clear to the Union why more training in restraint techniques and equipment is not provided, when in doing so our Members engender skills that safeguard their own wellbeing as well as that of the detainee.

During the process of restraining a non-compliant detainee, Members face the possibility that they will be assaulted or exposed to bodily fluids. As such, respondents to the survey were asked if they were provided with any personal protective equipment whilst providing care in the custodial facility. An overwhelming 21.5 per cent of respondents indicated they were issued with no safety equipment whatsoever. Just over 76 per cent were issued with cut down knives, 23.3 per cent were issued with

safety glasses, 19.3 per cent noted their custodial facility had extraction equipment for extremely violent detainees and 18.4 per cent indicated they were issued with spit masks. One Member noted that latex gloves were the only form of personal protective equipment at their station, and if shields or other equipment was necessary they were located in the armoury in another part of the building. Another Member indicated that one cut down knife to be used by all staff was the only personal protective equipment offered at their custodial facility, whilst a different Member indicated their station's cut down knives were blunt.

Without the administration of the necessary protective personal equipment to Officers who provide custodial care, especially equipment like cut down knives which is vital for the safety of detainees, the Union is deeply concerned that it is only a matter of time before an Officer's life is seriously jeopardised or that an incident occurs that could have been prevented with the provision of appropriate protective equipment.

Recommendation 124 of the RCIADIC specifies administrative arrangements that must be put into place by the Agency to critically analyse and assess the procedures implemented and actions of staff at Police custodial facilities where an incident of importance has occurred. The *Lockup Management Procedures* refers to this recommendation in its policy about debriefing following incidents of importance in Police custodial facilities such as deaths, medical emergencies and actual or attempted suicides. However, when our Members were canvassed, only 18 per cent of them indicated they had ever been involved in a debriefing session following an incident of importance relating to a detainee.

One Member indicated they had been involved in a death in custody investigation but there had been "no debrief, no concerns for Officer welfare and no support from WAPOL" following the incident. This was supported by another Member who claimed they had never formally been debriefed by the Agency's Health and Welfare Branch or a WA Police employed psychologist. Another Member noted that they had been involved in a situation where two juveniles, who were under the influence of drugs, were brought in to the Police lockup for a range of offences. The condition of one detainee had deteriorated to the point where they fell unconscious and required ventilation. The Member noted that "the OIC notified couldn't be bothered attending, let alone debriefing, unless you call an interview with Internal [Affairs] a debrief".

Whilst many Members felt that interviews with Internal Affairs, inquests or departmental charges were considered by the Agency 'a debrief', there were a handful of Officers who noted the importance of receiving support from their colleagues. One respondent noted:

> "Many years ago as the lockup keeper at Fremantle Police Station, a detainee died whilst in my custody... My shift supervisor took the time to debrief me that night and the next day. I have always been grateful for his concern. I was a young constable and had little experience with death, particularly when I was in charge of providing care to the deceased detainee. He walked me through my responsibilities and confirmed I had carried out my duties appropriately. This was very reassuring at a stressful time".

As such, it appears that even though the Agency has established procedures for the conduct of debriefing sessions following incidents of importance (within the *Lockup Management Procedures* at policy LP-3.5), the application of these procedures is evidently absent from Police lockups and watch houses, thus indicating the lack of efficacy of such a policy. The intent of the recommendation was to put in place these procedures in order to analyse the "operation of procedures, the actions of those involved and the application of instructions to specific situations" following an incident of importance with a "view to reducing risks in the future", and yet it appears that all that is occurring is that Officers are berated, chastised and punished for any incident of importance that occurs in their presence in a custodial situation.

The Royal Commission saw that the good management of Officers at Police custodial facilities required "training at both recruit and in-service levels to enable them to identify persons in distress or at risk of death or injury through illness, injury or self-harm" (recommendation 133). Members were asked if they were provided with such training, both at a recruit level and in-service, and only 56.7 per cent indicated that they were provided with formal training to identify persons at risk or in distress. A number of Members noted they only received very basic training about identifying excited delirium and positional asphyxia during their Critical Skills and Life Support Training and that this was largely at the beginning of their Policing career. A majority of respondents indicated that being able to identify an at-risk person or someone likely to self-harm was learned on the job. One Member stated that "more in-depth training needs to be provided to recruits... [as] self-harm risk factors only become apparent when you have been exposed to these numerous times". Another Member reaffirmed the necessity of hands on practice by stating that "critical skills and mental health training... cannot replace experience and real life situations".

An assessment of a detainee forms part of a recruit's "Duty of Care" training at the WA Police Academy. Recruits are taught within the session general guidelines about how to "evaluate the 'risk factor' of the [detainee] and take the appropriate action". The lesson plan allocates 40 minutes of time to learning how to assess a detainee if they have ingested harmful substances (drugs and/or alcohol) and the "Duty of Care" précis dedicates seven pages of 56 to suicide and depression risk and evaluation. The Academy has informed us that this module is not mandatorily relearned or refreshed by any Officer during their career. There is an assumption that most of the skills required to identify an 'at-risk' person will be learned on the job, specifically during an Officer's probationary period.

Members noted their concern that the minimal training they receive is "directed at acting upon something happening as opposed to identification [of an issue] prior to an event". The Life Support Training that is offered to Officers every two years is believed to focus on "first aid response – [there is] no formal medical training to identify causal factors or symptoms pertaining to acute medical risks or conditions". Given the vast range of medical conditions Officers have to deal with in Police custodial facilities (let alone in their day to day work), and the fact they are required to undertake risk assessments, develop protocols for caring for and managing prisoners at risk and accurately record detainee's medical matters, the adequacy of current training regimes for Police Officers and Auxiliary Officers is questionable when the training received is "minimal", "limited", reactionary and informal.

