CORRUPTION AND CRIME COMMISSION SUBMISSION TO THE COMMUNITY DEVELOPMENT AND JUSTICE STANDING COMMITTEE INQUIRY INTO CUSTODIAL ARRANGEMENTS IN POLICE LOCK-UPS

BACKGROUND

The Corruption and Crime Commission ("the Commission") has recently conducted public examinations, as part of its investigation, into two incidents that occurred at the Broome Police Lock-Up in March and April 2013.

In the lead up to the examinations the Commission conducted research into key issues relating directly to lock-up facilities. These issues were selected to guide the research because they aligned with, and further amplified from a practical perspective, the main misconduct themes in which the Commission had an investigative interest. Those themes included supervision, accountability, use of force, management of lock-up facilities, management of Indigenous detainees in lock-up facilities and management of injuries. The research involved an examination of documents, mainly policies and procedures from within Australia, and a literature review of national and international best practice.

The Commission compiled an overview of these issues and conducted an initial analysis. The Commission may conduct further analysis of the appropriateness of policies and procedures when all matters pertaining to its investigation have been concluded. At that time the Commission may form views and make related recommendations.

Any views contained in the research are preliminary views only, based on research undertaken in conjunction with the Commission's investigation of the matters above. The investigation is not yet complete and, therefore, any views are inconclusive and yet to be validated against cases.

It is hoped that the Commission's submission will assist the Community Development and Justice Standing Committee in its deliberations and inform its subsequent findings.

OVERVIEW OF RELEVANT ISSUES

What follows is a summary of main issues identified during the course of Commission research activities. This summary is not indicative of any final position taken by the Commission in relation to any of the issues identified.

Supervision and Accountability

1. Supervision of police officers by their superiors has been an issue identified over the past two decades in various literature without evidence of any significant improvement being achieved.

2. The role of supervisors is often unclear.

3. Anecdotally, it seems that heavy workloads are an issue, as is insufficient time available to supervise staff.

4. The level of supervision available and/or provided to staff is not consistent and the experience of supervisors varies.[1]

5. There is often a lack of experienced supervisors available for recruits resulting in probationers being supervised by recently appointed constables.[2]

6. The standard of supervision and the management of lock-ups varies around the world. Where consistent standards exist, they are not consistently applied.[3]

7. Supervision should be linked to accountability mechanisms such as the reporting and recording of incidents.

8. Supervision plays an important role in the handover and reception of a detainee in relation to ensuring the right information about the general circumstances and condition of the detainee is properly communicated.

9. Guidelines in relation to supervision are not used appropriately.[4]

10. There is no specific guidance for officers as to how to de-escalate situations and manage violent incidents which occur in the lock-up environment.

11. Special attention is required in relation to the assessment and supervision tasks of those managing Indigenous detainees.

12. There is a lack of initial training for supervisors and ongoing training is required.

Medical Attention in a Lock-Up

1. All staff should be informed of detainee's physical and psychological well-being at the commencement of each shift.

2. Police staff are not clinically trained and therefore sometimes limited in their ability to adequately screen detainees. Further, there is a potential risk associated with the confidentiality or otherwise of a detainee's medical information and whether and how it may be used for purposes other than lock-up screening processes. This factor may impact on what a detainee discloses.[5]

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[1] Western Australian Auditor General (2012). *New Recruits in Western Australia Police*, Report 8, June 2012.

[2] *Ibid,* pp. 14-15.

[3] *Literature Review of Best Practice in Police Lock-up and Watch House Facilities* (2013), Corruption and Crime Commission of Western Australia. p.24.

[4] Western Australian Auditor General (2012), Report 8, *op cit*.

[5] *Literature Review of Best Practice in Police Lock-up and Watch House Facilities* (2013), Corruption and Crime Commission of Western Australia. p.7.

3. Specially trained medical professionals should form part of the assessment process. This occurs in some South Australian, New Zealand and overseas jurisdictions where custody nurses are part of the assessment.

4. Some procedures relating to medical assessments are unclear or substantively incomplete. For example, a procedure may state that an assessment should be made but does not state who should make that assessment.

5. The Aboriginal Medical Service should be contacted for Indigenous detainees when that service is available.

6. Additional consideration should be applied to the assessment of persons presenting as intoxicated. A person displaying signs of intoxication may in fact be head injured or diabetic.

7. Alternatives to custody should be considered for detainees presenting as intoxicated. For example, placement within a sobering-up shelter may be more appropriate than detention in a lock-up facility.

8. A higher than usual level of supervision is required for intoxicated detainees as the potential for the rapid deterioration of their condition is greater.

9. In addition, specific reference to the medical care of all vulnerable persons, including juveniles, detainees with impaired intellectual or physical function, Aboriginal and Torres Strait Islanders and detainees from non-English speaking backgrounds, should be made within lock-up policies and procedures.

10. There is a need for on-going training in relation to awareness of medical issues in lock-ups.

Use of Force

1. There is a lack of guidance within policy and procedure in relation to the de-escalation of incidents in lock-ups meaning that the default provisions relate to use of force.

2. Lock-up policies and procedures should specifically refer to the handling of violent prisoners and the management of incidents requiring the use of force.

Indigenous Detainees

1. The kinship ties of detainees should be considered by lock-up staff.

2. To raise awareness of the risks associated with the detention of Indigenous persons, specific reference is required in lock-up policies and procedures to the findings of the Royal Commission into Aboriginal Deaths in Custody (1991).[6]

[6] *Literature Review of Best Practice in Police Lock-up and Watch House Facilities* (2013), Corruption and Crime Commission of Western Australia. p.24.

3. Indigenous detainees should be offered the services of the Aboriginal Legal Service, the Aboriginal Medical Service and the Aboriginal Visitors Scheme.

4. Best practice and duty of care in relation to Indigenous detainees needs to be kept current through training and awareness raising.[7]

5. Literature regarding the management of Indigenous detainees in lock-ups is lacking and would benefit from additional research being conducted.

