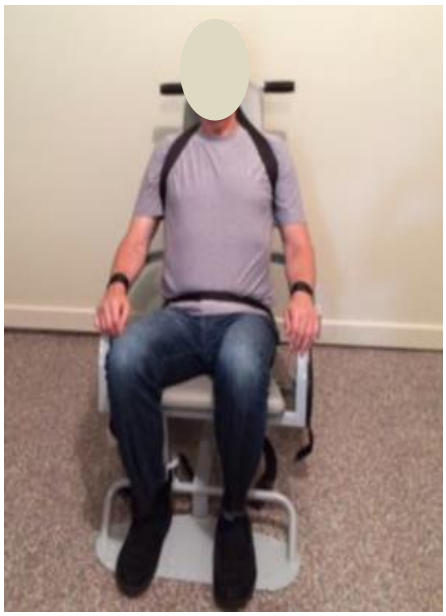
Ombudsman NT

Investigation Report



Extraordinary restraint:

Spit Hood & Emergency Restraint Chair Use on Children in Police Custody

June 2023

Acknowledgement of country

We pay respect to the past, present and emerging Traditional Custodians and Elders of lands throughout the Northern Territory.

GLOSSARY

Act	*Ombudsman Act 2009* (NT).
CAT	*Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, signed by Australia in 1985.
CHA	Custody Health Assessment.
CIIR	Custody Incident or Illness Report, governed by the NTPF *Custody and Transport Instruction*.
CSC	Custody Steering Committee, a cross-sectional working group which includes NTPF representatives between Director and Assistant Commissioner level.
ERC	Emergency Restraint Chair, a mechanical device which is effectively a seat with a number of straps. When the straps are engaged, the person seated is unable to move any part of their body.
Framework	The Custody Incident or Illness Review Framework, which governs the internal quality assurance process and appears as Annexure C to the Instruction.
Instruction	NTPF Custody and Transport Instruction (version 1.2).
NTPA	Northern Territory Police Association.
NTPF, NT Police	The Northern Territory Police Force, a subset of Police, Fire and Emergency Services.
OCC	Office of the Children's Commissioner.
OCC Position Paper	Research paper prepared by the NT Office of the Children's Commissioner entitled *Use of Spit Hoods and Restraint Chairs on Children*, published in June 2023 and available on the Commissioner's website.
OPCAT	*Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ratified by Australia in 2017.
OSTT	Operational Safety and Tactics Training, undertaken by all NT Police during recruit training and requiring annual re-qualification.
PAA	*Police Administration Act 1978* (NT).
PPE	Personal Protective Equipment.
PPP	Police Practices and Procedures Manual
RCIADIC	*Royal Commission into Aboriginal Deaths in Custody* (1991).
RMIA	Risk Management and Internal Audit Division of the NTPF.

Royal Commission	*Royal Commission into the Detention and Protection of Children in the Northern Territory* established on 1 August 2016 and concluded with the tabling of the Commission's Final Report in the Australian Parliament on 17 November 2017.
SJA	St John Ambulance NT.
Spit hood / guard	A device placed over the head of a person, in order to prevent them from spitting on other people.
TDO, TDS	Territory Duty Officer, Territory Duty Superintendent.

TABLE OF CONTENTS

SNAPSHOT

Spit hoods and children

- Spitting on anyone is abhorrent behaviour. It gives rise to a justifiable sense of revulsion and can disrupt the lives of police who need to take precautionary measures. Police deserve to be adequately protected.
- Genuine concerns of police officers about substantial risks of contracting communicable disease from being spat on are not supported by evidence.
- There are serious physical and psychological risks to children who are subjected to spit hood use.
- There were significant problems with the situations and ways in which police used and reviewed spit hood use on children in 2020 and 2021.
- The incidence of spitting can be reduced by improved understanding of, and communication with, children.
- There are viable alternative measures and protective equipment available to adequately protect police against spitting.
- Cessation of use of spit hoods on children should be maintained.

Spit hoods and adults

- The same factors are present for use of spit hoods on adults, although psychological risk factors may differ in degree for adults over 25.
- Those factors have supported cessation of use in all but one other police facility in Australia.
- NT Police should cease spit hood use entirely.

Emergency Restraint Chairs

- Use of ERCs is limited solely to use for protection against self-harm.
- The need for extraordinary restraint can be reduced by various steps, including better communication, enhanced therapeutic services and family and community member support.
- There may still be rare cases where physical restraint is necessary. Available options (including ERCs) are far from desirable.
- NT Police should work with mental health and therapeutic experts to develop a plan for alternative measures, with the aim of phasing out ERC use as soon as practicable.

NT Police support

- It is essential for NT Police to support, educate and equip its officers to achieve the above ends.
- It is important for NT Police to work with stakeholders, including the NTPA, in planning and implementing change.

INTRODUCTION

On 25 July 2016, the Northern Territory was thrust into the public spotlight when the ABC's *Four Corners* program broadcast disturbing images of a child restrained in a chair with a spit hood on.[1] This image became imprinted into the memory of many Australians, and the treatment of children in this jurisdiction was labelled "Australia's Shame".

The United Nations publicly denounced the treatment of children in this manner, and called on the Australian Government to ratify the *Optional Protocol to the Convention Against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment* (**OPCAT**),[2] which it did in 2017. The Northern Territory Government promptly ceased the use of restraint chairs and spit hoods in youth detention centres pending the *Royal Commission into the Detention and Protection of Children in the Northern Territory* (**Royal Commission**). Subsequent legislative amendments removed the use of these devices in youth detention centres by omitting them from the list of approved restraints.[3]

The Northern Territory Government did not extend the prohibition on use of these devices to children in police custody, relying instead on improved policies and strengthened internal quality assurance measures. As a result, the use of spit hoods and emergency restraint chairs (**ERCs**) on children by police both in field and in watch houses continued.

Spit hoods and ERCs are extraordinary restraints. Their use has been an area of concern for my Office for some time. I have previously scrutinised the use of these measures in complaints work, and discussed them in Annual Reports.

In doing so, I have highlighted that NT Police are frequently called on to make decisions regarding whether and how to use force in resolving situations involving risks to the safety of themselves, colleagues, people in custody and other members of the community. I have acknowledged that such decisions often have to be made within a short timeframe and subject to substantial risk and provocation.

I have previously expressed the view that the preferred approach to any use of restraint, including the use of these devices, is to use judgement, communication and persuasion aimed at de-escalation. However, where such measures are unsuccessful, the reality is that a use of force may be required. When use of force is contemplated, it is important that it be reasonable, necessary, proportionate and appropriate to the circumstances. Where force is used, it is important for police to make every effort to continually re-assess whether and what force is needed to effectively progress a situation.

The idea of anyone, particularly a child, being required to wear a spit hood is confronting. That said, I also acknowledge the impact that can be caused to the lives of officers if they are spat on and thereby subjected to indignity and uncertainty, testing and other restrictions for extended periods until the chance of contracting any infectious disease is confirmed or ruled out. In my view, both situations involve differing aspects of degrading treatment, and as a result, an appropriate balance must be struck which respects the human rights and underlying needs of all parties involved.

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[1] Australian Broadcasting Corporation, 'Australia's Shame', Four Corners, 26 July 2016 (Caro Meldrum-Hanna).
[2] '*UN rights office shocked by inhumane treatment of children in Australian detention centre*', 29 July 2016, https://news.un.org/en/story/2016/07/535722.
[3] *Youth Justice Legislation Amendment Act 2016* (No. 36 of 2016), s 5.

In a small number of past complaints raising these issues, I have accepted findings that the use of such devices was necessary in the particular circumstances raised. However, there have been a number of recent developments in this area which have prompted me to consider the matter further.

In February 2022, media reports appeared in relation to an increase in the frequency of use of spit hoods on children in police custody. A number of these reports also questioned the ongoing use of restraint chairs on children in police custody, despite recommendations made by the Royal Commission that their use be prohibited in youth detention facilities. The NT Minister of Police, Fire and Emergency Services requested that NTPF conduct a review of potential alternatives to the ongoing use of spit hoods.

On a brief preliminary survey of the national and international landscape, I observed that:

- Spit hoods were reportedly not used on children in most Australian jurisdictions, with the exception of Queensland (which later moved to prohibit use in September 2022) and the Australian Federal Police (which subsequently ceased using the devices in April 2023);
- South Australia introduced a legislative prohibition on the use of spit hoods (including by police officers) in November 2021;[4]
- A report commissioned by the New Zealand Human Rights Commission recommended abolishing the use of restraint chairs;[5]
- The New Zealand Children's Commissioner publicly called for the abandonment of the use of spit hoods and restraint chairs on children;[6]
- The Police Ombudsman of Northern Ireland expressed concern over the human rights impacts of spit hood use and recommended that their use be prohibited for children;[7]
- The United Nations Committee Against Torture expressed concern about the use of restraint chairs in the United States as a breach of the *Convention Against Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment*.[8]

As the Northern Territory continues towards implementation of OPCAT, it is important that we proactively strive to manage behaviours of concern utilising the most humane and contemporary methods possible. The cross-jurisdictional developments I observed in my preliminary review suggested that there may be better ways of meeting the needs of all concerned, and I decided to conduct an own initiative investigation.

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[4] Nadine Silva, 'Spit hoods now banned in SA as Fella's Bill passes lower house', *SBS* (online, 18 November 2021) < https://www.sbs.com.au/nitv/article/spit-hoods-now-banned-in-sa-as-fellas-bill-passes-lower-house/xg7602exe>.

[5] Dr Sharon Shalev, 'Thinking outside the box? A review of seclusion and restraint practices in New Zealand' (Research Paper, New Zealand Human Rights Commission, April 2017) <https://www.solitaryconfinement.org/_files/ugd/f33fff_2f0bda0d1f3e48c7a9694a1b445afd85.pdf>.

[6] Andrew Becroft, *The child and youth wellbeing jigsaw in Aotearoa New Zealand: five missing pieces* (Office of the Children's Commissioner, 31 October 2021) p 55 < https://www.occ.org.nz/documents/521/Andrew-Becroft-Reflective-Pieces.pdf>.

[7] Marie Anderson, 'The Police Ombudsman's Review of the Deployment of Spit and Bite Guards by the Police Service of Northern Ireland' (Public Report, Police Ombudsman for Northern Ireland, 7 October 2021) p 4 <https://www.policeombudsman.org/PONI/files/93/93f9e0e4-2b03-4162-9923-7a1f56589527.pdf>.

[8] Committee Against Torture, *Report of the Committee Against Torture*, UN Doc A/55/44 (2000) 32 [180].

The investigation was largely conducted by review of relevant documentation provided by NTPF, including:

- Police communications and documentation with respect to previous risk assessments, discussions and decisions with respect to potential changes to spit hood and ERC use on children in custody;
- PROMIS records, including Custody Incident and Illness Report Forms (**CIIR**) and Use of Force Report Forms for incidents during the relevant period;
- Custody Health Assessments, WebEOC Offender Journals and where applicable, Custody Management Plans, for the children involved in each incident;
- Where available, body worn video footage and CCTV footage depicting the apprehension and detention of the child concerned in each incident;
- Police policy documentation including General Orders, Instructions, Online Procedure Manuals, and local Standard Operating Procedures;
- Police training materials relevant to the use of spit hoods and ERCs, treatment of children, management of self-harm and general principles of arrest and custody; and
- Police quality assurance documentation including trending and analysis reviews, and where available, sentinel review documentation from the Risk Management and Internal Audit Division (**RMIA**).

The investigation reviewed every occasion on which a spit hood and/or ERC was used on a child in police custody during the 2020 and 2021 calendar years. The rationale and background to the ongoing use of these devices was considered, as well as the adequacy of policies, training and oversight mechanisms.

Since my enquiries commenced, the issue of spit hood use has continued to be a topic of interest in both the Australian and international landscape. In October 2022, the NT Minister for Police, Fire and Emergency Services announced a decision to cease the use of spit hoods on children in police custody.

In November 2022, the United Nations Committee Against Torture considered the sixth periodic report of Australia, noting with concern reports about spit hood use in police detention contexts. On 28 November 2022, the Committee's Concluding Observations were published, including a recommendation that:[9]

> *The State Party should also take all necessary measures to end the use of spit hoods in all circumstances across all jurisdictions and to provide adequate and regular training for those involved in detention activities on legal safeguards and monitor compliance and penalize any failure on the part of officials to comply.*

[9] Committee Against Torture, *Concluding observations on the sixth periodic report of Australia*, UN Doc CAT/C/AUS/CO/6 (28 November 2022) 3 [12], [14].

The issue was also discussed at the meeting of Standing Council of Attorneys-General on 9 December 2022. The communique from that meeting reported as follows:[10]

> ***National co-ordinated legislative prohibitions on 'Spit Hoods'***
>
> *Participants:*
>
> - *noted that Non-Government Organisations (NGOs) continue to express concerns about the ongoing use in some cases of spit hoods on both adults and children in detention. While spit hoods are used to protect police, corrections and other workers from acquiring a communicable disease or otherwise being harmed by being spat on or bitten by a detainee, the use of spit hoods can cause significant harm and distress to the wearer.*
> - *agreed to discuss, including with their Ministerial counterparts with relevant portfolio responsibilities, the issue of residual use of spit hoods.*

In April 2023, the Australian Federal Police, including ACT Police, announced a decision to cease the use of spit hoods following a review which found the risk of using spit hoods outweighed the benefits of their use, given they were found to be ineffective in protecting against transmissible diseases.[11]

It is clear that this issue continues to be a matter of significance, with a strong push for a better solution. The intent of this investigation has been to contribute to this discussion from the Northern Territory perspective, and to encourage movement towards more humane outcomes for all involved.