It also appears that regardless of previous or current job tenure as a custodial care provider, Officers whose work "is dedicated wholly or substantially to cell guard duties" do not receive "more intensive and specialised training than would be appropriate for other Officers" (as per part d of recommendation 133).

It would appear that recommendation 133 of the Royal Commission to some extent has been applied, as Auxiliary Officers whose classification is "Custody/Support" receive more specialised training in the area of restraint techniques because their primary role is to provide custodial care. However, given Auxiliary Officers are not employed in every station, the provision of custodial care still remains the domain of Police Officers, who are not afforded intensive or specialised training. Dedicated training with respect to identifying persons at risk or in distress is not delivered for either Auxiliary Officers or Police Officers at in-service levels beyond the Critical Skills Training or professional development courses that a Police Officer must undertake to move up the ranks. If the Agency elect to station a predominance of Auxiliary Officers at WA's major custodial facility, or if

Officers at small, regional stations are the only ones charged with custodial care, or if supervisors are specifically appointed for cell lockup duties, the Union believes that these Officers should be afforded regular specific and rigorous training to enable them to identify persons at risk or in distress.

Are custodial officers sufficiently trained with respect to cultural issues?

The 2000 Implementation Report, with respect to recommendation 96, noted no response from WA Police regarding the implementation of any training or development program (specifically, those designed to "explain contemporary Aboriginal society, customs and traditions"). Even though the RCIADIC recommendation does not specifically identify Police Officers as the required group of employees to undertake cultural training, the recommendation does advise that training is suitable for 'persons whose duties bring them into contact with Aboriginal people'.

Within our survey, Members were asked more generally if, as Officers performing custodial care duties, they were ever encouraged to participate in any training or awareness programs designed to promote cross-cultural understanding. An overwhelming 74.5 per cent of respondents indicated that they had not.

The WA Police Academy has indicated that diversity training is delivered at a foundation level within two days and that the module covers the breadth of diversity issues, not just Aboriginal culture. This diversity training is only offered at recruit level yet as part of their Critical Skills Training, all Officers are required to refresh their equal opportunity training every three years.

Despite the requisite Academy training, it would appear from our Member feedback that cultural training is an area within the Agency that requires consideration and further development.

Are the current oversight mechanisms, procedures and disciplinary measures for Police Officers involved in custodial processes satisfactory?

Generally, the oversight for all Police involved in custodial processes can be described as follows:

1. The senior Officer responsible for the arrest is accountable;
2. The Officer accepting the arrest at the lockup is accountable;
3. The Supervisor on duty is accountable;
4. The OIC of the station, although not necessarily present, is accountable as they need to ensure that any local area procedures address the particular needs of the specific lockup;
5. The District Office is accountable and is responsible for ensuring adequate staffing of the station or approval of necessary overtime;
6. Professional Standards is accountable for ensuring a fair and thorough investigation is conducted should any incident of self-harm, illness or injury occurs to the detainee whilst in Police custody;
7. The OSH Branch within the District is accountable to ensure that the OSH legislation, Codes of Practice and guidance advice is complied with and appropriate Police Manual policies are developed; and
8. The Corruption and Crime Commission (CCC) is accountable for ensuring proper oversight of all of the above.

In our opinion, the oversight mechanisms, procedures and disciplinary measures for Police Officers involved in custodial processes are satisfactory, given there is a chain of command through which accountability escalates and that an external agency retains overarching oversight of the actions of WA Police.

In canvassing the Membership, the majority of the survey respondents felt that the current oversight mechanisms were adequate, with 59.6 per cent agreeing that the procedures, mechanisms and disciplinary measures presently in place are satisfactory. When answering the question, 93 Officers proffered insight as to how the oversight mechanisms operated and highlighted their concerns about the current operations.

One Member duly noted that oversight mechanisms and procedures "do not take into account the use of old, outdated facilities that are poorly designed [combined with a] lack of staff". This was reiterated by another Member who noted that there seemed to be no "checks as to the suitability of the building or services provided", highlighting the need for preventative rather than reactionary measures to be put in place. Another Member felt that there was a great deal of uncertainty and a lack of clarity about "what [Officers] can do to ensure the safety of Officers and detainees. No updates are given and we do what we believe to be within the guidelines".

Members felt as if the disciplinary procedures were inappropriate, and that WA Police took a "guilty until proven innocent" approach. One respondent put it as a "blame mentality whereby the involved Officers are 'thrown to the wolves' without departmental support... The hierarchy appear immune from investigation or blame, despite being required to provide safe and adequate working environments".

Other Issues

Training

Beyond training regarding the identification of persons at risk or in distress and the application of restraint techniques, respondents to our survey identified other areas of Agency training that they believe require review. It appears from Member feedback that training received is too infrequent and impersonal; as one Member noted, "the most comprehensive training I have received on custodial processes was at the WA Police Academy over a decade ago. Any kind of similar training is briefly provided during annual critical skills lessons and by way of email (broadcast)". Other Officers also feel that the WA Police 'Blackboard' medium is not a desirable training format as it is perceived by Officers as "inadequate as it relies solely on theory and does not apply any practical involvement".