CONCLUSION

Lock-up and watch house facilities present a unique risk environment which requires specific management strategies. The detention of a person, that is, deprivation of their liberty, exercises one of the most significant forms of power available to any public authority.[8] The very nature of the lock-up means that detainees are likely to be in an emotionally charged state and a "significant proportion of persons taken into police custody have mental health issues and/or alcohol and substance abuse problems" which means that effective lock-up management practices are critical.[9] Failure to properly manage lock-ups can result in an increased risk of misconduct.

The Commission's general observations in relation to misconduct themes explored through research include that policy and procedure is sometimes unclear and that implementation of that policy and procedure at times requires specialist skills and heightened supervision. Further, in an environment where the chance of violence and aggression involving vulnerable individuals is likely, more could be done to guide related management actions. Literature and other documents indicate that where policy is well designed and implemented and where supervision is effective, misconduct risks can be managed.

[7] *Ibid,* p.13.

[8] *Ibid,* p.2.

[9] *Ibid,* p.2.

CORRUPTION AND CRIME COMMISSION OF WESTERN AUSTRALIA

Literature Review of Best Practice in Police Lock-up and Watch House Facilities

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Introduction

Around the world an estimated 10 million people are held in a range of institutional settings, such as prisons, mental health facilities, and asylum seeker detention centres (Nowak, 2010). Police watch houses or lockups (cells located in police stations) are a common category of detention; typically used to hold a person apprehended by police for a few hours until a decision can be made about whether they can be released or transferred to a remand facility to await trial. By detaining people in a watch house, police are exercising one of the most serious forms of power available to public authorities, the deprivation of liberty, and as such, the process of placing people in a police cell carries significant responsibility.

The watch house is a challenging and high risk environment. A significant proportion of persons taken into police custody have mental health issues and/or alcohol and substance abuse problems. Moreover, police often engage with people during times of crisis or serious emotional upset, such as an acutely agitated schizophrenic person experiencing hallucinations; angry family members involved in domestic disputes; or seriously intoxicated persons with poor self-control (Oliva, Morgan &Compton, 2010). The process of detaining persons and placing them in a watch house, quite often involving disturbing circumstances, can itself trigger irritation, fear and other emotive responses. The prevalence of mental health issues and alcohol/drug affected persons amongst watch house detainees, coupled with any conflict during police arrest, translates into a volatile watch house environment for both detainees and police.

When people detained by police come to harm or, in some cases, die, the treatment of people held in police custody attracts strong media attention, particularly when minority groups are involved. The literature notes that the issue of injury or harm in police detention is an especially controversial area of policing when it concerns cultural or ethnic tensions as is the case in England, Australia, New Zealand, South Africa and the USA (Hannan et al, 2011; Furman & Collins, 2005). In turn, the stakes involved in ensuring the safety of police and people held in watch houses are high

and relate to issues of procedural fairness, community harmony and public confidence in police and government.

Although a particularly contentious phenomena, deaths in police custody have not been the subject of much formal research (Hannan et al, 2011). In addition, the existing academic literature on deaths in custody is relatively outdated. In general, not much is known in the academic literature about custody in police cells. Unlike prisons which have been subject to formal research, police detention has produced minimal formal study (Blauuuw, Vermunt, & Kerkhoh, 1997). It appears that the police watch house is an area of detention that has been less examined than detention in prisons; partly because the detention role of police has traditionally been subsumed by their more prominent image as public crime fighters. Hence the custodial aspect of policing has received far less attention than other aspects of the police role, although custody practices commonly spark public and political attention following the uncovering of controversial watch house incidents.

This review of the literature aims to identify what 'best practice' is regarding the detention of people in police watch houses. The idea of "best practice" has been around for a century and is closely associated with managerial agendas that seek to determine what the best ways to produce the best outcomes are. Determining and applying 'best practice' is a way of setting professional standards. According to McCauley (2007) "custody Best Practices are those practices, techniques and methods that identify and analyze risks to prisoners' and officers' safety, security and well-being, and the best response to those risks" (p.9). As yet, a definitive set of best practice standards in the watch house is unavailable; much like the academic literature, international protocols for the treatment of persons in detention tend to focus on the imprisonment of sentenced people rather than those apprehended by police (Blauuw, Vermunt, & Kerkhoh, 1997). Still, there are a number of professional guides, government inquiries and certain key studies which collectively contribute toward the identification of basic standards or measures underpinning a well-run watch house. Their contribution to this field is outlined below.

International Watch House Practices/Conditions

In light of their status as a place of temporary detention, the majority of jurisdictions around the world do not invest in police lockup facilities (Nowak, 2010). Commonly, conditions in police lockups are extremely poor and overcrowded, notably worse than conditions in correctional institutions, and people held in lockups sleep on the floor (concrete or mud), without any bedding, covering, water, food or toilette facilities (aside from a hole in the ground or a bucket). More alarmingly, police lockups worldwide frequently hold people for periods far in excessive of a few hours, and instead hold them for days, weeks, months and years. For example, in Jamaica people detained by police are often ordered by judges to remain held in police lockups long-term because of spacing shortages in the country's remand centres. In addition, it is common for police across various world jurisdictions to reject any obligation to provide for persons detained in police lockups. Rather, police claim, lockup detainees are the concern of family members, and not police. In Equatorial Guinea, people held in police lockups are provided with water and food by their family; or have to rely on the goodwill of fellow lockup detainees if they have no family that can help them (Nowak, 2010). The poor conditions of police watch houses have been documented in various reports around the world, including Australia (*Conditions for persons*, 2006; Dissel & Ngubeni, 2000; Ruppel & Groenewaldt, 2008).

United Kingdom

Police watch houses (also called custody suites) in England, Wales and Northern Ireland are governed by an overarching framework called the Police and Criminal Evidence Act (PACE) codes (1984). The introduction of PACE in 1984 provided a legislative framework and codes of practice regarding various aspects of the custody process, such as the extent of police powers, the rights of suspects and treatment of persons in detention (Skinns, 2012). The specific code of practice contained in PACE regarding watch house detention is PACE Code C 2012 *Requirements for the detention, treatment and questioning of suspects not related to terrorism in police custody* (PACE code

C, 2012). The PACE custody framework guides dedicated police staff known as a 'custody officers' (or sometimes 'custody sergeants') in their management of watch house processes (Healthcare of Detainees, 2009).