This investigation has been conducted in collaboration with the Office of the Children's Commissioner given its particular expertise in this area. At the outset, I wish to acknowledge and sincerely thank that Office for its valuable contributions.

I acknowledge the timely assistance and cooperation of the NTPF with my investigative team. The subject of this investigation is not without contention, seeking as it does to find the right balance between the fundamental goal of the protection of children and the need to ensure that there are adequate safeguards for officers performing their duties. In this context, I commend the respectful and collaborative approach adopted by the Commissioner and his delegates on the matter.

Peter Shoyer
NT Ombudsman
June 2023

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[10] Media Release, Commonwealth Government Department of Attorney-General, 9 December 2022, available online <https://ministers.ag.gov.au/media-centre/standing-council-attorneys-general-communique-09-12-2022>.

[11] Australian Federal Police, Media Statement, 14 April 2023 (https://www.afp.gov.au/news-media/media-releases/media-statement-0).

EXECUTIVE SUMMARY

We, sadly, live in a world where we are regularly exposed to images of aggression, despair and degradation. However, there would be few images that elicit a visceral response as strong as the sight of a child entirely bound and immobile in an emergency restraint chair (**ERC**), head covered with a spit hood.

Yet both these extraordinary forms of restraint have been used in the NT by well-intentioned authorities as the best method to manage exceptionally challenging behaviours of children in their care: the ERC intended to protect against self-harm by a child and the hood to protect officers and others from spitting. Although spit hood use ceased some time ago in youth detention facilities, their use was sanctioned and continued under policies and procedures developed by NT Police.

The intent of this investigation was to go behind the confronting image – to consider:

- the harms that can attend their use;
- the self-harm to children in custody and harm to officers that may occur if they are not used;
- options to minimise the incidence of behaviour giving rise to their use; and
- less confronting alternatives that can protect officers and the children involved.

Early consideration of the matter revealed that few jurisdictions in Australia use these forms of restraint, and there has been concern expressed about their use internationally, including by the United Nations Committee Against Torture.

This investigation (with the assistance of the Office of the Children's Commissioner (**OCC**)) identified numerous serious physical and psychological risks for children. Physical risks include restricting the ability to breathe. For spit hoods, this could be through pressure of the material of the hood or due to the presence of vomit or other bodily fluids, with a number of reports from other jurisdictions identifying spit hood use as a contributor to deaths. For ERCs, physical harm can arise due to restraints being unnecessarily tight. Psychological harm from use of these devices may include the immediate trauma of being subjected to such restraint, as well as longer term stress arising from the incident and potential impacts on development (up to the age of 25).

To provide a clear picture of the reality of use, all 30 cases of use on children in 2020 and 2021 were scrutinised. The great majority of incidents involved restraint of Aboriginal children, although that must be viewed in light of the fact that the great majority of children detained by police are Aboriginal. That fact raises other issues of concern but they are beyond the scope of this investigation. The background of a child will nevertheless often be of particular importance in considering the manner in which police need to interact with them.

There were 27 cases of spit hood use and 6 cases of ERC use, with 3 combined. Six children were subjected to restraint use more than once. Clearly, this represents only a very small proportion of the interactions that police had with children over the two year period. However, it is a significant number in a jurisdiction with the NT's limited population.

NT Police had policies, procedures, training materials and quality assurance measures in place to guide and monitor use. However, the investigation identified a number of deficiencies in decision making and practical application of policies and procedures around the use of the devices and scrutiny of use.

These included, for example, the use of spit hoods in incorrect circumstances, incorrect placement of hoods, inadequate monitoring of wellbeing, and failures to identify non-compliance or other opportunities for improved performance during supervisory reviews.

On considering the incidents, it is clear there is considerable room for officers to improve their efforts at genuine communication and connection with children and that improvement in this area would have been a significant contributor towards minimising the frequency and duration of incidents that might have given rise to use of one of the devices. It was clear that police would benefit greatly from additional guidance and training around de-escalation and interaction with children, particularly children likely to come from a background of disadvantage, disability and trauma. Given the proportion of Aboriginal children involved, police would also benefit greatly from additional guidance and training on dealing with Aboriginal children, who are likely to experience particularly negative outcomes from the use of force and restraints.

The substantial risks to children, the deficiencies in process and the failures to communicate with children as children, all give rise to concerns regarding NTPF's continuing use of these extraordinary restraints.

Spit hoods and children

With regard to spitting, it is an undeniably repugnant act for a person to spit at another. Police officers have every right to protect themselves against being spat on. In that context, the investigation considered the harms to police of being spat on, the available alternative protective measures and equipment, and the protection that is objectively provided by using a spit hood.

The immediate affront at being spat on is clearly of significance. Police also have clear concerns about the potential for transmission of infectious diseases. However, the information available to the investigation variously described the transmission risk as 'negligible' and 'very low to non-existent'. In that regard, I agree with the view of the Northern Ireland Policing Board (adopted by the Australian Human Rights Commission), that educating members on the scientific evidence regarding the very low risk of transmission may assist to alleviate psychological consequences of being spat on. Even so, the ongoing need for officers to act, test and treat for the possibility of transmission is disruptive and distressing.

The investigation found there are a range of alternative measures already adopted in other jurisdictions that can reasonably be utilised such that the absence of spit hoods does not create an increased risk for officers. These include, for example, increased use of personal protective equipment (**PPE**) by members, tactical body positioning, and improved training on strategies to anticipate and de-escalate such behaviour.

The practical efficacy of spit hood use must also be considered. Comment was made around the ineffectiveness of alternatives such as PPE worn by officers in a physical struggle. However, having considered the incidents scrutinised in this investigation, along with many others over years of reviewing police conduct complaints, it is a rare occasion on which PPE or spit hoods are used in an initial apprehension situation, where uncontrolled physical struggle is more likely to take place. They are far more likely to be used in situations where there is already a significant measure of control in place, for example, the child is in handcuffs and/or in the cage of a police vehicle or at a watch house. While there is still some potential for physical struggle in those situations, the more controlled environment makes effective communication, and ultimately reliance on PPE by officers, a realistic option. In other words, from an officer perspective, the benefits and limitations of PPE use should not differ materially from spit hood use.

Ultimately, there is a need to strike the right balance between the fundamental goal of the protection of children and the need to ensure there are adequate safeguards for officers performing their duties. I consider that the risk of harm to children by continued use of spit hoods is high. That risk is increased when, as here, officers do not always comply with policies and procedures. The incidence of spitting can be reduced by improved understanding of, and communication with, children. There are viable alternative measures and protective equipment available to adequately protect police against spitting. I therefore conclude that the cessation of use of spit hoods on children should be maintained, in line with action taken in other jurisdictions.

Spit hoods and adults

Although extension of the cessation of spit hood use to adults is a step beyond the core of this investigation, I regard it as a small step. Accepting for the sake of argument, the proposition that adults present a greater likelihood of having communicable diseases, the actual risk of transmission remains 'negligible' or 'very low to non-existent'. I acknowledge that this does not decrease the odium of being spat on or the disruption of testing and treatment, but there is little to differentiate between adults and children in that regard.

I accept that some of the potential adverse psychological effects on children discussed in the report may not present as prominently for adults (at least those over age 25). However, the potential physical risks remain, as does the potential for psychological harm. The alternative protective measures and equipment are equally available for managing adults. The investigation provides ample evidence for me to form a similar conclusion to that reached in other jurisdictions, that spit hoods should not be used on adults.

Emergency Restraint Chairs

ERC use is intended to be limited to protection against self-harm. The use of an ERC is no less confronting than use of a spit hood, but patently preferable alternatives to dealing with violent attempts at self-harm are not self-evident. Communication should again be the option of first resort, with early involvement of family and community members encouraged. However, there are likely to be a very small number of cases where other action is needed - and the padded cell, sedation and hand/leg cuffing all present significant concerns of their own.

The preference is to cease use of ERCs entirely but there must be suitable options available to deal with those rare situations where violent attempts at self-harm need to be addressed immediately and efforts at communication and support are ineffective. In that context, I consider that NTPF should consult with the Department of Health, Territory Families and other stakeholders to formulate and test a plan for utilising alternatives to ERC use, with a view to absolute minimisation of use, followed by cessation as soon as practicable.

NT Police support

To ensure that cessation is effectively implemented without adverse impact on officers or individuals, it is important for NT Police to take a number of steps.

It is essential for NT Police to support, educate and equip its officers to achieve the above ends. This will include:

- providing officers with sufficient information, guidance, equipment and support to give them confidence that they can effectively and safely perform their duties without such devices, as officers already do in many other jurisdictions;

- implementing a training and development strategy for members with respect to child development, the impact of trauma and disability on behavioural responses, and specific de-escalation strategies for children and more generally;

- exploring options to fill the therapeutic gap for crisis support for persons in custody who are exhibiting extreme emotional distress or behavioural disturbance but are unable to be admitted to a medical facility for any reason.

These steps are resource intensive and will take time to implement. However, they will all contribute to better management of children and adults in custody, improving care and outcomes of custodial episodes and enhancing the work environment for officers called on to handle problematic situations.

It is important for NT Police to work with stakeholders, including the NT Police Assocation, in planning and implementing change.

Residual use of restraints

To the extent that recommendations on cessation are not fully accepted or there is temporary residual use of the devices, I have recommended a number of changes to policies, procedures, training and quality assurance measures that should be promptly addressed by NT Police.

My detailed recommendations are set out on the immediately following pages. The majority of recommendations (put forward in draft) have been agreed in principle by NTPF but I have requested a formal response to the finalised recommendations. Their implementation will be monitored by my Office. NT Police has not accepted the recommendation relating to cessation of spit hood use on adults.

RECOMMENDATIONS

Communication and patience

Recommendation 1 NT Police should, in all relevant documentation, guidance and training, place major emphasis on encouraging patience, empathy and connection as a routine first step in interaction with children and other members of the public.

Use of spit hoods

Recommendation 2 NT Police continue the cessation of use of spit hoods on children.

Recommendation 3 NT Police extend the cessation of use of spit hoods to all people in custody.

Recommendation 4 The NT Government consider legislating to preclude future use of spit hoods.

Recommendation 5 NT Police ensure that adequate personal protective equipment is available to all officers to provide for their reasonable protection against spitting or other transfer of bodily fluids.

Recommendation 6 To the extent that spit hood use is retained as an option for use of force by officers on adults, NT Police introduce into its recruit training and ongoing professional development program for members practical, scenario-based training on the correct use of a spit hood. This training should, at a minimum, address the real prospects of contracting infectious diseases through spit, mucous or other bodily fluids, and test members ability to:

a. utilise alternative strategies to avoid the use of a spit hood;

b. appropriately apply the threshold for use of a spit hood: that is, the existence of a threat to members or others beyond the general behaviour of spitting;

c. recognise the circumstances in which spit hoods must not be used; and

d. monitor the health and wellbeing of a person in a spit hood to a high standard.

Recommendation 7 To the extent that spit hood use is retained as an option for use of force by officers on adults, NT Police review and consider amendments to the Instruction to address the following matters:

a. Require members to first utilise PPE and other de-escalation and avoidance techniques before turning to the use of a spit hood;

b. Specify whether spit hood use is permitted in-field or within the watch house only;

c. Prohibit the use of a spit hood on any person who is intoxicated due to the associated high risk of vomiting;

d. Clarify the requirement to remove a spit hood once a person is "secured in a cell" so it is clear to members that it is not appropriate for a spit hood to remain in place while a person is secured in the rear of a police vehicle or in a cell;

e. Remove the statement with respect to monitoring a person in a spit hood by CCTV, as this creates ambiguity with respect to the requirement to remove a spit hood once a person is secured in a cell;

f. Require any person in a spit hood to be processed into custody as a matter of priority;

g. Implement a maximum time limit on the duration a person can remain in a spit hood.

Use of ERCs

Recommendation 8 NT Police promptly engage with a range of relevant experts and stakeholders to develop a more comprehensive therapeutic plan to provide and promote alternative approaches and support mechanisms that do not involve use of ERCs by police, with a view to immediately minimising ERC use and preferably phasing it out as soon as practicable.

Recommendation 9 NT Police explore options to fill the therapeutic gap for crisis support for persons in custody, or at risk of being taken into custody, who are exhibiting extreme emotional distress or behavioural disturbance.

Recommendation 10 For as long as ERC use is retained as an option for use of force by officers, NT Police expand on its ERC training module to incorporate scenario-based training on effective communication to avoid the use of an ERC, and practical strategies for effective health monitoring and rapid de-escalation to minimise the duration of use.