Members believed that training opportunities existed for the practice of removing difficult, aggressive, violent or aggravated prisoners from cells or Police vans. Cell extractions pose a major concern for Officers – when detainee well being and safety are touted as a priority, how do Officers handle a violent, uncooperative prisoner without injury to the detainee or themselves? When Officers are not afforded personal protective equipment beyond latex gloves and spit masks, they are forced to make do with what they have been given, which is not sufficient for dealing with these types of detainees. One Member noted, with regard to the lack of ongoing training regarding cell extraction, that they themselves were "originally trained [in cell extraction] by the Prison service as a district initiative with ongoing training and use of a practice cell... [Since joining WA Police I have] been given the Police package once with no refreshers". It would appear that any restraint training that is provided by the Agency, particularly for Police Officers, does not sufficiently deal with cell extractions.

Our Members also identified the need for training in relation to high-risk detainees who are drug or alcohol affected. Whilst the Royal Commission discussed the harmful use of drugs and alcohol in its report recommendations (recommendations 63 to 71) and identified the need for Officers to engage in cultural awareness training (recommendation 96), there was no reference in the RCIADIC to training Officers to provide custodial care for detainees affected by or addicted to drugs and alcohol, and how to mitigate the consequences of their behaviour or possible medical impacts of their substance abuse.

Restraints

Numerous Members voiced their concern about restraints for violent, non-compliant prisoners. Even in a padded cell, detainees can harm themselves (by hitting their heads on walls or the floor, or by punching, hitting or scratching themselves) or Officers attempting to enter the cell. These Officers proffered ideas about tools, equipment, training and administration but indicated their concern that, despite the benefits for the detainee and the custodial carers, the use of restraints would be generally frowned upon by society as a whole. One Member stated:

> "Use of Velcro restraints should be implemented. WAPOL, CCC etc need to acknowledge that many people arrested and detained are not happy and in fact behave in a violent manner. Leg and arm restraints may appear uncivilised however they are very effective in reducing or stopping injury... Many agencies that oversee custody have never dealt with an angry person and have no concept of the dangers involved".

Another Member observed that their current station did not have a padded cell and as such, it would be greatly advantageous if the station were issued with "Fast Straps which enable the prisoner to be secured with limited movement to prevent self-harm".

Detainee processing

Several Members identified the electronic Police custody system as laborious, time consuming and difficult to use. One Member stated that using the system is "time consuming to log in a detainee, it is unmanageable and... extremely difficult to unravel any entries to correct an error". It was noted as the cause of most of the time delays in the lockup and is not believed to be "designed to encourage Officers to record accurate and timely information, nor is that information once recorded easily seen and read". Given the emphasis on accurate and ample communication between and within all of the relevant agencies identified in the Royal Commission recommendations (particularly at recommendations 127, 130, 131, 132 and 138), it is concerning that the recording systems for detainee information in place by WA Police is considered by its users to be substandard.

Balancing custodial care with other work duties

Throughout the Union survey, Members expressed the unrealistic expectations that were placed on them with respect to managing their workloads. As one Member put it:

> "The conflict between the pressure not to incur overtime and pressure to manage CAD, front counter, incoming telephone calls, management of detained persons under section 139 of the CIA, as well as management of the persons within the custodial facility can fall to one or two people [particularly in Regional WA]. It is unrealistic. There is an equal responsibility to catering for the welfare of our colleagues on the road, members of the community requiring

assistance and persons in custody... Appropriate staffing levels are critical to risk mitigation, not a luxury".

Though lockup staffing is a broad concern we have addressed throughout this submission, what must be emphasised beyond the numbers of Officers stationed and rostered to work within a Police custodial facility are the duties of those who provide custodial care in stations and watch houses. Whilst we see dedicated custodial carers at WA's main Police lockup facility, the PWH, nowhere else in the state has such a dedicated custodial presence, despite the existence of major centres that warrant such staffing (for examples, see Appendix F).

In the meantime, Officers at stations who are tasked with custodial care are simultaneously having to undertake all of the other required duties – manning the front counter, answering telephone calls, completing necessary paperwork, and in some cases, leaving the station to ensure that a van is on the road. In doing this, recommendation 147 of the Royal Commission is disregarded, the well being of detainees is compromised and the obligations placed on Officers to successfully accomplish their required duties within a shift are onerous and unacceptable.

Satisfying the requirements of s. 139(3) of the *Criminal Investigation Act 2006*

The necessity of a holding cell, as discussed in the section of this submission regarding cell design, was a resounding concern amongst Members as they noted their ideas and experiences throughout the Union's survey. Section 139(3) of the CIA notes that

> "An arrested suspect who is detained under subsection (2) must be detained in the company of an officer and not in a lockup or other place of confinement, unless the circumstances make it impracticable to do so."

Given that no Police station, lockup or watch house in WA has a CIA compliant holding room, Officers are forced to 'get creative' with where an arrested suspect is placed. Officers have noted that a variety of rooms within the station are used to hold an arrested suspect, yet none of these rooms are safe for a non-compliant suspect. The makeshift holding rooms do not have CCTV (or some other audio/visual monitoring), unsecured furniture and office equipment/supplies are within reach, there are no beds or bedding facilities outside of the lockup cells for the arrested suspect and sensitive Police information is often within earshot or view of suspects who are forced to sit with Officers at their work stations. Not only are these situations potentially dangerous for an arrested suspect who may be at risk of self-harm, but it compromises Officer safety as it leaves our Members vulnerable to an attack from an aggressive or violent person. An unsecured room with easy access to station exits also means that an arrested suspect is liable to escape, especially if a station is understaffed and the Officer tasked to watch the suspect diverts their attention momentarily.