Before PACE, custody in the UK was governed by the Judges Rules (1906) which came under mounting criticism for their lack of clarity and effectiveness (Skinns, 2012). A Royal Commission on Criminal Procedure (RCCP) was held in 1981 to review the entire UK criminal justice system and its recommendations formed the bedrock of the emergent PACE framework during the 1980s. The introduction of PACE sparked a number of academic studies examining its operation and impact, particularly in regard to police misconduct, throughout the 1980s and 1990s (Skinns, 2012). These studies showed that PACE was accepted by police with some hesitation regarding added bureaucratic requirements for everyday police tasks, more rules to follow, increased risk of internally-enforced penalties against police, and perceived undermining of police effectiveness in criminal investigative processes (i.e. having to take notes during interviews with suspects).

The impacts of PACE on police practices involved clear guidelines regarding when, and for what length of time, persons can be detained in custody; basic standards of custody facilities; and when suspects can be questioned. Under PACE, the wellbeing of watch house detainees became the responsibility of 'custody officers' (rank of sergeant) who must remain separate to any criminal investigation process and who ensures detainees have certain rights met. These rights include access to legal assistance/representation, contact with friend/family member (rights which custody officers ensure detainees are made aware of). The other key impact on police operational procedures enacted by PACE was the introduction of a strong bureaucratic element to the custody process (Macguire, 1988). PACE called on custody staff to better monitor and record their practices which entailed establishing more stringent record keeping. Making officers sign against custody actions, in turn, made them more accountable in the event of adverse incidents. Suspects too, were expected to sign in agreement of their rights having been respected. These core

PACE practices were intended to protect both police and watch house detainees from harm and from false allegations of mistreatment.

The extent to which the record-keeping standards set by PACE have actually improved protections in watch houses remains undetermined (Macguire, 1988). Some research has modestly shown that "to some extent it would appear that the objectives of the [PACE] legislators have been (or are gradually being) achieved" (Bottomley et al, 1991). Some academics suggest that the new framework failed to genuinely reform police practice (Skinns, 2012). For example, where PACE stated that all suspects had a right to legal advice, it was found that police commonly discouraged them from accessing it through a number of strategies like readings their rights in a manner too fast for them to follow. Moreover, PACE codes direct rather than fully legislative police practice standards, which are, in turn, subject to disciplinary rather than legal censure (Macguire, 1988). As noted above, police themselves maintain that PACE has added a significant bureaucratic burden to the job of policing and has diminished opportunities for suspect confessions and case closure rates. It should be noted that since the late 1990s, there has been minimal empirical information available regarding police custody in the UK (Skinns, 2012).

America

In America, a comparative centrally governing framework such as PACE in the UK, does not exist. The operational management of various aspects of policing, such as accident reports, criminal investigation procedures, maintenance of police resources and others, have all developed checklists and record templates to guide police through how best to carry them out (McCauley, 2007). However, the custody process in America does not have an equivalent central or guiding procedural guide. Not one agency in America has a unified custody policy i.e. policy that comprehensively looks at all points of the custody process from arrest, to transfer, to watch house detention, to transfer/release. In turn, American police officers largely draw on their common sense, which, given the complex process of custody, does not adequately address the many risks involved.

Supervision of Lock-Up Facilities

Risk Assessments of Watch House Detainees

It is uniformly recognised in the literature that every person taken into a watch house should be risk assessed, irrespective of immediate indications of trouble (Bucke et al, 2008; Hannan et al 2011; Royal Commission, 1991). In the Australian context, this has been highlighted as of particular necessity in regard to Aboriginal detainees. The RCIADIC (1991) stated that police must make some assessment of people coming into custody, both physical and psychological. In England and Wales, persons taken into a police watch house are supposed to be screened for medical needs, including mental health issues, as a matter of standard practice (McKinnon & Grubin, 2012). For the most part this screening is conducted using a standardised process involving a custody sergeant and computer-based forms.

Assessing for risk means that watch house staff should consider if a detainee has any injuries, medical conditions or medication requirements (McCauley, 2007). They can do this:

> *Visually*: look for signs of injury, check to see if detainee comprehends language and can provide lucid replies, look for medical alert bracelets or necklaces.
>
> *Verbally:* Ask detainee if they have any injuries or take medications. Ask other people who know a detainee if they are aware of any injuries or medical conditions.

There are some limitations to the conduct of screening by police custody staff. Police staff are not clinically skilled and the screening process is invariably limited as a result (McKinnon & Grubin, 2012). Also, the information provided by detainees is not confidential and can be used for criminal investigations, which limits what some detainees disclose. In the only published study regarding the effectiveness of watch house screening tools in England and Wales (conducted in London), it was found that watch house screening failed to identify health risks in detainees in a

significantly high number of cases (i.e. half of asthma sufferers, 1/3 of detainees with diabetes, 2/5 of detainees with epilepsy, and most of detainees who arrived with a head injury) (McKinnon & Grubin, 2012). Hence the use of a screening tool by police custody staff alone cannot ensure detainees who need medical attention will be identified and diverted to medical attention in time. This either calls for more effective screening tools and screening training or for greater involvement of medically trained professionals in watch houses.