Recommendation 11 For as long as ERC use is retained as an option for use of force by officers, NT Police review and consider amendments to the Instruction to address the following matters:

a. to make clear the purpose of remaining with a child for the first five minutes they are placed in an ERC includes engaging with them in order to connect with and de-escalate their behaviour, and expand this requirement to any adult placed in an ERC;

b. require that the basis for an assessment of the need to continue restraint in a padded cell or ERC be recorded in the custody journal; and

c. ensure that the entire duration of ERC use, including wellbeing checks and assessments of the need to continue use, is recorded in a manner that captures both video and audio.

Recommendation 12 For as long as ERC use is retained as an option for use of force by officers, NT Police ensure that ERCs are stored out of sight, so as not to unnecessarily raise concerns.

Recommendation 13 For as long as ERC use is retained as an option for use of force by officers, NT Police ensure that spit hoods and ERCs are not used in combination under any circumstances for any people in custody.

Training

Recommendation 14 NT Police develop a strategy for training and ongoing development for all NT Police members with respect to child development, the impact of trauma and disability on behavioural responses, and specific communication and de-escalation strategies for children.

Quality Assurance

Recommendation 15 NT Police review its quality assurance framework and consider appropriate amendments to address the following matters:

a. Senior member reviews and RMIA reviews must not be finalised without the review of relevant CCTV, BWV footage and training records. In the event that footage is not available due to a failure to record, this should be addressed as a non-compliance issue; and

b. Reviewers should be specifically required to consider the broader police interaction with a view to identifying and reporting on escalation points or missed opportunities to de-escalate.

Recommendation 16 NT Police involve the RMIA and the Professional Standards Command in development of an appropriate referral mechanism for any identified potential non-compliance or other performance issues identified by RMIA during sentinel reviews to be further considered and addressed with members.

Recommendation 17 Until such time as the use of spit hoods and/or restraint chairs has been ceased for all people in custody, NT Police ensure that full sentinel review is conducted on all incidents involving use, as required by the Framework.

Record keeping

Recommendation 18 NT Police take steps to reinforce the importance of good record keeping, particularly in relation to decisions and actions around use of force/restraints and ongoing checks. Good record keeping would include, at a minimum:

a. A fulsome and accurate account of events which occurred prior to the use of force;

b. What less significant use of force options were considered or attempted;

c. Time of notifications made to superior officers;

d. Time and duration of wellbeing checks; and

e. Reasoning for any decision to continue the use of restraints, including the supporting facts and circumstances upon which the decision was based.

In order to progress consideration and implementation of these recommendations, I request that the Commissioner of Police give to me, within three months of provision of this report, written notice of:

a. the steps taken or proposed to be taken to give effect to each recommendation; or

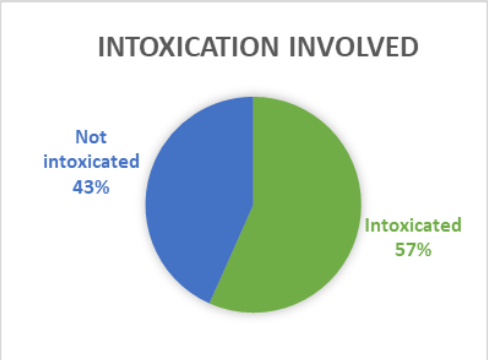
b. if no steps, or only some steps, have been taken or are proposed to be taken in respect of a recommendation, the steps taken and the reasons for not taking all the steps necessary to give effect to it.

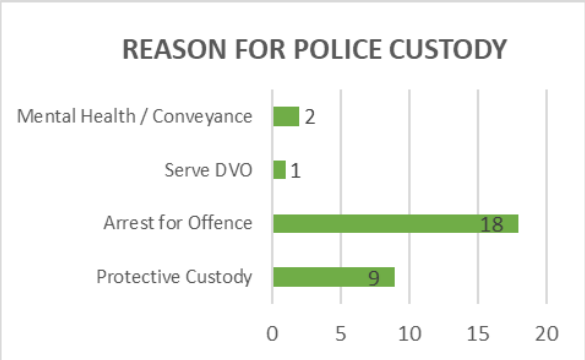
CHAPTER 1: OVERVIEW OF USE IN 2020/21

1. The investigation reviewed all incidents where a spit hood and/or Emergency Restraint Chair (**ERC**) was used on a child during 2020 and 2021. At the outset, it is acknowledged that there may also have been numerous situations in which a child engaging in spitting, biting or self-harm was managed without the use of these devices. However, these situations were beyond the scope of this investigation.

2. There were a total of 30 incidents reviewed: 23 incidents in 2020, and a further 7 in 2021. Of the 30 incidents reviewed, 3 involved the use of both a spit hood and an ERC. The 30 incidents involved 24 different children, with 6 children being involved in more than one incident. Some 83% were Aboriginal children.

3. Over half (57%) of the incidents involved children who were intoxicated or under the influence of volatile substances. A similar proportion (60%) involved the arrest of a child for an offence, however some offences were for minor incidents such as disorderly behavior, with the child taken into custody for the purposes of issuing an infringement notice under s 133AB of the *Police Administration Act 1978* (NT) (**PAA**).

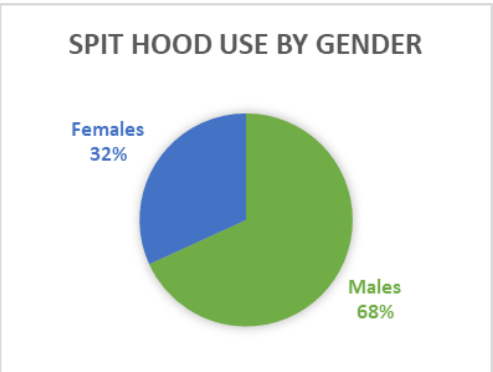


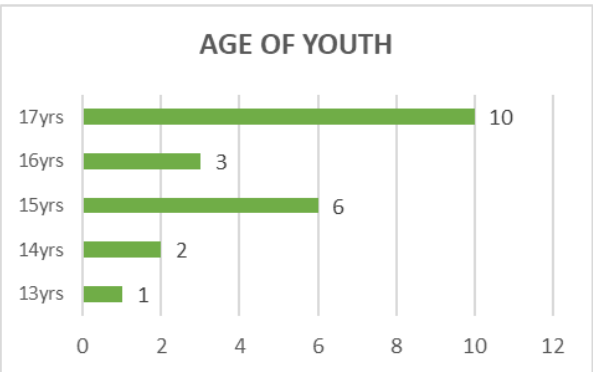


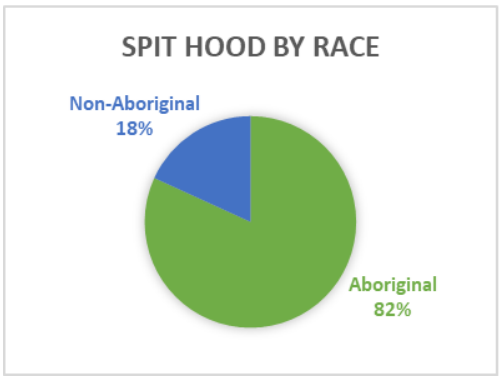
4. **Annexure A** is a schedule that outlines the circumstances of each incident considered in a de-identified manner.

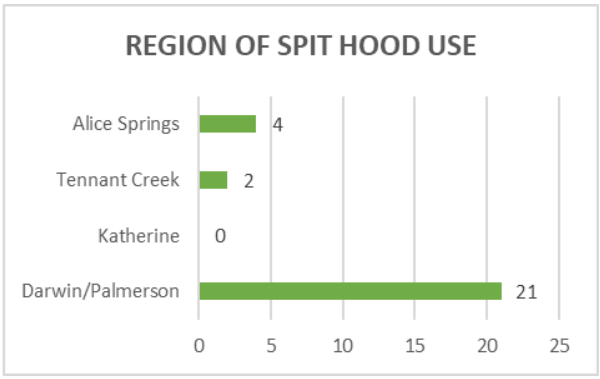
Spit hood incident profile

5. The investigation showed that the use of spit hoods during the relevant period was largely on 15-17 year old Aboriginal males. The majority of incidents occurred in the Darwin/Palmerston region.

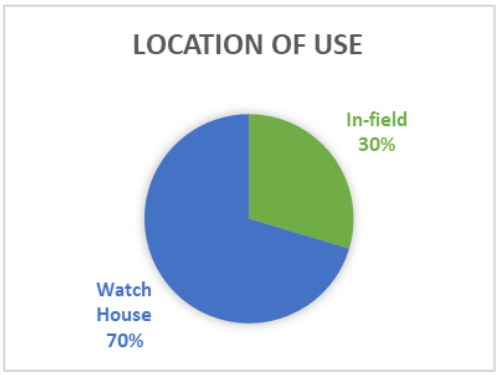


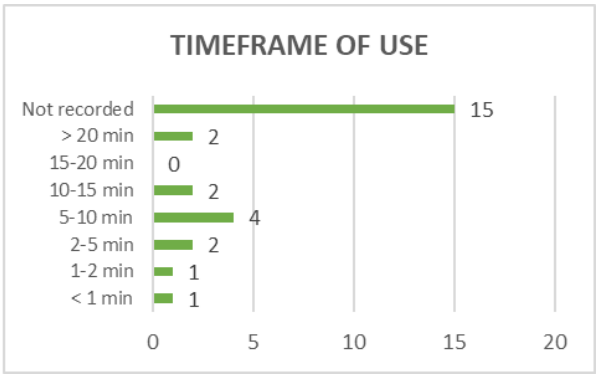






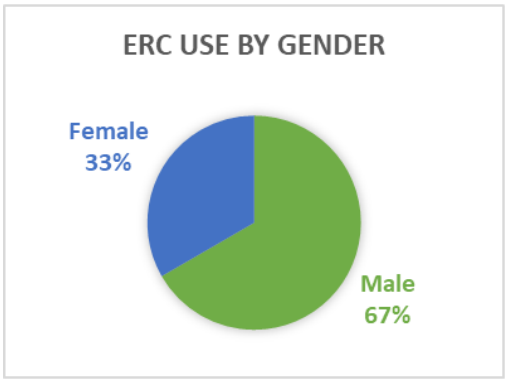
6. Around 30% of incidents involved an initial application of the spit hood in-field rather than in the watch house environment. The duration for which the spit hood remained in place ranged from less than 1 minute to 29 minutes, however for over half of the incidents, the timeframe of use was not recorded or was unclear from the documentation provided.

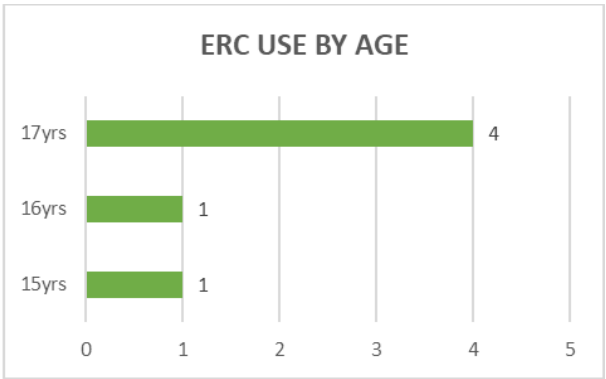


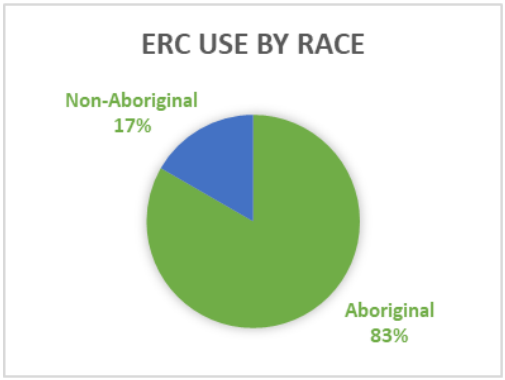


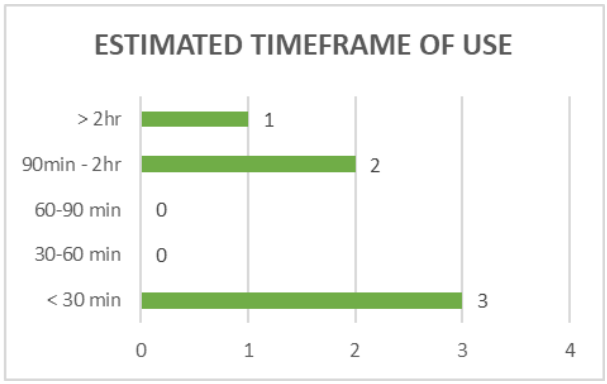
Restraint Chair incident profile

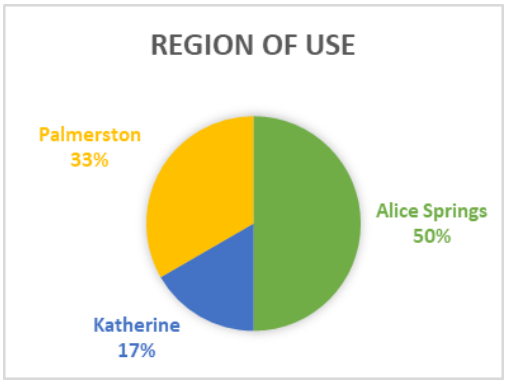
7. ERCs were used on 6 occasions during the two year period. They were used on children between 15-17 years of age, mostly Aboriginal males, and for timeframes ranging from less than 30 minutes to around 2.5 hours. They were used in Palmerston, Katherine and Alice Springs.