Prisoner escorts

A number of Members, predominantly from Regional WA, have identified some concerning issues with respect to prisoner escorts. Officers at smaller stations with courts attached or nearby are finding that prisoners are being unceremoniously left at the Police station by prisoner escort staff for Officers to watch over prior to, during and after their court hearings. In doing this, Officers become tied up with watching over prisoners, often in conjunction with other detainees and on top of any other Police work that is demanded of them. A concerned Member from Southern Cross spoke of their experience:

> "Prisoner on a court remand warrant transported to Southern Cross for the trial hearing. Escort agency attended station (as courthouse has no secure prisoner facilities. On arrival, [escort] staff stated he was to be handed over to [Police] for all subsequent custody/care as well as escort to and from the court house... I only have a secure pod, no approved cells...
>
> We had four staff on duty, three involved with the trial of the escorted person (and other matters), and one staff member conducting court orderly duties...
>
> The court has no adjoining access so the prisoner had to be walked (in handcuffs) through the front door of the Police station and in the front door of the courthouse. Not ideal with members of the public around as well as family members of the prisoner. Luckily we don't have media attend our courts here as that could have caused an issue as well".

A Member who was previously stationed at Mount Barker noted that:

> "The contractors would arrive with a prisoner, deposit him or her into a cell and basically forget about them until court had finished. The issue with this is that they were remand prisoners not in Police custody, but Police were still expected to look after them".

At Meekatharra Police Station, this is noted as being a significant issue, with one Member recalling a recurring incident:

> "...six SERCO staff would fly into town, deposit the prisoners in the lockup then sit down in the lunch room with their feet up refusing to look after the prisoners. With court running and normal tasking requirements, the extra burden was outrageous... I spoke to the SERCO supervisor on a number of occasions who advised it was not their role or part of their contract and it was a Police lockup".

Again, at Bridgetown, the same is noted:

> "SERCO deliver the remanded individual to the station and the person is placed in the interview room. This is the only room in the building in which we can lock the door and

(most) of the room can be viewed remotely from the OIC's office. It requires an Officer to constantly deal with this person as well as the issues of toilet breaks where the only ones available are staff toilets at the other end of the building".

Members at Narrogin have numerous concerns relating to SERCO and prisoner arrangements. If a prisoner has a bring up order, SERCO staff will arrive at the Narrogin Police Station without notification of attendance or arrival time. They deposit the prisoner in the custody of Police and 'disappear'. SERCO then refuse to assist with the escort to court or custody. Officers stationed at Narrogin have noted that there have been circumstances where SERCO has arrived at 7am, when day shift staff do not commence until 8am, with the intention of leaving the prisoner at the station with whoever was on duty.

Narrogin Members have illustrated other examples where issues exist with SERCO and the provision of prisoner escorts. Where Police are holding remand prisoners or prisoners with warrants of commitment, contact is made with SERCO Operations. It appears that SERCO advise the Narrogin Police that they are unable to collect the prisoner and invoke their "pickup within 24 hours" directive. As Narrogin is not a 24-hour centre, Officers from the station are then required to escort the prisoner to Hakea or a larger 24-hour centre (such as Armadale or the PWH). Our Members have advised us that a number of escort options have been explored:

- To meet SERCO halfway at North Bannister, which becomes a two hour round trip for Narrogin Police Officers;
- Escort the prisoner to Armadale Police Station and have SERCO, PWH or available Auxiliary staff escort the prisoner to Hakea, which is a three hour round trip for Narrogin Police Officers; or
- Narrogin Police Officers escort the prisoner to Hakea or PWH, which becomes a six hour round trip.

According a Sergeant at Narrogin Police Station, 80 prisoner escorts were conducted by the station's staff last financial year, which appropriated approximately $30,000 from the Narrogin Police Station budget.

The OIC of Narrogin Police Station has written numerous emails to the District Office outlining his concerns (see Appendix G), including:

- The number of Police FTEs required to fulfil anticipated court and subsequent custodial services, who are therefore not available to attend the station's required tasking and administration duties;
- The lack of assistance from SERCO which convey remand prisoners to Narrogin;
- The benefits of SERCO conducting the duties associated with the Magistrate's Court; and
- The overtime that is incurred by requiring Police Officers to escort prisoners to Perth.

However, it appears that requests for action have been in vain as SERCO continue to run its business often to the detriment of our Members.

Recommendations

1. Resourcing Police custodial facilities

The resourcing of Police custodial facilities is the utmost priority of the Union. Single Officer custodial duties are completely unacceptable and should be treated in the same manner as the Agency's single Officer patrol policy. It is the view of our Membership that if custodial duties remain the responsibility of WA Police then all lockups and watch houses must be staffed not only with the appropriate number of Police Officers and Auxiliary Officers, but with staff whose sole responsibility is custodial care. As such, the Union strongly recommends the following:

- A designated minimum staffing level for all lockups and watch houses that considers the detainees' needs, district demands, heightened periods of activity of the town/district and cell and station design and facilities;
- Ensuring a minimum of two Officers are tasked to custodial duties at any given time so that
    - the risk of assault on an Officer is decreased
    - an Officer is provided assistance should a detainee suffer a medical emergency
    - any allegations against an Officer are corroborated
    - Officer fatigue issues can be adequately and appropriately addressed
    - communication is maintained between members of staff
    - a detainee (or detainees) can be more vigilantly monitored, as per recommendation 137 of the RCIADIC;
- Tasking Officers *solely* for custodial duties within their shift or role so that these Officers can provide a diligent, expert and thorough duty of care to detainees and enable fellow Police Officers to undertake the necessary duties of a station, including manning the front counter, answering phones, paperwork, attending to other members of the community, providing back up to colleagues, CAD and VKI; and
- An extra 50 custodial staff for the Perth Watch House, Western Australia's largest Police lockup, so it can operate effectively and safely.