Forensic Medical Practitioners

In the UK, an accepted part of the assessment process for persons detained by police involves specially trained medical professionals, such as forensic doctors and nurses. Forensic medical professionals are "contracted by police forces. Part of their role is to offer medical care to detainees and to advise whether they are well enough to be kept in police custody or interviewed by police officers" (Hannan et al, 2011, p. 4). Increasingly, UK police managers have begun to introduce multidisciplinary teams of medical staff in custodial settings, replacing a once traditional reliance on forensic physicians (doctors). This major shift in the way medical practitioners operate in policing contexts was precipitated by changes to the PACE framework in the UK in 2003; various health care professionals were allowed to work in policing as well as doctors (Substance Misuse Detainees, 2011). In particular, police custody facilities in the UK began drawing on the services of nurses as "part of a global service modernization agenda" (Bond, Kingston & Nevill, 2007, p. 128). The introduction of nurses to custody facilities addresses several critical issues: general lack of forensic physicians; expands police medical services; and, sets level of medical care offered to custody detainees on par with other detainees (i.e. prisoners) who have access to various health practitioners as a matter of standard practice.

In one study of a custody nursing service in northern England, it was found that, in comparison to forensic physicians, nurses were prompter in responding to custodial inquiries, spent equal time attending detainees, and

were seen as police custody staff as better communicators during handovers (Bond, Kingston & Nevill, 2007). Likewise, in the Scottish city of Tayside a dedicated custody nursing service was piloted and was found through evaluation to have significantly improved health outcomes and minimised risks for watch house detainees (Elvins et al, 2012). The pilot service included nurses available 24/7 in medically-resourced rooms within the watch house. One example of the minimisation of risk in the watch house enabled by having on-call nurses was the greater efficiency in provision of methadone to detainees who were then less likely to 'act out' and attract restraint.

In New Zealand, the beneficial role of nursing practitioners to watch house functioning has recently been acknowledged by the Independent Police Conduct Authority (IPCA). Following a review of deaths in police custody over a ten year period in NZ, the IPCA recommended that police work with the national health agency to expand the availability of nursing services in watch houses and improve custody staff's access to medical information (Thematic Report, 2012).

In South Australia, a City Watch House Community Nursing Service (CWHCNS) was created during the early 2000s to more adequately meet the health needs of custody detainees (Toepfer, Patterson & Nicholson, 2008). The CWHCNS was part of a wider Arrest Referral Project jointly developed by the South Australian Police and the Drug and Alcohol Service of South Australia (Trifonoff & Pfitzner (2005). The Service has secured 3 full-time nursing staff located in the City Watch House. The service targets vulnerable and high-needs detainees including people with drug/alcohol issues; mental health problems; physical conditions; homeless people etc. The custody nurses conduct clinical assessments and then refer detainees to appropriate health services, rather than keep them in the criminal justice system.

It should be noted that whilst detainee assessments may be included as part of standard operational procedures, this may not be enough to ensure it becomes standard practice. In a report regarding deaths in police custody in

England and Wales (1998-2009), the authors found that of 247 people who were booked at a police station and later died, less than half were assessed for risk despite custody processes entailing such assessments as standard (Hannan et al, 2011). The most common reason police gave for forgoing a risk assessment was issues with drunkenness. Similarly, the Crime and Misconduct Commission in Queensland found that even though Queensland Police had developed medical assessment forms and a dedicated information system (Polaris) to record detainee details against which all watch house detainees are screened, there was some indication they were not consistently practiced.

Recording and Communicating Knowledge of Watch House Detainee Vulnerabilities

In addition to assessing detainees, the literature notes that information about watch house detainees' physical and psychological wellbeing needs to be documented and communicated in a manner that alerts other staff of any risks. At the start of their shift, lockup staff need to be briefed on each detainees' needs and risks (Hannan et al 2011). This is in keeping with the UK Association of Chief Police Officers' *Guidance on the Safer Detention of Persons in Police Custody* (2nd Edition, 2012), as well as American literature regarding best custody practice (McCauley, 2007). According to McCauley, it is best practice for police to maintain a continuous record or information flow of detainees' physical health and emotional state that is reviewed by every officer at different points of the custody process. Likewise in New Zealand, the IPCA recommends that police initiate an official handover procedure to ensure detainees receive adequate care (Thematic Review, 2012).

It follows, McCauley (2007) explains, that custody staff should have suitable recording templates (electronic and/or hard copy) which clearly prompts them to follow best custody practices and to record all necessary information. In other professions, procedural checklists are considered best practice and the same should apply to custody work. For example in aviation, pilots have systematic check sheets before take-off and landing. Similarly, in medical settings, hospital patients have individual medical charts to minimise the risk of professional error. Properly

recording and communicating information about detainees is particularly important in regard to Aboriginal detainees. The RCIADIC (1991) emphasised the necessity of creating consistent processes for gathering and communicating knowledge about detainees' vulnerabilities.

Monitoring Detainees

As a matter of standard practice all detainees should be regularly checked in a watch house (Hannan et al, 2011). Monitoring should be both in the form of CCTV as well as in-person visual checks by watch house staff at 30 minute intervals (McCauley, 2007).

Supervising Vulnerable Watch House Detainees

Mentally Ill

It is a widely known, and an empirically established reality, that people with mental health issues are more likely to engage with police, courts and prisons (Ogloff et al, 2013). Moreover, everyday policing has increasingly involved dealing with people who have a mental illness. This trend has evolved from the decline in the care of the mentally ill in institutionalised settings, ongoing restrictions in the availability of psychiatric facility spaces and tightening of involuntary commitment laws (McLean & Marshall, 2010). Despite the growing relevance of people with mental illness to policing practices, the vast majority of academic publications examining the link between mental illness and the criminal justice process focus on prisons and psychiatric provisions, overlooking the point when people with mental health issues initially come into contact with police (Baksheev, Thomas & Ogloff, 2010; Ogloff et al, 2013).

In a unique Australian research project, it was found that from a sample of 614 people held in Victorian police watch houses; 1/3 reported psychiatric symptoms at the time of their detention, over half had previously accessed a public mental health service, and close to 1/3 were receiving psychiatric care at the time of being taken into custody (Ogloff et al, 2011). In addition, a

substantial 70% of this sample reported abusing drugs, often various sorts at the same time; and 21% of detainees needed medical help with acute drug withdrawal ailments. These figures, by the authors' own admissions, are likely applicable to other Australian states. As is the finding that a significant number of watch house detainees with mental health issues are not being recognised by existing screening tools. Australia lacks a standardised, uniformly applied screening tool for people who come into watch houses and some states have no screening processes in watch houses whatsoever (Baksheev, Ogloff & Thomas, 2012). This is a serious shortfall, because how to handle people with a mental illness is a significant matter in regard to minimising risks in watch houses. Research has shown that of the 48 people who died as a result of police force between 1980 and 2008, over half had an established mental health illness (1/3 had more than one condition); and those killed were 12 times more likely to have a severe mental illness like schizophrenia than someone from the general community.