ERC USE BY RACE
Non-Aboriginal
17%
Aboriginal
83%


ESTIMATED TIMEFRAME OF USE
> 2hr
1
90min - 2hr
2
60-90 min
0
30-60 min
0
< 30 min
3
0
1
2
3
4


REGION OF USE
Palmerston
33%
Alice Springs
50%
Katherine
17%

CHAPTER 2: RECENT HISTORY OF USE

Spit hoods

8. The type of spit hood used by NTPF since before the Royal Commission was a combination piece featuring white mesh on the upper half over the head, a strip of elastic designed to sit over the bridge of, or just underneath, the nose, and a thicker, loose-fitting black fabric that was intended to cover the mouth.

9. The looser fabric at the bottom of the hood was designed to block the trajectory of bodily fluids, while at the same time allowing sufficient passage for the fluids to be released from the hood so as not to constrict the person's ability to breathe.

10. The documentation provided during the investigation showed that a large amount of work was conducted by the NTPF during 2016 and 2017 in relation to refining whether and how spit hoods should continue to be used by police, particularly with respect to children.

Figure 1: Spit hood design in use during the period considered by the investigation.

11. In July 2016, a senior executive group within NTPF contemplated whether use should be ceased as an interim measure pending the Royal Commission, however it was decided to continue use with improved governance. The Risk Management and Internal Audit division (**RMIA**) was requested to prepare a statistical report and risk assessment on the subject.

12. That same year, the NTPF was invited to comment with respect to the potential to remove the use of spit hoods and restraint chairs from the list of approved restraints for use on children. NTPF submitted that it wished to continue the use of the devices on the following basis:

    - Police Watch Houses and cell complexes are not places of long term detention, but rather places of short term custody;

    - Police are called upon to deal with children who are still '*in extremis*' at the time they come into custody. The options for Police to deal with child offenders demonstrating genuine self-harm behaviours is limited in the first instance;

    - The NTPF changed internal policy to implement strengthened controls around the use of both items. ERCs are only to be utilised for persons (inclusive of children) actively committing self-harming behaviours. Each use on a child must be pre-approved via the relevant Superintendent. Each ERC or spit hood use event is subjected to an independent 'sentinel review' with the outcomes reported to the Police Executive.

13. The NTPF submission was accepted. The use of spit hoods and ERCs within police places of detention continued.

14. The RMIA Risk Assessment was completed in October 2016. It identified a number of weaknesses in existing internal controls around the use of spit hoods, including:

    - Lack of instruction for members in the General Orders and Instructions with respect to whether the devices can be used in-field, length of use and contra-indications for use;

    - The spit hood design impeding the ability of making an assessment of a person's skin tone (for health monitoring);

    - No training provided to members regarding spit hood use, appropriate circumstances of use or the level of care to be provided to a person in a spit hood;

    - Use of force reporting mechanism not subject to trending analysis by RMIA.

15. In addition, it was noted that the spit hood then in use by NTPF was often applied incorrectly such that it was pulled down so the white mesh covers the mouth. It was noted that this reduces the effectiveness of the spit hood.

16. It was noted that other risk mitigation options were also available, including personal protective equipment (**PPE**) (face shields) being available in all watch houses (but not practical for in-field use), perspex spit screens on police vehicles, and personal avoidance (evasive) actions. However, it was noted that no training was provided in personal avoidance actions and that this may not be easy to do in close contact situations.

17. The Risk Assessment concluded that there was an almost certain likelihood of eventuation of a major risk, noting that "*[i]nternal controls do not meet an acceptable standard as many weaknesses/inefficiencies exist. Internal controls do not provide reasonable assurance that the risk is being mitigated to an acceptable level*." A number of recommendations were made for risk mitigation, including:

    - Procurement of an alternative spit hood which allows for better visual assessment of the person's skin tone for health monitoring;

    - Updating of General Orders and Instructions to ensure there are clear and consistent directions for use, including prohibition of use on people who have been exposed to OC spray and those at risk of vomiting, and that they only be used by officers who have completed mandatory training;

    - Developing and updating training material, and to include spit hood training within defensive tactics training and refresher training;

    - That spit hood use should trigger the completion of a Custody Incident or Illness Report (**CIIR**) to enable trending and analysis by RMIA;

    - Developing a maximum use time and observation requirements which would eliminate use during transport and after being placed in a cell.

18. In February 2017, it was noted by the Custody Steering Committee (**CSC**) that the Risk Assessment was considered closed, and that General Order documents were to be updated.

19. By September 2017, there had been little movement on implementation of the recommendations. An RMIA report to the CSC noted that the CSC needed to endorse the mitigation strategies identified in the Risk Assessment, and that ownership and progression of

the mitigation plan should be formally handed to the Custody Working Group. A trial was to commence of an alternative spit hood that would provide for better health monitoring of skin tone, but this appeared to suffer a number of delays and challenges and was never finalised.

20. In November 2017, the Royal Commission reported its finding that "*[s]pit hoods have the potential to cause distress to young persons, particularly when used in combination with other forms of restraint*" and recommended that use of spit hoods should continue to be prohibited.[12] It does not appear from the material reviewed that this prompted any further consideration of the matter by the NTPF.

21. In September 2018, a new Custody and Transport Instruction was implemented which included some of the improvements recommended by the RMIA in the Risk Assessment. It introduced some contraindications for use of a spit hood, expected standards of monitoring, and stated that the spit hoods must permit an unobstructed view of the person's facial complexion. It also required members to don appropriate PPE where there is a risk of biohazard exposure, and spit hoods to be removed immediately upon the person being secured in a cell. The new Instruction also commenced the sentinel review process whereby the RMIA were to conduct an in-depth review of all spit hood incidents.

22. From the material reviewed during the investigation, it does not appear that the RMIA recommendations with respect to training were implemented.

23. Following media reports highlighting the ongoing use of spit hoods on children in early 2022, the then Minister for Police, Fire and Emergency Services requested the NTPF to conduct a review and consideration of alternatives. This was conducted by the RMIA. The review noted that it was not possible to provide an accurate statistic as to the number of spitting incidents that occur, as these are not specifically recorded by NT Police. However, the number of spit hoods used could be identified from CIIR submission.

24. The review noted that, despite the CSC endorsing the 2016 Risk Assessment, which determined that the type of spit hood being used was unsuitable, it was still in use some 5½ years later. It stated that "*the current spit hood does not allow for assessing the pallor of the detainees skin tone which is an early indicator of emotional and physical distress and is imperative in monitoring a person's wellbeing.*" The review identified that the amended Custody and Transport Instruction still involved a number of ambiguities, including a lack of clarity with respect to:

    - whether spit hood use is permissible in field, and how such use is regulated;
    - whether spit hoods may remain in place during a conveyance; and
    - restrictions on use and physical checks required where there is no ongoing risk of spitting on members. The report stated that: "*… spit hoods should only be required when there is the chance the person in custody may spit at members. If no members are present the spit hood should be removed which would discount the need for physical checks.*"

[12] *Royal Commission into the Detention and Protection of Children in the Northern Territory* (Final Report, November 2017), Vol 2A, p 248-9 (Recommendation 13.1).

25. The review identified that one training package had been updated so as to provide instruction to members on ways to physically restrain a person who is actively trying to spit on them. Other than this, the training recommendations from the 2016 Risk Assessment had not been implemented.

26. A number of alternative options were presented for consideration, however a new Minister was appointed before the process was finalised.

27. On 7 October 2022, NTPF publicly announced that it would be discontinuing the use of spit hoods on children in police custody effective immediately. The media release stated that:[13]

> *Alternative options for watch house staff to protect themselves when dealing with youths will now be implemented when required.*
>
> *Police will be utilising increased Personal Protective Equipment (PPE) to protect officers from the impacts of spitting in the watch house environment. In-field officers will have access to both PPE and existing operational safety tactics can be utilised to reduce the risk of exposure.*

Emergency Restraint Chairs

28. The use of ERCs in the Northern Territory as a method of preventing self-harm by people in custody originated in Alice Springs due to the lack of a padded cell for use in that region. The first request to trial the use of an ERC was made in 2010, but the request was initially rejected, with the device being described by superior officers at the time as "*barbaric and archaic*".

29. The request was renewed in July 2011, following a serious self-harm incident in the Alice Springs Watch House. The memorandum outlined the incident and recommended installation of a padded cell or trialing the use of an ERC, as follows:

> *This report addresses restraint chairs and a proposed trial of these devices in the Alice Springs Watch House.*
>
> *NT Police currently hold a restraint chair in the Darwin Armoury. The purchase of the restraint chair stemmed from request made by Tennant Creek Police Station to the Police College several years ago with regard to a high risk prisoner. The prisoner displayed extreme self harm behaviour whilst in police custody (head butting walls and floor of the cell). They requested flexi cuffs help deal with these types of prisoners. The request for flexi cuffs was not approved as it was considered that they pose a greater risk to prisoners than police issue handcuffs.*
>
> *[A Superintendent] was attached to the Police College at the time and made enquiries with other jurisdictions. He found that self harm behaviour of prisoners in custody is problematic throughout Australia. He found that some Watch houses were fitted with restraint beds however the restraint beds presented difficulties when attempting to move or relocate prisoners.*
>
> *The Officer in Charge of the Operational Safety and Training Unit … was asked to research the issue and identify an alternative. He found that the ERC restraint chair was a viable option ... A restraint chair was sourced and tested by the OST Unit. It was found that it worked well and enabled easy relocation of prisoners (i.e. transport to a mental health facility).*

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[13] *Statement – Acting Deputy Commissioner Michael White – Use of Spit Hoods*, NT Police Media Release, 7 October 2022 (https://www.pfes.nt.gov.au/newsroom/2022/statement-acting-deputy-commissioner-michael-white-use-spit-hoods).

Restraint chairs are currently used in both Darwin and Alice Springs Prison [in 2011].

…

A recent custody incident in Alice Springs Watch house highlighted the need for appropriate restraint devices ... [in July 2011] [a person] was held in protective custody in the Alice Springs Watch house. He is a high risk prisoner who has numerous alerts for attempt suicide, self harm and attempt self harm whilst in Police Custody.

During this recent incident [the person] was so intent on self harm that he made a tourniquet, wound it around his right arm and bit himself. The wound punctured a vein and he proceeded to spray the cell with blood ([the person] is believed to be Hep C positive).

This is not an isolated incident. There has been several recent custody incidents in the Alice Springs Watch house involving violent and mentally disturbed individuals intent on harming themselves. These prisoners have harmed themselves by either by biting themselves and drawing large amounts of blood or by leaping from the toilet or bed and hitting walls or the floor at impact.

These types of prisoners will not be accepted by Alice Springs Hospital if they are intoxicated and/or in a drug affected state. The only recourse is to hold these individuals in the Watch house until they either sober up and or their demeanor settles to be able to transport them safely to undergo medical assessment and treatment.

The Alice Springs Watch house does not have a padded cell and the only option available to police with individuals intent on self harm is to have them restrained by both their hands and feet with handcuffs to prevent them from inflicting further harm to themself. This procedure presents the inherent risk of positional asphyxiation. Therefore a better and safer option is sought.

The preferred option would be the installation of a padded cell of a similar design as the one currently in use in Darwin Watch house. It provides a safer means [of] holding a range of prisoners displaying high risk behaviour. However as there appears to be an organization (sic) *aversion to padded cells a restraint device is an alternate option.*

The failure to provide a means to manage these individuals continues to leave police officers in remote and rural centres with little alternative but the (sic) *"hog tie" violent and disturbed individuals. This is not a humane or reasonable way to deal with high risk individuals.*

Alternative options are available which can minimize risks of harm to both prisoners and police.

Recommendations

1. Fit out a cells (sic) *in Alice Springs and Tennant Creek as padded cells (similar to the Darwin padded cell) alternatively*

2. Trial the restraint chair which is currently held in the Darwin Armoury in the Alice Springs Watch house.

30. In response to the memo, the Assistant Commissioner advised that the Police Operations Group had approved transfer of the restraint chair to Alice Springs and a trial of ERC use after development of a standard operating procedure. The trial was to be reviewed after 6 and 12 months.

31. The ERC which has been in use since 2011 is pictured below. It is a rigid seat into which a person can be placed, and then secured by straps around both shoulders, ankles and wrists, and the waist. Once strapped in, the person has minimal residual movement of their head, elbows and knees, preventing serious self-harm.