Of the Liberal's 550 promised Police Officers and Auxiliary Officers, the Union wants an assurance that 50 Officers will be employed to work at the PWH[11]. The current staffing levels do not match the modern size and technological advances of the PWH and it is vital that WA's largest Police custodial

[11] As per the Ministerial Media Statement delivered 7 August 2013 < http://www.mediastatements.wa.gov.au/Pages/StatementDetails.aspx?listName=StatementsBarnett&StatId=7633 >

facility is adequately staffed to provide a level of care to detainees and safeguard the well being of the Officers it employs.

2. Provision of medical staff

Recommendation 127 of the Royal Commission specifically notes a regular medical presence in all principal watch houses in Perth and other major centres and the ready availability of a medical practitioner or nurse in all other locations. We have outlined in this submission that the PWH is the only watch house in WA that has any kind of medical presence, being a registered nurse (RN) who is rostered to be present at particular times of the week. Even though Members at PWH have indicated that the presence of the RN was appreciated, the substantial numbers that passed through the PWH warranted a dedicated, full-time nursing presence and during busy times, more than one RN.

Though a 24/7 on-call nursing service is available to the Metropolitan area, the majority of survey respondents were not aware this was in existence or if they were aware, had an RN refuse their request for nursing assistance. At Regional WA stations, the situation is greatly concerning as medical arrangements are far more ad hoc. Some stations indicated a good relationship with their remote area nurses, whilst others indicated it was entirely up to the Officers to transport a detainee to receive medical assistance as SJA was unlikely or unable to attend and medical practitioners or nurses would not attend the lockups.

The frequency with which Officers take detainees to medical facilities is often withholding them from providing a continued service to the whole of the community. Members also deal with detainees who experience an abundance of medical situations, many of which are due in part to substance abuse, mental health issues or age. Police Officers and Auxiliary Officers are not medical practitioners or nurses or health providers and cannot possibly be trained to recognise every single medical condition.

Taking all of the above into consideration, the Union strongly recommends that medical practitioners be permanently employed to work at the PWH and all other major centres (see Appendix F) outside the Metropolitan area, with at least one practitioner stationed in the lockup 24 hours a day, seven days a week. A doctor is not only able to provide the appropriate level of medical assistance when necessary, but they are also able to provide "fit to hold" certification should a detainee present with medical concerns but are well enough to be detained in the lockup.

If a doctor cannot be employed, then a nurse must be employed. This nurse can perform a dual function in their role once the Union's disease testing legislation is enacted. A nurse who is stationed at the PWH 24/7 will be able to take blood samples from offenders who expose Police Officers to bodily fluids capable of transmitting an infectious disease.

For all other locations, the Union recommends that a 24/7 on-call medical practitioner or nursing service is arranged, especially in areas where SJA is unlikely or unable to attend in a timely fashion.

3. Reviewing the *Criminal Investigation Act 2006*

The fact that there is not one single Police facility in the state of WA that possesses a CIA compliant holding room, including the newly built Perth Police Complex, is cause for concern. If WA Police and the WA Government are not willing or cannot afford to construct the appropriate holding facilities for arrested suspects, then consideration should be given to rewording or removing this provision in the CIA.

The Union recommends that when the Minister reviews the CIA (as they are tasked to do under section 157 of the Act, and which ought to have been completed in 2011), section 139(3) be reworded, removed or redefined so that the intent of this section of the Act aligns with the status quo of Police custodial facilities.

4. Cell design requirements

It is unacceptable that the age and state of cells in stations across the State vary so greatly that the Union is able to provide such extreme examples like Southern Cross (where the cells do not form part of the station, there is no sally port and no CCTV monitoring) and Armadale (where the cells are so far from the main office, an Officer must walk down stairs to a 'basement' type level to make checks on prisoners). Where the Royal Commission calls for the maximisation of visual surveillance and monitoring devices in cells, these two considerations should be paramount in considering the redesign of Police cells. Where the Royal Commission entrusts the formulation of guidelines about Police custodial facilities to a national body for state jurisdictions to adopt, the resulting document (the WA Police Building Code *Custodial Design Guidelines*) should be absolutely paramount in considering the redesign of Police cells.

As such, the Union recommends that every effort be made to modernise all Police cells to comply with the specifications outlined in the *Custodial Design Guidelines*. Despite the relatively frequent revision of these guidelines, the Union believes that the Membership should be canvassed for its

input regarding cell design (as per page 16 of this submission), as they are the people who work primarily within these cells and are positioned to comment about the functionality of these cells. The Union calls for consistency in the development and construction (or reconstruction) of these cells with a goal to achieve the utmost safety for both detainees and Officers.

5. Improving access to welfare services

The availability of representatives from the ALS was noted as a main concern for Officers with respect to the provision of welfare services in Police lockups. Many Officers, and there was no notable discrepancy between Regional and Metropolitan WA, found representatives from the ALS to be unavailable, unresponsive and indifferent. We are not in a position to comment on the reasons as to why this is the experience of our Members, but the Union believes that staffing and resources at the ALS are impacting the delivery of a specific welfare service to detainees and should be reviewed.

Access to mental health educators, assessors and amenities are becoming increasingly necessary in the operation of a custodial facility and beyond access to the Aboriginal Medical Service, there are no providers of mental health assistance. With respect to Aboriginal peoples, the Mental Health Commission has noted that Indigenous Australians have a greater incidence of mental health issues and recommend guidelines specific to identifying and providing mental health first aid to Aboriginals and Torres Strait Islanders[12]. Generally, our Officers have acknowledged the need for the provision of mental health care to *all* detainees given the unpredictability of mental health conditions.