The situation in Australia is not unique. Other researchers have observed that "worldwide there is a need for secure mental health facilities in which to place offenders where they will have access to treatment, and for the resources and programs for specialised training of police who encounter mentally ill people on a daily basis" (Moore, 2012). In the UK, police are allowed to detain people under the Mental Health Act in a 'place of safety', but given the limitations of mental health facilities this often means that mentally unwell people are taken to a watch house; causing frustration for police and leaving vulnerable people without appropriate care. Much like the diversionary preferences suggested in watch house guides for people who are intoxicated (see below), there are a number of diversionary initiatives to identify mentally ill people at the watch house and redirect them to suitable care. For example, in London three police stations have introduced a Community Psychiatric Nurses service with numerous reported benefits.

Likewise in America there are three dominant models used by police stations to divert people with a mental illness away from the normal custody route (Martinez, 2010). These three diversionary models are the Crisis Intervention Team (police specially trained to identify and direct mentally ill people); the Mobile Crisis Team (police working with mental health practitioners); and the Community Service Officer (social workers with some police training accompanying regular police staff on duty). In America, as elsewhere however, it is clear that regardless of diversion options available to police, without alternative pathways or places to divert mentally ill people to, police are often left with no choice but to place a person in a watch house. One of the challenges posed by vulnerable groups like people who are mentally ill is that effective care requires cross sectorial involvement; police, *in conjunction* with health, social and community services, are best positioned to meet the complex needs of mentally ill offenders (Baksheev, Thomas & Ogloff, 2010). As Martinez (2012, p.173) explains, "police cannot solve the problem on their own. Community mental health facilities that provide around-the-clock service are essential. These mental health facilities must have a relationship with the criminal justice system in order to begin reducing the number of individuals experiencing mental health issues that end up in prison or jail [or a watch house]."

Aboriginal Australians

Police engagement with Aboriginal Australians has a long history of opposition and struggle, which all police services and practices must address (Webber, 2007; Substandard cultural awareness, 2011). Like with mentally ill persons, Aboriginal people are significantly more likely to come into contact with the justice system and are thus an important group to consider when determining best practice in the watch house (Blanford & Sarre, 2009). In the early 1990s, the Royal Commission into Aboriginal Deaths in Custody RCIADIC (1991) placed national emphasis on trying to minimise the risk of

detaining Aboriginal people in police custody by looking for alternatives to arrest/detention or curbing the length of time they are held.

In terms of academic information, the literature contains information regarding various diversionary programs targeting Aboriginal offenders as well as many publications which critically discuss police policies or practices that contribute to the massive over-representation of Aboriginal people in prisons. However, less is available in the academic literature regarding Aboriginal-police engagement specifically in the watch house. It appears that best practices are primarily informed by the various inquiries held regarding Aboriginal deaths in custody; the benchmark of which was RCIADIC. Hence, the AFP's *National guideline on persons in custody and police custodial facilities* uses RCIADIC as its source for determining best practice with Aboriginal detainees (Review of ACT, 2007). The AFP guidelines state that when an Aboriginal person is taken into custody, custody staff should contact an Aboriginal Legal organisation and an 'interview friend'.

The AFP guide is in keeping with the "standards for police cells" presented by the Office of Police Integrity in Victoria. The Victorian guide states that the cultural rights and status of Aboriginal and Torres Straight Islander people held in detention should be recognised as follows: "People of Aboriginal or Torres Strait Islander descent are recognised as having distinct cultural rights. These include the right to maintain their kinship ties and their distinct relationship with the land and waters under traditional laws and customs" (2008, p. 10). Similar to the AFP guide, the Victorian guide suggests that custody staff need to enable detainees from this cultural group to meet with someone from the Aboriginal Legal Service or Aboriginal Community Justice Panel.

A review of ACT police watch houses found that although watch house staff were aware of the heightened risks involved in Aboriginal detainees they lacked training and knowledge of best practice with Aboriginal detainees (Review of ACT, 2007). Moreover, staff had limited communication with

Aboriginal individuals or organisations who could provide ongoing advice regard cultural best practice. One of the recommendations following this finding was "ensuring all staff are aware of their duty of care obligations to Indigenous and juvenile detainees; and instituting monitoring arrangements to ensure that these obligations are met" (Review of ACT, 2007, p. 72). The broader significance of training, awareness raising and monitoring to establishing best practice in watch houses is discussed further below.

Alternative Watch House Models

Custody Investigation Units

In England, a new custody model was introduced in 2011 in the Norfolk and Suffolk counties with the creation of Custody Investigation Units that contain dedicated custody staff and interviewers. A dedicated custody unit means that the custody process is managed and delivered by focused and trained staff; further allowing arresting officers to return to community policing activities much faster. Previously, officers who arrested persons during police patrol were the ones to take detainees into custody, which could take a full day to finalise. The Custody Investigation Units were created as part of larger new Police Investigation Centres established in the counties and had proven a more cost-effective way of processing people detained by police. The Head of Joint Custodial Services, Chief Inspector Roger Wiltshire, reported that their capacity to take people into custody had significantly increased with the new Centre facilities and added cells, so that on New Years Eve (their busiest night of the year) they could process double the number of detainees than under the old custody model.