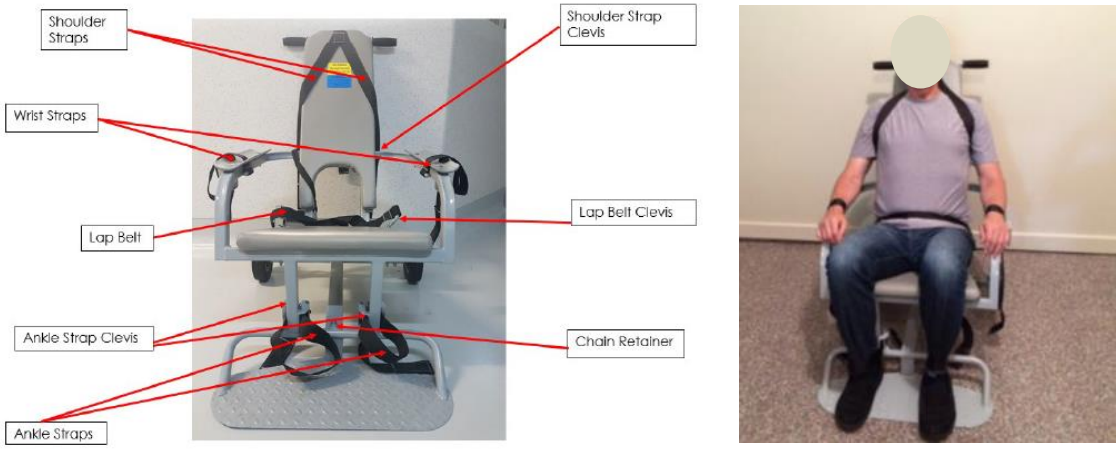

Figure 2: ERC in use during the period considered by the investigation. The image on the left shows each restraint component labelled. The image on the right shows a person restrained in the device.

32. In 2012, amendments to the Custody General Order included a similar provision to the standard operating procedure requirements developed in Alice Springs. It stated:

> *The use of the ERC is only to be used when a person is in custody and is demonstrating behavior likely to cause death or serious harm to themselves and when other* [Operational Safety and Tactics Training] *restraint techniques (the use of handcuffs) has been ineffective.*

33. Since that time, the use of ERCs has continued, and expanded to other urban and regional Watch Houses. A statistical report prepared by the RMIA showed ERC use across the Territory had increased to 19 instances during the 2015/16 year.

34. As with the situation for spit hoods, the NTPF executive leadership team declined to temporarily cease the use of ERCs pending the outcome of the Royal Commission, resolving instead to continue use with strengthened controls, and not being included in legislative amendments prohibiting their use on children in detention centres.

35. A Quarterly Watch House audit conducted by the RMIA in July 2016 identified that members in multiple watch houses had raised concerns about a lack of training in the use of ERCs, particularly given the General Order at the time only permitted use by someone with relevant training. It was noted that Alice Springs Watch House had developed a training package, but that this had not been endorsed for Territory-wide use. The RMIA concluded that:

> *… the lack of training in the use of restraint chairs poses significant risk to the organization and that the progress of the training package should be expedited as a matter of urgency.*

36. In December 2016, the RMIA reported on a Youth Custody Process Review it had been tasked to complete. This was a Territory-wide exercise in order to assess compliance with legislation and international standards, and to identify opportunities for improvement. Among other things, the review recommended:

- Every use of the ERC should be subject to a 'sentinel review' by the RMIA, assisted by other subject matter experts;
- Further consideration be given to integrating aspects of programs or models operating in other jurisdictions that were effectively reducing the number of children coming into custody;
- Improvements be made to training packages, including the provision of specific information to members on the concept of "last resort" and further emphasis that Operational Safety and Tactics Training (**OSTT**) relates not only to physical skills, but also the utilisation of other tactics such as communication and negotiation. The RMIA stated:

  > *… member should* (sic) *trained to recognise when an intervention itself is triggering continuing volatile behavior and that de-escalation should be considered as an option.*

37. In January 2017, the RMIA was tasked to provide a position paper with respect to a proposal to expand the use of the ERC to situations where a person in custody was behaving in a violent manner towards others. The RMIA identified that ERCs were not used in any other Australian jurisdiction, but were used in New Zealand. It was noted that most negative publicity around the use of ERCs, including comment by the United Nations Committee Against Torture in a past report to the United States, focused on the idea that being restrained in that manner may be considered "*cruel, inhuman or degrading treatment*" in breach of the Convention Against Torture. The position paper recommended:

    > *As the use of the ERC has the potential to be controversial and given the obligations that the Northern Territory has under a number of international conventions it is suggested that the focus should remain on the benefit and protection of the person alone. All decision making should be firmly focused on the wellbeing of the person in custody and all decision making processes should have this demonstrated in any justification for this use of force.*

38. The ERC training package received final approval in late April 2017, and rollout was substantially completed by July 2017.

39. In its Final Report published in November 2017, the Royal Commission noted the legislative amendments that had recently been made to prohibit the use of ERCs, and recommended that their use continue to be prohibited.[14] This recommendation did not expressly refer to police or police watch houses. The outcomes of the Royal Commission did not prompt any further consideration of ongoing use by the NTPF.

40. Sentinel review of each incident involving ERC use by the RMIA commenced in September 2018. There appeared to be little further discussion or contemplation of ERC use until the Children's Commissioner raised concerns with the Commissioner of Police and Chief Executive Officer of Territory Families regarding ongoing use in October 2021. The Commissioner of Police responded to the Children's Commissioner noting the basis on which the NTPF had been excluded from the legislative amendments prohibiting the use of ERCs on children: that enhancement to internal policies would ensure they were only used for self-harm purposes; each use was approved by a Superintendent; and each use was subject to independent sentinel review and reported to the executive. The Commissioner of Police advised that the NTPF had no intention to discontinue the use of these devices.

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[14] *Royal Commission into the Detention and Protection of Children in the Northern Territory* (Final Report, November 2017), Vol 2A, p 251 (Recommendation 13.2).

41. The review requested by the Minister for Police, Fire and Emergency Services in early 2022 (discussed above) did not include consideration of the use of ERCs on children. There is no current NTPF intention to prohibit the use of ERCs on children in police custody.

CHAPTER 3: NTPF POLICIES AND PRACTICES

42. The use of spit hoods and ERCs by NT Police is internally regulated by the Custody and Transport Instruction. Version 1.2 of that Instruction (**the Instruction**) commenced on 12 February 2020. This version was in effect for all but one of the incidents considered in this investigation. Version 1.2 did not make any changes to the previous provisions regarding the use of spit hoods, ERCs or padded cells, or the care of persons considered to be "at risk".

43. NTPF have advised that a number of changes have been made to the Instruction since this investigation commenced, however it is appropriate to set out the provisions of the Instruction as they were during the relevant period being considered by the investigation. As a result, only this Version 1.2 is discussed below.

Spit hood use

44. The Instruction contained the following paragraphs relevant to the use of spit hoods on persons in custody:

> ***Spit Hoods***
>
> *363. Purpose designed spit hoods are to be available for use in all Watch Houses and police cells. These spit hoods must be designed to enable an unobstructed view of the person's facial complexion.*
>
> *364. Spit hoods maybe* (sic) *used when a person in custody has or is threatening to spit at or on members or other person/s in custody. The risk of biological contamination form* (sic) *spittle is considered low, however a risk still exists and no staff member or person in custody should be exposed to another person's body fluids.*
>
> *365. A spit hood must not be used on a person who has been in recent contact with Oleoresin Capsicum (OC) spray or any other mucus creating chemical.*
>
> *366. A spit hood must not be used on a person who has recently vomited or who is at risk of future vomiting.*
>
> *367. At the earliest opportunity after a spit hood has been utilised, the Watch House Keeper must be notified and the TDO* [Territory Duty Officer] *contacted to provide approval for continuing use.*
>
> *368. The request for approval and the response from the TDO is to be recorded in the relevant Watch House log including the name of the TDO who provided approval. A CiiR must be generated.*
>
> *369. The person wearing a spit hood must be under constant observation – CCTV can be utilised for this purpose.*
>
> *370. Physical checks must be performed on the person every 10 minutes while the spit hood is in place – noting that extended use of a spit hood will normally be in alignment with the use of the ERC.*
>
> *371. Persons in custody once secured in a cell should have the spit hood removed immediately and members should exit the cell as soon as possible to reduce the risk of contamination.*

45. The Instruction also stated:

Bio-Hazard Procedures

422. All reasonable precautions are to be taken by members when confronted with a person in custody who spits, due to the risk of biohazard contamination. The operational safety principles should be applied. Members are to utilise appropriate Personal Protection Equipment (PPE) by way of a face mask, goggles or other protective measures available including taking avoidance action.

423. Escorting members are to advise the Watch House in advance if they are conveying such a person, to allow Watch House staff to don appropriate PPE.

ERC use

46. The provisions in the Instruction regulating the use of the ERC were contained within a group of sections which collectively addressed the management of self-harm and violence of persons in custody. The Instruction relevantly provided:

Management of Self Harm and Violence

332. The health and safety of a person in custody who attempts self-harm or actually self-harms is a priority matter. Where a Custody Nurse is on duty in a Watch House, a medical assessment of the person in custody is to be undertaken as soon as practicable to determine if the person in custody should be subject to a medical assessment by a medical practitioner or mental health specialist.

333. Where a person in custody demonstrates potential or continued risk of self-harm behaviours, the level of intervention should be guided by the seriousness of the self-harm and urgency of the intervention required.

334. A person in custody who demonstrates violence towards others, or is at potential or continued risk of self-harm, is considered to be high risk or requires an increased capacity to monitor, if circumstances permit, be placed in separate cells and also may be placed in an observation cell.

335. A person in custody who intentionally demonstrates the potential or continued risk of self-harm, may be placed in a padded cell or Emergency Restraint Chair (ERC) as a safety measure. In such circumstances, the Watch House Keeper should cause an alert to be recorded in the relevant information system.

336. The processes for the management of persons showing emotional or physical distress detailed in this Instruction are to be strictly adhered to for persons requiring the use of the padded cell or the ERC.

337. Where an actual or attempted self-harm incident occurs within police custody, a CiiR CNE is to be completed and all members involved in the incident recorded, including the Watch Commander, TDO and Custody Nurse, including all instructions and events.

Padded Cell

338. Where a Watch House has a padded cell, it may only be used when a person is considered to be high risk of self-harm and when other Operational Safety and Tactics Training (OSTT) techniques have been ineffective. On the determination that this level of risk is reduced, the person is to be immediately released from the padded cell as a priority.

339. *A Watch House Keeper may initiate use of the padded cell on a person in custody. At the earliest opportunity after it is utilised, the Watch House Keeper must provide the circumstances and seek approval from the TDO for continuing this restraint.*

340. *The request for approval and TDO response is to be recorded in the relevant Watch House log including the name of the approving TDO. A CiiR must be generated.*

341. *In circumstances where there is a requirement to remove clothing from a person every effort must be made to preserve the person's privacy and dignity. There are tear resistant smocks available in the Watch Houses which must be offered to the person.*

342. *A person who has had their clothing removed for their protection and placed into a padded cell is not to be left in that cell for any longer than is absolutely necessary. Welfare checks are to be conducted on the person a minimum of every 10 minutes by entering the cell and speaking with the person. An assessment of the requirement to remain in the padded cell is to be conducted at each check.*

Emergency Restraint Chair (ERC)

343. *An ERC is available at some police Watch Houses and police cells. The use of the ERC is only to be used when a person in police custody is demonstrating behaviour likely to cause the potential or continued risk of self-harm after other OSTT restraint techniques (the use of verbal engagement, handcuffs etc.) has been ineffective.*

344. *The main focus when utilising an ERC is the duty of care to the person in custody.*

345. *An ERC is a safety device intended to assist with temporary control of self-harm behaviours of a person in custody. When used properly it can reduce the risk of harm to the person. Self-harm behaviour can mask serious medical conditions and staff must remain vigilant to pre-existing or potential health issues.*

346. *A Watch House Keeper may initiate use of an ERC on a person in custody. At the earliest opportunity after it is utilised the Watch House Keeper must provide the circumstances and seek approval for continuing this restraint from the TDO.*

347. *The request for approval and the response is to be recorded in the IJIS Offender Journal or WebEOC including the name of the TDO contacted. On each and every occasion the ERC is used, the use is to be the subject of a CIIR and Use of Force Form. The PROMIS case number relating to the CIIR is to be referenced in the person's Offender Journal in IJIS and WebEOC.*

348. *An ERC is only to be utilised by members who hold current OSTT, First Aid qualifications and have successfully completed training in the use of an ERC.*

349. *A person in custody who is restrained in an ERC is to be placed into an observation cell where practicable, with the person facing outwards to allow observation at all times. Directly after being placed in an ERC, the Watch House Keeper will ensure the Custody Nurse, where available, assesses the person.*

350. *Welfare checks are to be conducted on the person a minimum of every 10 minutes by entering the cell and speaking with the person. An assessment of the requirement to remain in the ERC is to be conducted at each check.*

351. *The use of the ERC is to be used for only as long as the person is demonstrating a willingness to continue behaviour likely to cause potential or continued risk of serious self-harm. When the Watch House Keeper determines that this level of risk has subsided, the person is to be immediately released from the ERC as a priority.*

352. *The Watch House Keeper and Custody Nurse will determine how frequently the person is examined at intervals no longer than hourly. The Custody Nurse where available should examine the person including checking limbs for neurovascular compromise. Where a Custody Nurse is unavailable this will be performed by a Watch House member and recorded in the relevant Watch House log.*

353. *A person should not be restrained in an ERC for any longer than two (2) hours in a single session. After two (2) hours the person's limbs should be released individually to ensure blood flow and limb movement. Where available, the Custody Nurse will also be present during this process to assess the person in custody.*