As such, the Union recommends that in conjunction with permanent 24/7 access to a medical practitioner or nurse, Police lockups and watch houses also have access to 24/7 mental health care. Moreover, the PWH should be staffed with a mental health assessor, be it a counsellor, psychologist or mental health nurse, so that accurate assessments can be made of a detainee prior to and during their detention in Police custody.

6. The provision of custody specific training

Within this submission, numerous types of training have been identified as necessary to learn the skills to adequately perform custodial care duties. The ability of Officers to provide general first aid and know how to use resuscitative equipment is essential to preserving the health and wellbeing of detainees. Training in the correct restraint techniques and use of equipment is important to ensure

[12] Accessed from The Government of Western Australia's Mental Health Commission, *Aboriginal mental health* website, < http://www.mentalhealth.wa.gov.au/mental_illness_and_health/mh_aboriginal.aspx> 7 August 2013.

that both Officer and detainee safety is maintained. Being trained to identify an 'at-risk' or 'in-distress' detainee is a vital component of providing a duty of care. Having an empathetic and respectful approach to cultural differences could facilitate a smoother custody process. To ensure that all of these skills are maintained, it is imperative that this training is thoroughly refreshed throughout an Officer's career.

From information provided to us by the WA Police Academy and our Membership, it is clear that the training concepts noted above are not uniformly applied to all Officers employed by WA Police. We have concerns that this training, essential for providing a satisfactory standard of custodial care to members of the community and for protecting Officers whilst performing their duties, is not adequate. We understand that many skills are developed whilst on the job, the Union believes a 40 minute portion of a 3 hours and 20 minute long session on "Duty of Care" does not adequately train our Members to accurately assess a person at risk or in distress. A five hour St John Ambulance refresher course, held every two years, does not sufficiently assist in identifying the breadth of medical issues, particularly with the prevalence of substance abuse, that our Members face on a daily basis. It is concerning that only Police Auxiliary Officers are afforded such intensive restraint technique training, when similar training is just as worthwhile for our Sworn Members who face intense scrutiny with any use of force applied in a custody situation.

The Union is also concerned about the delivery of training to Police Officers. Are there enough programs run by WA Police that advance cross-cultural awareness and are Officers being encouraged to utilise this training? How can the Agency better utilise their training tools beyond Blackboard so that Officers can learn the real-life, practical applications of advancements in a variety of training modules?

Officers require intensive and rigorous training to undertake their vital role as custodial carers. As such, the Union recommends that the aforementioned training components are reviewed by WA Police to ensure that Officers are being appropriately trained with respect to:

- The ability to identify a detained person who is at risk or in distress;
- The ability to use the appropriate resuscitative equipment and being able to identify major medical concerns beyond positional asphyxia and excited delirium;
- All Officers being trained to properly and appropriately restrain a detainee, with or without force;
- All Officers being trained in cell extraction;

- The provision of diversity awareness programs across all levels and ranks of the organisation, beyond equal opportunity training, that aims to facilitate custodial processes; and
- More training that focuses on drug and alcohol affected detainees, including identifying side effects of particular substances and how to mitigate dangerous behaviours.

7. Oversight and review mechanisms

Recommendation 124 of the Royal Commission requires that Officers follow a process of debriefing following an incident of importance yet only 18 per cent of the survey respondents indicated they had ever been involved in an official debrief. As noted by the recommendation, the debrief should review the "operation of procedures, the actions of those involved and the application of instructions to specific situations". The experience of the Membership indicates that following an incident of importance, any Officer present is subject to intense scrutiny and their actions and integrity are doubted from the outset. It appears the Agency is not engaging in facilitative discussions with Officers about their actions and decisions at the time of an incident of importance nor does it seem to be re-examining the instructions issued by senior Officers and procedures followed so that these incidents do not occur again. As a result of a lack of appropriate debriefs and the subsequent conduct of the Agency (the "guilty until proven innocent" attitude), a culture of suspicion and guardedness is fostered.

The Union recommends that WA Police properly implement recommendation 124 of the RCIADIC by formulating, in conjunction with the Union, a policy regarding the appropriate manner of debriefing following an incident of importance in a Police lockup or watch house and implementing the process of debriefing in a non-inflammatory, facilitative manner.

8. Role of SERCO

Current SERCO practices with respect to prisoners involve leaving prisoners at Police stations for the care of already time and resource pressed Police Officers and making the prisoner escort process difficult and time consuming. Consequently, the Union is adamant that changes to the Regional WA, Police-related SERCO processes are enacted so that our Members are removed from the custodial care of remand prisoners. The Union recommends that SERCO contracts be altered to encompass total responsibility for all persons within its custody. The Union understands that this would still necessitate that SERCO utilise the respective Police station, but we believe that under the circumstances outlined within this submission, prisoners should remain under SERCO guard for the totality of their court appearance. In instances of prisoner escorts, Police Officers should only ever

have to escort a prisoner to a prison or watch house under extraordinary circumstances – SERCO must endeavour to collect prisoners from the appropriate Police station in a timely fashion.

Appendix A

Table 72 Deaths in Police custody and custody-related operations by type of custody, 1989–90 to 2010–11 (n)

	Institution	Escaping	Detaining	Other/marginal	**Total**
1989–90	20	0	9	0	**29**
1990–91	16	0	10	0	**26**
1991–92	13	0	11	1	**25**
1992–93	11	0	26	1	**38**
1993–94	8	0	21	2	**31**
1994–95	7	0	23	0	**30**
1995–96	7	0	24	0	**31**
1996–97	5	1	28	0	**34**
1997–98	10	0	18	0	**28**
1998–99	9	0	10	2	**21**
1999–2000	4	0	32	0	**36**
2000–01	5	0	27	1	**33**
2001–02	6	0	30	6	**42**
2002–03	7	1	30	3	**41**
2003–04	5	2	35	0	**42**
2004–05	7	0	28	1	**36**
2005–06	4	0	19	0	**23**
2006–07	5	0	24	2	**31**
2007–08	4	0	30	0	**34**
2008–09	4	1	32	0	**37**
2009–10	5	0	21	2	**28**
2010–11	3	0	23	0	**26**
Total	**165**	**5**	**511**	**21**	**702**

Appendix B

LP-3.4 Surveillance until Release or Discharge

In the case of an attempted self-harm in a Police lockup, the member in charge shall ensure that a constant watch is kept on the particular detainee until release, discharge, removal to medical care or medical clearance received.