In a study of 60 police stations during the early 1990s, the use of dedicated police custody staff and facilities was found to deliver better custody outcomes than when custody was handled in a non-specialised police process (Blauuuw, Vermunt, & Kerkhoh, 1997). The higher quality of custodial services offered by dedicated custody staff was supplemented by specialist

custody resources and practices; specifically, a comprehensive set of documented custody procedural guides and the standard use of recording practices regarding daily activities and detainee status. The researchers of the Netherlands study concluded that "assigning the custodial task to specialised custodial divisions, developing good duty prescriptions and registering daily activities in the cellblock are likely to be good measures to improve detention circumstances in police stations" (Blauuuw, Vermunt, & Kerkhoh, 1997, p. 67).

Community Supervision

Currently across Australia, there are a number of prisoner visitor schemes, particularly focussed on providing Aboriginal detainees with care and comfort. One possible extension of the visitor scheme involves the involvement of community members in not only visitation but also the supervision of watch houses. The Queensland Crime and Misconduct Commission has commented on the potential for a new service delivery model for watch houses to involve community supervision (Restoring Order, 2009). Such a model would require funding and the payment, training and security screening of selected community members. In Australian jurisdictions, which currently engage Police Liaison Officers (PLOs), the watch house community supervision model could be fulfilled by extending the current roles of PLOs from 'liaison' to include certain supervisory functions.

The Queensland CMC has cautioned that the community supervision model of watch houses poses significant challenges in terms of clarifying the legal liabilities of community members in the events of deaths, injury or accident (Restoring Order, 2009). The Commission further pointed to concerns that there are difficulties providing existing police staff with necessary watch house training, which suggests additional training for community members may not be practical; and, community engagement with prisoner visitor schemes can be difficult to maintain, which may mean a community supervision model may lack sustainable community support. In turn, the

Queensland CMC concluded that community supervision of watch houses is a valuable model, however, should only be done with community members officially employed by police. Local community members can be employed as civilian watch house assistants (currently done in some regional and metropolitan watch houses in Queensland); and/or, Aboriginal police officers can be placed in watch houses to assist with supervision. The adoption of some form of community supervision would increase the capacity of existing watch house police staff to attend to calls or other operational priorities.

Handover/Transfer of Arrestees to Lock-Up Facilities

For the American Professor of Criminology, R. Paul McCauley, best practice in police watch houses can only be established when treated as part of a wider custody process or an entire "system of continuous and interactive activities, events, and information" (2007, piii). Placing a person in custody involves apprehending them from a different location and transferring them to a watch house which can take several officers over the course of many hours or even days to perform. Hence procedures in a watch house alone are not enough to determine best practice. All points of the custody process must be addressed; including steps in the custody process *prior* to watch house detention. Best practice in police custody prior to a persons' placement (i.e. transferring person to watch house) in a watch house facility includes the following practices.

1. Point of police arrest. Begin record of detainee; including circumstances of arrest and level of force applied (detainee resistance and types of restraint used i.e. pepper spray, held to ground, by how many officers etc). This is crucial information for medical professionals or watch house staff in the event of later health deterioration or injuries.

2. Escorting detainee to police car: Handcuff hands behind back and stand to side of detainee. Hold detainee to prevent escape or falling.

3. Putting detainee into police car. Cars must be clean and inspected for weapons. At this point police must decide if there are reasons a

detainee cannot be restrained with a seatbelt and safely transported i. e. obesity, covered in body fluids, violent, or any other reason. Instead, medical transport should be sought to divert detainees to appropriate medical care.

4. Determining if detainee has any injuries, medical conditions or medication requirements. Do this visually by looking for signs of injury and checking to see detainee comprehends language and can provide lucid replies. Look for medical alert bracelets or necklaces. Ask detainee if they have any injuries or take medications. Ask other people who know detainee if they are aware of any of this. Likewise, take detainees' medications (with their names/labels) to watch house. Verify with relevant information (i.e. prescribing doctor) what detainee needs are.

5. Determining if detainee has any mental health or behavioural issues that are risky. Document detainee mood at point of arrest and changes to disposition during custody (i.e. angry, happy, sad, upset, unspoken etc.). Such information is significant to self-harm and suicide risk. This information must be passed on to watch house staff. Any behavioural displays, like seizures, must be conveyed to staff.

6. Deciding where detainee should be sent. A police watch house is not the only place a person in custody can be sent. Police should also consider- hospital, mental health centre if detainee is showing signs of the following: Unresponsive, unconscious, bleeding, highly inebriated or drug affected, talks about suicide, appears mentally unstable.

7. Escorting from police car to watch house. Police should conduct a visual examination of detainees before opening car door to make sure he is handcuffed and restrained properly. Resistant detainees are high risk but remain alert and careful with all detainees. Once detainee is out of the police car, search for weapons and or drugs.

In McCauley's formulations of police custody best practice above, emphasise is placed on minimising the opportunity for detainees to physically confront or threaten police, and, in turn, for the need for police to apply force in response.

Managing De-Escalation of Incidents During Arrest and Handover

How to manage resistant or hostile people has been the subject of research and discussion amongst a variety of social service groups, including nurses, social workers and counsellors. A number of occupational groups face uncooperative people on a regular basis within their client load. These can include court-ordered clients at drug/alcohol services or family members involved in domestic violence cases. In the police context, some literature examines police behaviours in difficult situations including in times of crisis (i.e. hostage negotiations) and when engaging with high risk persons, such as the mentally ill (Klein, 2010). Other occupations dealing with resistant clients seek to redress client-resistance primarily for the purpose of achieving therapeutic or social goals. In a police context, dealing with resistant people involves the added burden of avoiding physical injury as resistance to police may provoke restraint and therefore lead to injury (Kerr, Morabito & Watson, 2012). Hence de-escalation skills are significant for securing public and police safety.

In various American states, police are taught de-escalation skills in certain training programs, such as the Crisis Intervention Team course (Olivia, Morgan & Compton, 2010). These skills are designed "to provide an effective and helpful resolution to the situation while reducing liability and risk of injury" (Olivia, Morgan & Compton, 2010, p. 16). CIT training runs over 5 days and includes theory instruction as well as practical performance training scenarios to practice de-escalation skills first hand. Key attributes of de-escalation include:

- effective communication: remain calm and talk slowly using concise sentences, create dialogue; and
- active listening: acknowledgment statement, build rapport, mirror expressions, summarise statements, show empathy.