354. *If the person in custody continues behaviour likely to cause potential or continued risk of serious self-harm, each limb is to be individually released, allowed movement and then resecured.*

355. *After each two (2) hour period of a person being restrained in an ERC, the Watch House Keeper in consultation with the Custody Nurse, where available, will assess the person and if required seek approval from the TDO to continue to hold the person in the ERC.*

356. *The maximum total time a person in custody can be held in an ERC is six (6) hours.*

357. *Where the person in custody is not an adult the maximum total time an ERC can be utilised is four (4) hours.*

358. *Where a youth in custody is placed in an ERC, a member will remain with the individual for the first five (5) minutes. At further ten minute intervals until the youth is no longer considered at risk of serious self-harm, a member will conduct visual observations and speak with the youth.*

359. *An ERC is not to be utilised where a female appears to be or has indicated that she may be or is pregnant.*

360. *The use of an ERC on an intellectually or physically disabled person may exacerbate the behaviour. An ERC is not to be utilised on persons that are intellectually or physically disabled unless all other methods of control and avenues of releasing the person from custody has first been explored.*

361. *When a person has been released from the restraint of an ERC, a medical assessment is required to be undertaken.*

362. *When a person who has been held in an ERC for any length of time is transferred to a medical facility or to a detention or youth facility, the start and stop times of the ERC use are to be recorded in the comments section of either the Custody Health Assessment Form or the Health Handover Form.*

47. With respect to persons showing emotional or physical distress, the Instruction also stated:

Persons Showing Emotional or Physical Distress to be Examined

516. *When a person taken into custody exhibits any sign of significant emotional or physical distress, or a member is in doubt about that person's medical or psychological condition at the time of being taken into custody or at any time thereafter, arrangements are to be made for that person to receive a medical examination.*

517. *General Order – Mentally Ill Persons outlines procedures for the referral of a person already in custody to the Northern Territory Mental Health Service. Procedures therein should be followed when dealing with a person in custody who members believe on reasonable grounds may require a mental health assessment.*

518. If the person displays distinct indications of mental illness including irrational thought processes, highly aggressive behaviour or displays any other symptoms of erratic behaviour, a mental health assessment is to be considered in conjunction with a medical assessment. Where a medical or mental examination, or both is required, the Watch Commander is to be notified immediately and advised of the circumstances. All details and actions taken must be recorded in the relevant Watch House log.

519. Where practicable, the Watch House Keeper, OIC or Watch Commander, is to make sure a relative is notified as soon as possible when a person in custody has been transferred to a medical or mental facility.

48. I am not aware of any pending amendments to these sections of the Instruction, other than those recommended in this report for which NTPF has expressed agreement in principle.

Role of the Custody Nurse

49. In considering the care provided to persons in custody engaging in self-harm, particularly self-harm serious enough to warrant full body restraint in an ERC, it is helpful to also understand the role of the Custody Nurse.

50. The Custody Nurse is a Department of Health employee who works within the Watch House environment under a Memorandum of Understanding (**MOU**) between the NTPF and Department of Health. The MOU was developed following a recommendation in a coronial inquest in 2012.[15] It was negotiated over a lengthy period of time and was implemented in 2016. Custody Nurses are now rostered to work at the Darwin/Palmerston,[16] Katherine and Alice Springs Watch Houses. Due to funding limitations, it is not possible for a Custody Nurse to be present at all times. Rostering is based upon peak demand and high risk times, generally prioritising the presence of a Custody Nurse for overnight and weekend shifts.

51. When present, the Custody Nurse provides a health screening service, and is responsible for providing medical support and first aid to persons in custody. However, as outlined in the Instruction, "*[t]he presence of a Custody Nurse on duty in a Watch House does not derogate responsibilities of members relating to duty of care*."[17]

52. In addition to conducting their own health screening (by way of visual assessment and medical history check), a key aspect of the Custody Nurse's role is to observe and/or review the Custody Health Assessment performed by police upon receiving a person into custody. In doing so, the Custody Nurse effectively assists with determinations as to whether a person is "fit for custody". This phrase is defined in the Instruction (and in substantially similar terms in the MOU) as:

> *… a general principle applying to a person in custody who can be safely managed by police and/or by the on duty Custody Nurse (when present) within a Watch House or police cells, provided their health or any health condition does not deteriorate during the period of custody.*

53. The Custody Nurse is also responsible to assist NT Police with monitoring persons in the Watch House who are "at risk" or suspected to be "at risk of self-harm".[18]

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[15] *Inquest into the death of Terence Daniel Briscoe* [2012] NTMC 032 at [243].
[16] Police custody is presently managed through the Palmerston Watch House, with the Darwin Watch House only operating when required for significant events.
[17] Paragraph 472.
[18] MOU, Annexure C (*Police Watch House Nursing Service – Scope of* Practice), paragraph 11(a).

54. The Instruction contained the following paragraphs relevant to the role of the Custody Nurse:

Duties of the Custody Nurse

475. The Watch House Keeper will arrange for a person in custody requiring or seeking medical attention to be examined by the Custody Nurse as soon as practicable. This may include any person who requires medication or medical treatment for illness, injury or other physical or mental disability on the basis of:

- *their own claim or assertions;*
- *assessment by a member based upon observation and/or advice received; and*
- *observations of the Custody Nurse.*

476. Where practicable, a person in custody should be examined by the Custody Nurse to determine whether hospital treatment is required. The Custody Nurse will record all medical observations/treatments on the relevant IJIS card. If the Custody Nurse, in consultation with the Watch House Keeper, determines that the person requires treatment, appropriate arrangements will be made for the transferring the person to hospital. All relevant information is to be recorded on the Health Handover Form and the completed form is to be provided to the recipient medical facility. The ultimate decision rests with the Custody Nurse. This determination is to be noted on the Offender Journal in IJIS and/or the WebEOC Custody Board.

55. From the information provided during the investigation, it does not appear that there are any imminent changes to the Police Watch House Nursing Service or the scope of the Custody Nurse's role, although NTPF have expressed strong support for expansion of health-based collaborations for therapeutic care of people in custody.

Quality assurance measures

56. The NTPF oversight and quality assurance measures in place for the use of these devices that were observed in the investigation appeared to be at multiple levels:

- **Senior member review (Watch Commander and Territory Duty Superintendent):** These senior members were required to provide contemporaneous approvals at the time of use, as well as conduct incident reviews to sign off on the subsequent CIIRs;
- **Operationally independent review (RMIA):** The RMIA were involved in regular watch house audits, quarterly (and more recently, monthly) CIIR trending analysis, and "deep dive" or "sentinel" reviews into individual incidents;
- **Executive review:** The Custody Steering Committee, which consisted of various representatives between Director and Assistant Commissioner level, were involved in the review of trending reports and sentinel review reports prepared by the RMIA.

57. These quality assurance measures and the expected procedures required to complete them to an acceptable standard were detailed in the Instruction:

Custody Incident or Illness Report (CiiR)

439. Every custody incident, injury or illness is to be reported in PROMIS using a CiiR CNE irrespective of where that incident occurs.

440. It is the responsibility of the Watch House Keeper or the most senior member present to complete the CiiR CNE with all relevant details.

441. Every CiiR is to be tasked via PROMIS to the Watch Commander and TDO for review.

442. Each formalised CiiR is reviewed and undergoes data analysis and trending by the Risk Management and Internal Audit Division (RMIA). RMIA will additionally complete sentinel reviews of all high risk incidents as detailed in the Custody Incident or Illness Review Framework at Annexure 'C'.

58. Annexure C to the Instruction, the 'Custody Incident or Illness Review Framework' (**the Framework**), provided further information on what was expected to occur following the submission of a CIIR, including the process for sentinel reviews. With respect to RMIA trending analysis, the Framework stated:

> *RMIA currently maintains a register of all CiiR events for trending purposes. Each completed CiiR CNE is manually extracted from PROMIS. The details and information recorded in the CiiR are extracted and undergo an extensive trending analysis review. The high level data trending is of the location the event occurred and the details of the persons involved (members and offenders).*
>
> *The second layer of data trending is to identify the point in the custody process where the event occurred (i.e. taken into custody, during transport or at the Watch House or police cells).*
>
> *Each event is then categorised into key high level trend headings and key incident types, for example - self harm, escape, medical, use of force events (ERC, padded cell, spit hood use).*
>
> *Each of these high level incident types are then further trended into more granular data sets, for example – self-harm requiring medical treatment or self-harm no medical treatment, Escape attempt or actual escape.*
>
> *The RMIA team publish a Quarterly Report of all CIIR data – the draft Quarterly Report is presented to the Custody and Escort Working Group for operational level feedback and commentary. This feedback and additional commentary is reviewed and included in the final Report which is then formally issued to the CSC and the Divisional Officers.*
>
> *The NTPFES as a values led agency is at all times committed to the ongoing continuous improvement of our practices and processes. In alignment with this aim the CSC have endorsed the progression of this Review Framework.*

59. With respect to sentinel reviews, the Framework provided:

> *RMIA will conduct 'sentinel reviews' for each of the custody events listed in the table below. These events have been selected, as they have been determined, to be the event types that have the highest potential to place the NTPFES at risk. It is expected that at times additional event types will be identified for closer review, in response to 'at time' operational needs.*
>
> *This process may involve subject matter experts from the occurrence location as well as the Superintendent of Custody and Judicial Operations when appropriate.*
>
> *The review of these events will allow causal factors to be identified and analysed with a focus on both systems and processes, (not on individual performance). Each incident will undergo a root cause analysis to determine if any core systemic problems exist and to identify emerging trends and issues. These assessments will include the entire custody process as well as reviewing BWV and/or Watch House footage to enable a holistic perspective on the entire process and not the event in isolation. Individual reports for each event reviewed will be generated and provided to the relevant stakeholders and the Custody and Escort Working Group.*

It is anticipated that the data collected will enable the identification of process improvement opportunities within the current custody framework. It is expected that they will result in enhance training packages and staff capabilities.

Any proposed actions and process changes will also be tracked and reported to the CSC.

…

All sentinel custody incident and illness events will be reviewed in accordance with the checklists which have been developed for this purpose. Detailed assessments will be conducted for all mandatory and by exception events. Emerging trends and findings will be documented in the Quarterly Reports. If deemed appropriate the reports which will be provided to the NTPFES College to allow for the enhancement of training packages where training issues are identified.

60. The investigation considered compliance with, and the efficacy of, these quality assurance measures.

CHAPTER 4: NTPF TRAINING

61. The investigation considered the training available to members from two key perspectives - the proper use of the devices, and broader training offered which would enhance the ability of members to successfully de-escalate situations in which these devices may otherwise be used.

62. The initial request for information sent to NT Police included a request for relevant training material, as follows:

> *4. A copy of any General Orders, Instructions,* [Police Practices and Procedures] *information, Broadcasts, policies or relevant training material from the Police College (both the current version, and any superseded versions in force during 2020 or 2021) in relation to:*
>
> *a. The expected use of the devices;*
>
> *b. The expected treatment of youths while in police custody;*
>
> *c. De-escalation strategies for youth presenting with challenging behaviours; …*

63. Subsequent requests for information sought further information on other training previously and currently conducted within the NTPF.

64. The following training packages and modules were provided and reviewed by the investigation:

- A 90-minute Custodial Care training package developed for online delivery, which members are expected to complete on an annual basis;
- A Watch House Procedures Induction Package;
- The ERC Application and Use Training Package (including assessments);
- A Persons in Care or Custody module on Principles of Custody;
- A Persons in Care or Custody module on Watch House Procedures;
- A module on Tactical Communication (forming part of Operational Safety Theory training);
- A draft training module regarding Police Use of Force (forming part of Operational Safety Theory training);
- The Defensive Tactics / Operational Safety annual re-qualification course;
- A module on Youth Justice;
- A module from Investigation Training on Child Forensic Interviewing;
- A module on the NTPF Decision Model;
- Relevant internal Broadcasts to members; and
- Relevant extracts from the online Police Practices and Procedures manual (**PPP**).

65. Upon reviewing the Facilitator and Learner guides for these modules, it was decided that an observation of the sessions was not required.

Use of restraint options

66. The online Custodial Care training course includes information for members on the appropriate use of padded cells and ERCs, as well as some specific information regarding the expected treatment of children held in protective custody. It does not address the use of spit hoods.