A constant watch can be maintained by an officer via CCTV or physical presence.

If a medical clearance is received frequent cell checks no more than 10 minutes apart are to be made.

Record details of all actions on Custody, on the detainee running sheet if applicable and in the Occurrence Book.

...

LP-10.1 Cell Checks/Health, Safety, Welfare

A member shall regularly visit each detainee to ensure the safety and welfare of that detainee and to determine any reasonable needs.

Officers should be fully cognisant of the antecedents of detainees and ensure due caution is taken with detainees who are aggressive, dangerous or mentally unstable.

When medical attention or advice is sought relating to the welfare of a detainee, a notation is to be made on the detainees running sheet and on Custody detailing the following points -

1. The time when the medical attention or advice was sought,
2. The name of the medical facility and staff member giving the advice or diagnosis,
3. The advice or diagnosis given by the medical staff member.

...

LP-10.3 Records of Checks and Observations

Members conducting cell checks shall record the time of each check and their observations of each detainee.

The type of cell check that is appropriate for each detainee will depend on the past history of the detainee, if known, and the information available and assessment made, at the time of admission. All information is to be recorded on the detainee running sheet and Custody.

A cell check may include physical arousal of an apparently unconscious detainee/detainee if this is necessary to ensure health and safety. Methods of arousal should be restricted to:

- shaking;
- noise (calling out);
- pinching with fingers in web of hands or feet; and
- watching for the rise and fall of the chest.

If there are any doubts about the condition of a detainee, or if a detainee fails to respond to these arousal techniques - **SEEK MEDICAL ASSISTANCE IMMEDIATELY**.

Appendix C

Within the cell, is there:

Answer Options	Yes	No	Response Count
adequate drainage internally (inside the cell) for a vigorous washing down	164	204	368
adequate drainage externally (outside the cell) for a vigorous washing down	129	240	369
a push button cell alarm enabling a detainee to call for assistance	323	45	368
an Audio Monitoring System	154	215	369
where an Audio Monitoring System is not provided, an intercom that allows the detainee to communicate with Police who are situated in a continually manned location	193	134	327
CCTV	343	28	371
CCTV that produces a clear picture on the monitor with good contrast in full colour	252	114	366
duress alarms installed along cell block corridors	322	49	371
fixed bench seats with rounded edges set into a wall recess	238	128	366
a natural ventilation system (adequate air flow)	218	152	370
a mechanical ventilation system (heating and cooling, temperature sensors, sufficient air circulation)	230	136	366
		answered question	373
		skipped question	89

Appendix D

Assault Incidents on Police Officers in Prison/Lockup and Police Premises

Offence Region	District	Place Description	2008	2009	2010	2011	2012	2013 YTD
Metropolitan Region	Central Metropolitan	Police Premises	20	14	12	7	12	4
		Prison / Lockup	18	12	2	6	8	0
	East Metropolitan	Police Premises	2	5	3	2	3	2
		Prison / Lockup	0	0	0	0	1	0
	North West Metropolitan	Police Premises	0	1	1	5	0	1
		Prison / Lockup	0	0	0	2	1	0
	Peel	Police Premises	1	1	2	1	6	1
		Prison / Lockup	1	1	1	0	0	0
	South East Metropolitan	Police Premises	5	4	3	4	2	3
		Prison / Lockup	0	0	0	0	3	2
	South Metropolitan	Police Premises	6	3	0	1	5	2
		Prison / Lockup	4	0	0	0	1	1
	West Metropolitan	Police Premises	3	1	6	4	3	1
Metropolitan Region Total			60	42	30	32	45	17
Regional WA Region	Goldfields-Esperance	Police Premises	9	19	4	2	6	0
		Prison / Lockup	3	0	0	2	1	0
	Great Southern	Police Premises	3	5	2	2	2	0
		Prison / Lockup	0	0	1	0	0	1
	Kimberley	Police Premises	11	6	12	9	9	5
		Prison / Lockup	2	2	0	4	3	2
	Mid West-Gascoyne	Police Premises	4	9	4	2	3	4
		Prison / Lockup	2	1	0	2	0	0
	Pilbara	Police Premises	5	6	7	1	3	1
		Prison / Lockup	1	0	0	2	0	0
	South West	Police Premises	4	4	3	5	9	0
	Wheatbelt	Police Premises	2	0	2	0	1	1
Regional WA Region Total			46	52	35	31	37	14
Grand Total			106	94	65	63	82	31

Appendix E

Number of detainees processed by the Perth Watch House by month, 2011-13

	2011	2012	2013
JAN	710	1003	1195
FEB	771	999	1085
MAR	892	1038	1226
APR	884	977	1137
MAY	952	974	1073
JUN	857	1010	1046
JUL	848	1059	1106
AUG	936	1014	0
SEP	849	998	0
OCT	927	1068	0
NOV	814	1091	0
DEC	1023	1109	0
TOTAL	10463	12340	7868

Appendix F

Major centres outside of the Metropolitan Area:

- Albany
- Broome
- Bunbury
- Carnarvon
- Esperance
- Geraldton
- Halls Creek
- Kalgoorlie
- Karratha
- Kununurra
- Meekatharra
- South Hedland.