As the program director of one CIT course in Chicago emphasises, de-escalation involves good "people skills … as long as you're talking, you're not going to get hurt" (Klein, 2010, p. 207). These skills apply to cross-cultural contexts where effective crisis management and culturally sensitive policing involves the ability to demonstrate understanding of other persons' perspectives and worldviews (Furman & Collins, 2013). Being able to de-escalate a tense situation with someone from a culturally diverse background entails having a basic level of cultural awareness and of trying to change behaviours using a collaborative approach that involves the person.

Injury Management (Arrest, Transfer and Lock-Up)

In the Australian context, the Royal commission into Royal Commission into Aboriginal Deaths in Custody (RCIADIC, 1991), has been pivotal to producing a numerous changes to the way persons held in custody are treated and managed. One of the many outcome of RCIADIC was the National Deaths in Custody Monitoring Program run by the Australian institute of Criminology since 1992. Despite the national data on deaths in custody, no parallel data collection efforts has occurred in Australia, nationally or in any of the states/territory, to capture rates or trends in detainee injuries during police custody (Sallybanks, 2005). This lack of reliable and consistent data limits opportunities for identifying 'trouble spots' and responding with necessary interventions in police watch houses with higher than normal numbers of injuries.

Leadership and Cultural Practice in Managing Lock-Up Facilities

The literature notes that custodial duties are not highly regarded or valued within police forces around the world (Hounmenou, 2010). Moreover, police are often working with limited resources and under time pressures. It follows that investing in training, education, and awareness-raising amongst police regarding the importance and practicalities of fulfilling custodial functions would represent a clear signal from police leadership that the duty is valued. As stated by the AFP and Commonwealth Ombudsman, maintaining appropriate standards of care for watch house detainees

"requires high level organisational commitment to proactive management of Watch house operations … sound supervisory structures, comprehensive reporting arrangements and leadership that is informed, and responsive to, the challenges of custodial care" (Review of ACT, 2007, p. 81).

Watch House Staffing

One of the advantages of the creation of dedicated 'custody officer' positions in the UK under the PACE framework was the ability to staff watch houses with persons holding the most suitable skills required for the role. The high-risk environment in watch houses calls for people with above average people skills. There are certain known personality traits that maximise the potential for effective crisis management and minimise need for the application of force, these include officers who "are assertive, precise, considered team-players, who have exceptional listening skills and demonstrate empathy; ability to utilize effective problem solving; and characterised by the capacity to stay calm and remain in control" (Olivia, Morgan & Compton, 2010, p. 19). In the UK, the custody officer role seeks suitable officers; a custody officer job advertisement in the UK describes the ideal candidate as someone with "great people skills, a non-judgmental approach … This role requires the ability to deal with vulnerable and difficult people whilst maintaining high standards of security and service delivery. Strong communication and interpersonal skills are vital" (Prisoner Custody Officer, 2013).

Although the dominant image of policing is one of active crime fighting, the reality is that police must perform a variety of roles and often provide social services to people in times of heightened vulnerability and crisis (Olivia, Morgan & Compton, 2010). Hence, investigative skills are one dimension of a larger skill-set required by the police force. In the watch house, as the job advertisement highlights above, the skills most needed are those regarding people management and communication. In turn, police working in watch houses require people skills and training in related communication and de-escalation methods.

Ongoing Training for Custody Staff

Most custody guides and studies point to the need for ongoing training for custody staff (Blauuuw, Vermunt, & Kerkhoh, 1997). The first imperative component of custody staff training is First Aid skills. Lockup staff must have First Aid Training and regular refresher courses as a standard part of their role (Hannan et al, 2011). In a British study of deaths in custody it was found that overwhelmingly (less than 1 in 5 cases) police or lockup staff had not been trained in First Aid Training (even less refresher training), which are key to immediate responses to detainee injuries. The IPCA in New Zealand further recommends that all custody staff are training to understand the risks of restraining people in particular ways (i.e. face down on floor with hand behind back) and of suffocation or other serious physical conditions in certain positions (Thematic Review, 2012). The IPCA suggests that training should teach staff best practice in restraint tactics.

In Wales, a new custody training program was developed by the South Wales Police to better equip officers working within custodial settings (Sommers, 2013). The training provided to all Welsh custody includes detainee:

- mental health issues;
- risk assessments; and
- rights and entitlements.

The custodial training program involves refresher workshops for custody sergeants twice yearly to keep them updated on relevant legislative changes; further advice regarding professional standards and best practice in custody settings.

McCauley (2007) makes the point that training alone will not ensure best practice is carried out. Police training must be accompanied with education. It's not enough that police *know* the policies and procedures, they must understand *why* they are important. Understanding can generate sustainable motivation to uphold best practice. In a similar vein the Independent Police Conduct Authority (IPCA) in New Zealand maintains that police should be exposed to an awareness raising strategy

which alerts custody staff to key issues in their role in the context of New Zealand's obligations under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) (Thematic Review, 2012). Overall, the idea of a multipronged approach in which training forms part of a larger system of custody best practice is supported in the literature. Minimising risks to detainees involves establishing awareness raising amongst custody staff; continual renewal of custody policies and guides; independent watch house monitoring programs *and* ongoing training and professional development opportunities for staff (Kamolins & Tait, 2008).

How Can Misconduct be Prevented?

Around the world, the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is the guiding framework in which countries consider the treatment of people held in various forms of detention. OPCAT was created in 2002 and is an international agreement designed to prevent the serious mistreatment of people in detention (Optional Protocol, 2007). Although not having ratified OPCAT yet, Australia is a signatory to the agreement and in mid-2012 a Commonwealth government Joint Standing Committee on Treaties for Consideration recommended its ratification. Hence there are sound indications that Australian police have good cause to pre-empt the OPCAT framework, either as part of an awareness raising strategy or in relevant operational contexts.