67. Regarding the use of padded cells, the course materials state:

> *Where a Watch House has a padded cell, it may only be used when a person is considered to be high risk of self harm and when other Operational Safety and Tactics Training (OSTT) techniques have been ineffective. A Watch House Keeper may initiate the use of the padded cell on a person in custody. At the earliest opportunity after it is utilised, the Watch House Keeper must provide the circumstances and seek approval from the TDS for continuing this restraint.*
>
> *Paragraphs 338 - 342 of the Instruction - Custody and Transport, relating to persons showing emotional or physical distress to be examined, are to be strictly adhered to for persons requiring the use of a padded cell.*
>
> *In circumstances where there is a requirement to remove clothing from a person, every effort must be made to preserve the person's privacy and dignity.*
>
> *Persons are not to be left naked in a padded cell for any longer than is absolutely necessary for reasons of prevention of self harm.*
>
> *Welfare checks are to be conducted on the person a minimum of every 10 minutes by entering the cell and speaking with the person.*
>
> *An assessment of the requirement to remain in the padded cell is to be conducted at each check.*

68. With respect to the use of an ERC, the course materials provide:

> *An ERC is available at some police Watch Houses and police cells. The use of the ERC is only to be used when a person in custody is demonstrating behaviour likely to cause the potential or continued risk of self-harm after other OSTT restraint techniques (the use of verbal engagement, handcuffs etc.) has been ineffective.*
>
> *Paragraphs 343 – 362 of the Instruction – Custody and Transport, relating to persons showing emotional or physical distress to be examined, are to be strictly adhered to for persons requiring the use of an ERC.*
>
> *An ERC is only to be utilised by police members who hold current OSTT, First Aid qualifications and have successfully completed training in the use of an ERC.*
>
> *A Watch House Keeper may initiate use of an ERC on a person in custody. At the earliest opportunity after an ERC is utilised, the Watch House Keeper must provide the circumstances and seek approval for continuing this restraint from the TDS.*

A person in custody who is restrained in an ERC is to be placed into an observation cell where practicable, with the person facing outwards to allow observation at all times.

Welfare checks are to be conducted on the person a minimum of every 10 minutes by entering the cell and speaking with the person. An assessment of the requirement to remain in the ERC is to be conducted at each check.

A person should not be restrained in an ERC for any longer than two (2) hours in a single session. Approval to continue restraining the person in an ERC is to be sought by the Watch House Keeper, in consultation with the custody Nurse, where available and if required seek approval from the TDS to continue to hold the person in the ERC.

If an extension is approved by a TDS, a range of motion exercises for each limb must be conducted at the 2 hour mark and then every hour thereafter.

Note

Initially a person will only be restrained in an ERC for no longer than 2 hours.

The use of the ERC is to be used for only as long as the person is demonstrating a willingness to continue behaviour likely to cause potential or continued risk of serious self-harm. When the Watch House Keeper determines that this level of risk has subsided, the person is to be immediately released from the ERC as a priority.

Note

When a person has been released from the restraint of an ERC, a medical assessment is required to be undertaken. .

On each and every occasion the ERC is used, the occurrence is deemed to be a 'Custody Incident' and the use of the ERC is to be the subject of a CiiR CNE.

69. Lastly, with respect to children being held in protective custody, the materials state:

Where a youth is apprehended for protective custody, all other reasonable avenues for care of the youth are to be explored, – including transferring custody to a sober suitable person or placement in a medical care facility.

Strict adherence to time restraints must occur. Where possible, the Watch House Keeper must make attempts to locate the youth's parent, or guardian, or other suitable person, by phone, to take custody of the youth.

Where a youth is transferred from police custody to the custody and care of another person, for example: sober suitable person, medical care facility, Territory Families etc, members must activate BWV cameras to record the transfer of custody event.

70. Similarly, the Watch House Procedures Induction Package outlines a number of provisions of the NT Police General Orders and Instructions relevant to the use of spit hoods and ERCs, as well as expectations for managing distressed persons in custody and those displaying difficult behaviour. The package does not expand on the content of those policy documents or include any practical activities relevant to the investigation.

71. The ERC training package provided during the investigation was developed for members ranked Constable and lower. The training package appears to have been developed from the perspective that a decision had been made to use the ERC, and concentrates on policy requirements relevant to use of the ERC, member safety considerations and how to operate the ERC correctly. It did not appear to include any theoretical or practical components on strategies for de-escalation to avoid the use of the ERC, or how to speak to someone restrained in an ERC to assist them to calm down.

72. NTPF confirmed that at the present time, no practical training is conducted with respect to spit hood use.

Child development, the impact of trauma and de-escalation

73. This investigation is not the first time that consideration has been given to NT Police training with respect to child development, trauma and de-escalation. The Royal Commission examined the issue in detail, concluding that:[19]

> *… the different needs of children and young people, the benefit of deflecting them from patterns of criminal behaviour early, and the importance of police in that task, warrants the creation of a specialised, highly trained police division in the Northern Territory to work with children and young people.*

74. The Royal Commission closely examined the New Zealand Police Youth Aid model, and included the following recommendations in its report:

> ***Recommendation 25.1***
>
> 1. *The position of Aboriginal Community Police Officers be expanded and include the position of Youth Diversion Officers.*
> 2. *Establish a specialist, highly trained Youth Division similar to New Zealand Police Youth Aid.*
> 3. *All officers involved in youth diversion or youth engagement be encouraged to hold or gain specialist qualifications in youth justice and receive ongoing professional development in youth justice.*
> 4. *Northern Territory Police organisation and remuneration structures appropriately recognise officers with specialist skills in youth justice.*
> 5. *All Northern Territory Police receive training in youth justice which contains components about childhood and adolescent brain development, the impact of cognitive and intellectual disabilities including FASD and the effects of trauma, including intergenerational trauma.*

75. In my 2021/22 Annual Report, I stated:

> *In reviewing footage relating to investigations, we see many cases of highly effective and positive interaction and communication by police officers with young people. However, there continue to be some cases in which we identify situations where further attempts at genuine conversation and clearer communication with youths may have avoided escalation of situations that ultimately resulted in use of force.*

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[19] *Royal Commission into the Detention and Protection of Children in the Northern Territory* (Final Report, November 2017), Vol 2B, p 222-3 (Recommendation 25.1).

These situations often appear to arise from an emphasis on gaining immediate control of the situation, at the expense of communication. This is not to say that every situation lends itself to ongoing discussion or that attempts at effective and genuine communication will always prove successful. However, it is important for officers to make all reasonable efforts to positively engage with youths in the course of interactions with them.

The establishment of a Police Youth Division is a welcome development. However, the reality is that the first point of contact between police and youths may fall to any officer at any time. With that in mind, it is important for NT Police to consider all available options for providing training and guidance to officers across-the-board.

76. In November 2022, the Australian Government Mental Health Commission released its consultation draft of the *National Stigma & Discrimination Reduction Strategy*. It also commented on the importance of police, often as the first responders to situations of mental distress, ill-health or trauma, to receive targeted education and training:[20]

Improve police training and responses to mental health-related incidents

A major area where people report experiencing stigma and discrimination in relation to justice and legal services is in responses to mental health-related incidents. This has been reported in particular in relation to police... Unfair treatment is described by the majority of people with complex mental health needs as being unfairly detained or questioned by police, being subjected to excessive police force, or being unfairly denied police assistance when needed. This unfair treatment is presumed to be driven by a lack of understanding of complex mental health needs, including the impact that trauma can have on someone's response to stressful situations. Discriminatory police responses are also said to stem from negative stereotypes about people with personal lived experience having impaired decision-making or awareness. This highlights the importance of targeted education and training for this cohort.

Police are typically the first responders to incidents involving people experiencing mental distress, ill-health or trauma. However, there is broad acknowledgement of the limitations in police training and the scope of their role in these situations. Efforts have been made to improve police responses and promote inter-agency collaboration in crisis response. These include a suite of programs and services supporting and advising police, such as the Victorian Police Ambulance and Clinical Early Response (PACER) program, which is a "joint crisis response from police and mental health clinicians to people experiencing a behavioural disturbance in the community." Evaluations of the PACER service in Victoria indicate that it works well, but that workforce challenges exist in rural areas, and that the program should be expanded in high-demand areas.

77. The investigation was advised that NT Police recruit training incorporates a two day module on Tactical Communications into its Operational Safety training. This module is taught by Defensive Tactics Instructors at the Police College within the early part of recruit training, with the intention that it can be incorporated and built upon during the remainder of recruit course. The Induction and Operational Safety Division summarised this training for the investigation as follows:

Tactical Communications is taught to all recruits at the college by Defensive Tactics Instructors, normally this occurs during the two week theory block and is taught alongside other topics such as DT's theory, Use of Force theory and Decision Making (Tactical Options Model, Ten Operational Safety principles). The session consists of two days of training, the first day

[20] Mental Health Commission, *National Stigma & Discrimination Reduction Strategy* (Consultation Draft, November 2022) p 58 <accessed online: 356c734a765c6fbf927bf0895dac3da2_V8_-_Stigma_Strategy_-_Consultation_Draft_-_for_Public_Release_-_7_November_2022.docx (live.com)>.

focusses on theory of communication and covers topics such as avoiding conflict, active listening, persuasion process, question types and making effective contacts. During this theory session recruits also practice some of their listening and questioning skills in some group scenarios and as homework. The de-escalation of conflict more draws upon the theories and concepts from Defensive Tactics theory as a bi-product of Tactical Communications but does not form its own topic.

The second day is mainly focussed on the practical aspects of making effective contacts ... [The] scenarios are very low level and focus on the recruits practicing their use of the processes as well as self-analysis and feedback, this is due to the lessons occurring very early on in the overall recruit course so there is not as much knowledge around police processes and legislation at this stage and our focus is on maintaining self-efficacy and engagement with the learning.

The intent is then that these skills will be used throughout the rest of the course and built upon in [Defensive Tactics] and Firearms skills blocks as well as other training such as Reality Based Training.

78. All NT Police members are required to re-qualify in Defensive Tactics / Operational Safety on an annual basis. The re-qualification course appears to reiterate the need to avoid or minimise the use of force wherever possible, and emphasise the importance of communication to assist with de-escalation within the tactical options model. It does not, however, appear to review the specific communication strategies learned in the initial tactical communications theory.

79. NT Police also advised that it previously offered "Verbal Judo" training to members to enhance general de-escalation and conflict resolution skills. Verbal Judo is a methodology developed in the 1980s which focuses on resolving situations without the need for coercive force wherever possible, by achieving "voluntary compliance" through persuasion.[21] It has been described as a more scripted version of de-escalation training than other methods. An evaluation of a truncated version of this training (1 day rather than the recommended 2 days) for police officers in Canada was undertaken in 2017, and reported on in 2020. The study found that:[22]

    While the main conclusion of this evaluation is that VJ training worked reasonably as expected, there were many behaviours that did not change. The behaviours that were immediately adopted post-treatment – for example, identifying oneself and their agency, avoiding excessive repetition, and refraining from using verbal commands, may have been less complex (or more 'natural') behaviours to adopt than some of the behaviours where no pre-post change was observed – for example, asking the subject for a justification of their actions, making empathetic statements, or confirming non-compliance before moving to use force. Indeed, the VJ package as delivered may have been considered largely 'observational' learning, which tends to be more effective for simple skills than for complex skills (Chance, 2013). It may, in turn, be the case that more intensive training, repeated training, or ongoing coaching would be needed to encourage adoption of these potentially more complex behaviours. (Footnotes omitted.)

[21] C Giacomantonio, et al, *Learning to de-escalate: evaluating the behavioural impact of Verbal Judo training on police constables* (2020) 21(4) Police Practice and Research 401 at 403.
[22] Giacomantonio, at 413.

80. Verbal Judo training was discontinued by NTPF in 2007, primarily due to the ongoing cost of utilising a registered trademarked training package. It was replaced by the current Tactical Options Model, which is largely based on the Victorian Police model. The Tactical Options Model is described in NTPF documents as follows:[23]

> *Throughout the tactical options model the common theme is a safety first attitude, together with communication skills, which are used to promote de-escalation of the incident and thus ensure the minimum use of force. It can be seen on the circular representation of the model that central to the whole issue of the use of force is safety. Prior to the application of any level of force, communication skills should be exercised.*

Figure 3: Diagrammatic representation of the NT Police Tactical Options Model

81. As a result, it appears from the materials available to the investigation that the training available for general de-escalation occurs early in a member's career, which may be impacted either positively or negatively by other officers who they subsequently work alongside.

82. Although the training materials provided to the investigation did include a module for Youth Justice, these materials are largely focused on specific requirements for dealing with children in custody and under the *Youth Justice Act 2005* (NT). The training available to general duties members does not appear to cover theories of child development, the impact of trauma or specific de-escalation strategies in those contexts. However, for members who undertake training on child forensic interviewing, the course stresses the importance of rapport building and includes a session by an external presenter with respect to child development and the impact of trauma.

83. Internationally, other studies have been conducted into various forms of developmental and de-escalation training. For instance, in 2021, a report was released regarding a pilot study conducted by the University of Alabama into the observable impact of "*brief trainings that could increase officers' knowledge about adolescent development and their capacity to de-escalate situations with trauma-exposed adolescents through collaborative interactions.*"[24] The training was designed collaboratively between police and developmental and clinical psychologists. It was a

[23] Description taken from the Defensive Tactics Learner Guide (Annual Re-qualification), p 15.
[24] K Mehari, et al, *Evaluation of a police training on de-escalation with trauma-exposed youth* (2021) 66 International Journal of Law, Crime and Justice 100491 at 1.