Appendix G

Email one

The Narrogin Magistrate Court sits for 5 consecutive days once per month.

The Monday is a trial hearing day, Tuesday being for arrest/remand hearings, Wednesday morning for Children's Court matters with the afternoon set for trial hearings. Thursday is again set for trial hearings with Friday as another trial day if required.

Wednesday through to Friday are generally also used for Family Law Court matters such as restraining order hearings.

Historically Monday, Tuesday and Wednesday are the days of high workload and therefore maximum Police staffing requirement.

The current Magistrate demands an orderly to be present at every sitting she sits upon, regardless of the court.

Five Police FTEs are generally required to full-fill anticipated court and subsequent custodial services. This encompasses the duties of a court orderly, two staff to ensure custodial processing and care, and a further two to provide prisoner escort duties to and from the court house when and as required. Frequently there are two or more prisoners, therefore these separate duties cannot be combined and conducted by the same two officers.

Average station staffing levels during the court sitting period is 6. This includes the Officer in Charge and Administration Sergeant, but excludes the Customer Service Officer. This diverts both the OIC and Administration Sergeant from their core functions, whilst at the same time eliminating available staff to attend required tasking and administration duties.

Out-station assistance is usually obtained to supply a local tasking vehicle for the Narrogin sub district. This in turn removes that tasking vehicle from their sub district, generating a flow on effect to that station's surrounding sub districts.

Due to the often volatile nature of the local family interaction, external court security is regularly required to ensure uninterrupted court proceedings. When the likely-hood of such anti social or violent behaviour is anticipated, extra out station assistance has been provided. Difficulty in providing that service arises when spontaneous anti-social behaviour erupts within the court precinct, especially when officers are fully committed to custodial care and prisoner escort security.

Currently, when remanded prisoners are conveyed to Narrogin by SERCO, they are delivered into the lockup custodial system and become the full responsibility of Police. During the custodial period, Police attend to the prisoner's security, care and escort to and from the court. The SERCO staff do nothing by way of assistance until the prisoner is returned to their custody. Two Police FTEs are committed to the stated duties whilst the SERCO staff, who are already in attendance at the station, do nothing other than read the paper, drink coffee or stroll around the townsite.

Past difficulties have arisen when the Magistrate has handed down an imprisonment term, late in the day, which has not been expected. SERCO have enforced the 24 hour transport period, leaving the station with the responsibility of either retaining the prisoner overnight (usually forfeiting the tasking vehicle and thus necessitating recall overtime to attend urgent tasking duties), or conducting the escort to the prison/ Perth watch House. This again removes a tasking vehicle from the sub district, enhancing the possibility of recall overtime for any urgent tasking that may arise in their absence.

The benefits of SERCO conducting the duties associated with Magistrate Court are:

- It will enable Police FTEs to conduct their core function duties which, especially for the day shift staff, are currently placed on hold until the following week. This impacts on investigations, timely brief submissions, etc.
- Narrogin Police will be able to provide a consistent service to the sub district.
- Outstation FTEs will also be better positioned to service their localities without being removed to assist with Narrogin tasking duties.
- A reduction in orderly overtime will be experienced as often court will still be sitting when shift completion occurs.
- The immediate attendance of SERCO staff to the court, as opposed to undesirable waiting periods when prisoner removal/ escort from the court is required.

The difficulty experienced by Narrogin Police members, as will also be experienced by SERCO planning staff, is that each court day has different work load and requirements. Some court sitting weeks will have no remanded prisoner attendance, nor terms of imprisonment handed down, whilst during other weeks there will be numerous incidents of such requirements.

Email two

Our SOP's require ALL escorting staff/ supervisors to contact PWH first; Armadale Police Station second; to ascertain if a half way meet is possible.
Therefore, all 'full way' escorts to PWH would have had requests for assistance made prior to them being conducted. They are very helpful when staff are available; especially Armadale when they have auxiliary staff working as they allow us to drop off the offender; saving us usually 2-3 hours of travel and wait time at PWH.

Our actual figures for the total July to current date are:
To PWH – 13 full escorts at an overtime cost of 108 hrs
Half way (North Bannister) escorts – 3
Armadale drop off escorts – 4

Our records indicate 20 requests for half way meets have been made, 3 have been conducted.

Email three

Good Afternoon

In relation to your email, please find herewith the above information – re Narrogin Police Station Police Escorts to PWH.

<u>July 2012:</u>

1 trip to PWH, 2 Officers – Normal Hours 15 hrs Overtime Hours 16 hours total

<u>August 2012:</u>

2 trips to PWH, 4 Officers - Normal Hours 30 hrs Overtime Hours 16 hours total

<u>September 2012:</u>

4 trips to PWH, 8 Officers - Normal Hours 47hrs Overtime Hours 32 hours total

Do hope this information to your satisfaction

Email four

Of late some of you have had issues with PWH not assisting with half way meets for escorts.

This is a subject we want to take up with them and most of the information we need re: number of times you've had to escort and costs etc we can get from the escorts returns, however, one stat we'd like to use in your favour but can't get from the escort returns is how many times you sought assistance with a half way meet and were knocked back.

We are looking at the period Jul 2012 – current.

Please reply by return email (even if a nil return) so I can be sure I've heard from everyone.

Before you ask I understand I could look at the escort returns and see how many full escorts you did and use that number, but that doesn't account for the times you may not have asked.

Please respond before COB Wednesday so I can provide accurate information to the superintendent.