One of the primary mechanisms used by OPCAT to prevent mistreatment in places of detention is known as a "national preventative mechanism" or NPM. An NPM is an independent body with a mandate to conduct both announced and unannounced visits to places of detention, to make recommendations to prevent ill treatment and improve conditions, and to report publicly on its findings and views. Australia does not currently have an NPM. However, according to Phil Lynch (2012), the *Executive Director of the Human Rights Law Centre* in Australia, the "overwhelming evidence and international experience show that external scrutiny of places of detention can prevent ill-treatment and ensure that detainees are treated with dignity and respect."

Aside from the formal investigative processes of oversight agencies, monitoring and prevention can be achieved through less formal means. For example, in the Netherlands, community members visit police watch houses in visitor programs (Blauuuw, Vermunt, & Kerkhoh, 1997). Several reports regarding the effects of community victory programs in police stations have suggested that one of the main benefits of community members entering police watch houses is that they remind custody staff of expected standards and contribute to an ongoing process of awareness raising. When coupled with custody training, community visitor programs can have the potential to enhance watch house facilities and maintain a higher level of staff engagement with basic standards. Similar 'custody visitor schemes' operate in England, Wales and Northern Ireland and involve unannounced and strictly private meetings with detainees (Healthcare of detainees, 2009).

This more informal approach to monitoring has been recommended by the Commonwealth Ombudsman and the AFP who suggest that police should develop ongoing dialogue and meetings with various watch house stakeholders (i.e. government agencies, community and cultural groups) (Review of ACT, 2007). These dialogues can feed back into watch house polices and guides regarding best practices with high risk detainees and can "facilitate broader community awareness of watch house operations, and provide opportunities for informal assessment and adjustment of watch house performance, where appropriate" (Review of ACT, 2007, p. 73). The AFP and Commonwealth Ombudsman further recommend that watch house supervision and leadership should establish 'accountability mechanisms' and reporting/monitoring processes in watch houses (Review of ACT, 2007, p. 86). For example, watch house data will need to be collected regarding injuries, complaints etc so that watch house leaders can respond to emerging trends and issues.

Alternative Models of Custodial Detention

Adopting alternative custodial models may reduce risks of injury and death a) custodial facilities operated by organisations separate to the Police (i.e. Corrective Services) b) custodial facilities staffed by both police and non-police staff. In a joint Report (2007) by the Commonwealth Ombudsman and the AFP, a number of

recommendations were presented to improve ACT watch house operations. The recommendations included transferring the responsibility of Lockup facilities to a party independent of the Police, such as Corrective Services. Currently Australian police regard for the task of managing detainees and custodial facilities is low; the job is considered as deflecting police resources away from more pressing crime prevention concerns and is regarded more a punishment than a prized position. This is an attitude that has been found amongst police elsewhere in the world (Hounmenou, 2010). If Lockups were operated by non-police staff, a number of benefits should follow.

Another consideration often discussed in the literature regards more preventative measures to ensure that vulnerable people are not needlessly taken to watch houses (i.e. prevention and diversion). For example, the UK Association of Chief Police Officers (ACPO) Safer Detention Guidelines (2006) state that people arrested for drunkenness alone, should be taken to alternative places of detention. This recommendation does not appear to be widely followed in England. Alternatives to police custody include "drunk tanks" or "SOS buses" (Hannan et al, 2011). In England, around ¾ of the 333 people who had died in police custody between 1998 and 2009 had issues with alcohol and/or drugs; 72% were affected by one and/or both at the time of custody, arrested on alcohol and/or drug charges, and/or alcohol/drugs contributed to their cause of death (Hannan et al, 2011). Alcohol and/or drug involvement significantly elevates risk of injury, overdose etc. Hence, developing alternative avenues for diverting or managing people with alcohol and/or drug problems is an effective way of minimising the potential for people to come to harm in a police watch house.

This is a suggestion that has found strong support in New Zealand. The number one recommendation of the Independent Police Conduct Authority's (IPCA) deaths in police custody review in New Zealand was for police and the national health agency to create detoxification facilities or short-term shelters to enable alcohol and/or drug affected people to get necessary medical attention (Thematic Review, 2012).

Summary

The available sources regarding best practice in the police watch house are diverse. Many professional bodies (police and medical, particularly in the UK) have developed standards, indicators, and practice guides to help people working in the watch house understand their responsibilities and the risks associated with their role. There is far less empirically-based information or academic studies determining best practice in the watch house. Practice guides are predominantly informed by lessons learnt form case studies of deaths in custody (individual and trend analysis). Despite some of the shortcomings in the police watch house literature there are certain key points made.

1. Wide variation in the standard of watch house conditions around the world, from extremely poor to dedicated watch house staff and police frameworks (i.e. PACE in the UK).

2. Risk assessments for watch house detainees are accepted as best practice but are inconsistently applied and do not always capture risks.

3. In the UK there is a trend toward staffing watch houses with multidisciplinary medical teams (especially nurses) with reportedly improved outcomes for staff and detainees.

4. De-escalation of incidents in watch houses and avoidance of injuries involves people skills: communication and listening; watch house staff should be selected for their people skills or appropriately trained.

5. Watch house staff should receive ongoing training including First Aid Skills, de-escalation skills, information regarding vulnerable people and cultural competence.

6. An awareness-raising strategy amongst police is advised to ensure watch house responsibilities are genuinely integrated into everyday practice and culture.

7. Independent oversight of watch houses is a necessary part of misconduct prevention; oversight can be formal or informal (i.e. government agency or community visitor schemes).

8. Misconduct prevention in the watch house can involve diversionary strategies i.e. ensure police take vulnerable people to alternative places of detention to minimise opportunity for harm and/or injury.

9. Variety of watch house models available, including the involvement of community members and/or non-police staff (i.e. nurses) running the watch house.

Overall, it can be concluded that there is no single policy, program or intervention which can address the complex risks involved in running a police watch house. Achieving best practice is a multi-pronged process that requires genuine commitment from police leadership to continually reflect on changes needed and to hold any officers accountable who act against service standards.

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