2-3 hour session focused on increasing knowledge of typical development, the potential impact of trauma on cognition and behaviour, and improving the ability to resolve situations using collaborative and proactive solutions. The study generally found that the intervention was effective for increasing knowledge about adolescent development, building more age-appropriate expectations for adolescent behaviour, and decreasing officer anxiety around dealing with adolescents.[25] The study concluded that:[26]

> *… this workshop has the potential to positively impact officers' understanding of adolescents, especially adolescents who have been exposed to trauma, and their knowledge of strategies and tactics to de-escalate conflict situations with adolescents. It is likely that officers may need more practice and coaching before their self-efficacy for de-escalating conflict significantly improves. A promising factor was that this workshop was very time-limited (2-3 h) but resulted in significant effects. Therefore, increasing the dosage may increase the impact even more. Notably, this training is low cost and easy to administer. Integrating such a training into the existing system may impact law enforcement officers' comfort with and knowledge of adolescents and their development…*

84. The investigation also received information that other Government bodies working with children may have previously received specific de-escalation training through the Crisis Prevention Institute. The Institute offers tailored foundational and advanced courses on Verbal Intervention and Safety Intervention, with a focus on verbal de-escalation, prevention and early intervention.[27]

[25] Mehari, at 8.
[26] Mehari, at 9.
[27] Further information on course details available online at https://www.crisisprevention.com/en-AU/Our-Programs/Verbal-Intervention-1.

CHAPTER 5: IMPACT OF USE

85. This investigation has been conducted in co-operation with the NT Office of the Children's Commissioner (OCC) from the outset. The Children's Commissioner has provided comment on individual uses of spit hoods and ERCs (see Chapter 6). The Children's Commissioner also prepared a detailed Position Paper to assist in advancing the investigation.[28] This chapter draws to a substantial extent from that Paper.

86. An important aspect of understanding the impact of the use of these devices is to understand who they are most likely to be used upon. When it comes to children, the OCC Position Paper explains typical child development as follows:

> *Children's physical, emotional and cognitive maturity is different to adults. A human brain is not considered to be fully developed until the age of 25 years. Complex behaviour, emotional regulation and sense of morality relies on the healthy development of the pre-frontal cortex from birth to age 25.*

87. The Children's Commissioner also highlighted the very high proportion of children within the justice system who come from a background of adverse child experiences including neglect, domestic and family violence and physical harm. An audit conducted in 2021-22 found there were 691 child protection notifications for the 27 children audited (averaging 26 notifications per child).

88. The impact of this kind of traumatic background on a child's daily life was summarised in the OCC Position Paper as follows:

> *… when a child's development is interrupted or impeded it can have significant, lifelong impacts. The relationship between children with ACEs* [Adverse Childhood Experiences] *and their subsequent involvement with the justice system is not unique to the Northern Territory. International studies demonstrate the psychobiology of violent and aggressive behaviours, including 'trauma triggers' and the connection between shame, guilt and displaced revenge. In addition to this, many Aboriginal children bear intergenerational trauma stressors through physiological, genetic, behavioural and psychological factors, as well as environmental factors such as overcrowded living arrangements and poverty.*
>
> *The symptoms of developmental trauma can make it extremely difficult for a child to respond calmly and coherently in a stressful environment. These symptoms include: emotional dysregulation, somatic dysregulation (e.g. aversion to touch, sounds, distress/illness that cannot be medically resolved), hyper- or hypo vigilance to actual or potential danger, extreme risk taking or recklessness, intentional provocation of conflict or violence, non-suicidal self-harm, impaired ability to initiate or sustain goal-directed behaviour, impaired interpersonal empathy and reactive verbal or physical aggression.*
>
> *In addition to this, a history of maltreatment or trauma can have a more pronounced and direct impact on a child's engagement with positions of authority, which often manifests in the education and justice systems. Research has shown that a diagnosis of oppositional*

[28] *Use of Spit Hoods and Restraint Chairs on Children*, (June 2023) https://occ.nt.gov.au/resources/occ-publications/other-reports. Quotes drawn from the OCC Position Paper have references omitted.

defiance disorder is associated with an increased likelihood of prior trauma. Oppositional defiance disorder is characterised by disruptive behaviour, a pattern of angry and irritable mood, and argumentative and vindictive behaviour. It also often leads to or occurs alongside conduct disorder, which is characterised by aggressive behaviour, defiance to authority figures and antisocial behaviour.

89. The OCC Position Paper also outlined the significantly higher likelihood that children in contact with the justice system may also have a disability such as attention deficit hyperactivity disorder (ADHD), communication impairments, fetal alcohol spectrum disorder (FASD), learning impairments or traumatic brain injuries. These conditions can further complicate the complex behaviours displayed by a child who has come from a traumatic background.

90. From a practical policing perspective, this kind of complex background requires police to utilise additional skills in order to:

- Ensure children are able to understand explanations, and listen to and follow instructions;
- Calmly and patiently respond to situations involving extreme emotional responses and poor impulse control; and
- Assist children who may be having difficulty returning to a state of calm.

91. As described in the OCC Position Paper:

In a stressful police setting, such as an arrest, such disorders clearly limit a child's ability to regulate their emotions, communicate effectively and conduct simple problem solving. This can cause anger and defiance, as a child may simply not know how to respond to a stressful situation. It is therefore crucial that front line services such as police have the training and resources to be able to safely engage with the child without causing further physical or psychological harm to them.

92. Use of these devices on children, particularly children from the above described backgrounds, can be particularly harmful. The potential harm was summarised in the OCC Position Paper as follows:

The NT Royal Commission found the use of spit hoods and restraint chairs (as well as other forms of restraint) exacerbate discomfort and distress of children with potential to cause harm and recommended that the use of both be prohibited.
…
In an independent review of seclusion and restraint practices in New Zealand, Dr Sharon Shalev … states that the use of restraint chairs, either in isolation or conjunction with spit hoods, is known to have significant adverse physical and psychological effects on an individual. These risks are elevated where the detainee is a child or adolescent, if there are medical or situational conditions (such as asthma or intoxication) and for people who have a history of abuse, as they can experience restraint as a re-enactment of their original trauma.
…
Spitting is a behaviour that can result from the experience and expression of trauma symptoms (inclusive of other aggressive behaviours like verbal abuse, punching, kicking, biting, and self-harm). Tools such as spit hoods and restraints can be re-traumatising, as observed by other co-occurring trauma presentations such as dissociation, sobbing and outbursts of rage.

93. The Australian Human Rights Commission submission to the Australian Federal Police Review of the use of spit hoods referred to similar risks and impacts, noting comments from previous studies and reports that the use of spit hoods can cause excessive disorientation, anxiety (particularly for children or those with underlying medical or mental health conditions), hyperventilation, extreme behaviour and panic attacks.[29]

94. With respect to restraint chairs, in 2014, the Australian Human Rights Commission made findings that the repeated use of a restraint chair and chemical restraint to control self-harming behaviour of a man with a cognitive impairment being detained in the Alice Springs Correctional Centre amounted to cruel, inhuman or degrading treatment in contravention of Australia's international human rights obligations.[30]

95. Studies available on the impact of restraint chairs are rare. In 2015, a review of medical and legal databases for material regarding the impact of restraint chair use was conducted (funded by the Canadian Ministry of Community Safety and Correctional Services).[31] The Canadian review found only one study that had been conducted on human subjects to measure the physiological impacts of restraint chair use after vigorous exercise. That study noted a small decrease in the largest volume of air a person can breathe in and out over a defined period, but no drop in oxygen or increase in carbon dioxide levels in the blood, which would have been the first markers of a clinically significant impact on ventilation. The remaining 20 studies reviewed were of the impacts of restraint chair use on primates, but it was noted the findings were "*difficult to interpret and even more challenging to apply to humans.*" The study concluded that restraint chairs pose little to no medical risk and are "safe and appropriate for use" when used appropriately. However, there were no studies identified in the Canadian review regarding the psychological impact of restraint chair use on subjects who were already psychologically distressed.

96. A further study conducted in 2018 compared the use of the restraint chair with seclusion and four-point restraint across three different psychiatric hospitals in the United States.[32] The study referenced previous work regarding the patient experience of restraint, noting that the experience was predominantly negative with four main themes: "*the feeling of being re-traumatized, negative psychological implications, the sensation of a broken spirit, and a perception the restraint process was unethical.*"[33] Again, however, this study failed to consider the psychological aspect of restraint chair use, instead focusing on a comparison of whether medication would be taken voluntarily, the duration of restraint and any physical injuries. It is the psychological impact that continues to drive the domestic and international push towards abandoning the use of this form of restraint.

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[29] Australian Human Rights Commission, *The Australian Federal Police's review on its use of spit hoods: Submission by the Australian Human Rights Commission*, 17 February 2023 (https://humanrights.gov.au/our-work/legal/submission/australian-federal-polices-review-its-use-spit-hoods), [11]-[12], and [19]-[20].

[30] *KA, KB, KC and KD v Commonwealth of Australia (Department of Prime Minister and Cabinet, Department of Social Services, Attorney- General's Department)* [2014] AusHRC 80 (1 September 2014).

[31] EM Castillo, et al, *Review of the medical and legal literature on restraint chairs* (2015) 33 Journal of Forensic and Legal Medicine 91.

[32] N Visaggio, et al, *Is it safe? The restraint chair compared to traditional methods of restraint: A three hospital study* (2018) 32 Archives of Psychiatric Nursing 723.

[33] Visaggio, at 724.

97. Another aspect to be considered is the comparative impact of use on NT Police members. By using a spit hood, members may feel protected from communicable diseases through preventing the bodily fluids of others coming into contact with their body and/or spreading within their work environment. This was addressed in the OCC Position Paper:

> *A common justification for applying a spit hood is to prevent the transmission of communicable disease by way of infected body fluids (i.e. blood or saliva). Such diseases include Hepatitis A and B, Tuberculosis and HIV. However, the facts do not support this justification and evidence proves this risk is overstated. In its investigation into the use of spit hoods in youth detention, the South Australian Ombudsman stated:*
>
> > *There is a relatively high rate of blood-borne illnesses within Australia's adult custodial population, although the risk of transmission from bloody saliva or bites to the skin ranges from very low to non-existent, depending on the illness.*
>
> *In Canada, the 2012 determination in R v Ratt established that there is no evidence of any documented verifiable transmission of any disease to a police officer in a spitting incident.*
>
> *Further, there has been no incident of HIV being passed on through spitting, even when the spitting contains blood, in the entire history of the disease.*
>
> *In a recent systematic review of HIV transmission, it was concluded that there was no risk of transmission through spitting.*
>
> *It has also been recently established that there is a lack of evidence to support that Hepatitis B or Hepatitis C can be transmitted through spitting or biting.*
>
> *Similarly, spit hoods are understood to be ineffective in preventing the transmission of infections, such as COVID-19. Significant public research outlines surgical masks are a far more practical and effective measure of infection control regarding respiratory viruses.*
>
> *Furthermore, Australian and international medical associations recommend full vaccination against diseases such as Hepatitis A, Hepatitis B and COVID-19 as preventative measures to increase safety from contracting the illness.*

98. In a similar vein, the Australian Human Rights Commission submission to the AFP Review on the use of spit hoods stated:[34]

> *In the Australian context, Hepatitis Australia has stated that 'saliva can contain but not transmit blood borne viruses unless there is sufficient blood contamination. Even then, the risk of transmission of these viruses to police, bus drivers and other workers in the community via occupational exposure is negligible.'*
>
> *The Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) and the Australia New Zealand Policing Advisory Agency have also partnered to produce resources for police officers which demonstrate that HIV, Hepatitis B and Hepatitis C transmission through saliva exposure or bite are very low risk.*

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[34] Australian Human Rights Commission, *The Australian Federal Police's review on its use of spit hoods: Submission by the Australian Human Rights Commission*, 17 February 2023 (https://humanrights.gov.au/our-work/legal/submission/australian-federal-polices-review-its-use-spit-hoods), [35]-[37].

The Northern Ireland Policing Board Review has rightly asserted that 'if officers were better equipped with the scientific evidence surrounding the very low chance of transmission, this may lower the risk of any psychological impact.' We would argue that the same is applicable in the Australian context. (Footnotes omitted)

99. In terms of restraint chair use, some material provided to the investigation by NTPF suggested that there may be a higher risk of physical injury to members through the use of a padded cell (through cell insertions, wellbeing checks and extractions) than to place a person into a restraint chair. It was also noted that there can be some types of serious self-harm that cannot be effectively prevented without the use of a restraint chair – such as a person biting themselves, scratching themselves to the point of drawing blood, or hitting their head on hard parts of a padded cell (such as the floor, door or window). In such cases, members may feel more comfortable that they are complying with their duty of care to prevent the person in custody from self-harming through the use of a restraint chair.

CHAPTER 6: SPECIFIC INCIDENT EXAMPLES

100. A number of incidents were reviewed during the investigation which shed light on important aspects of procedure and performance regarding the use of the devices. Although it is not feasible to discuss in detail in this report all 30 of the incidents reviewed, **Annexure A** summarises each incident, as well as outlining various issues of interest that this Office would likely have considered further if a complaint against police had been submitted.

101. A selection of these incidents are discussed in detail below. In addition, the Office of the Children's Commissioner (**OCC**) was requested to provide commentary on these specific incidents due to their significant expertise in child engagement and trauma.

102. The incidents detailed in this Chapter were selected as demonstrative examples of themes that were more broadly observed in the investigation. The list below briefly outlines the nature of the incidents detailed in this Chapter and the themes they touch upon:

- ***Incident 1: Conveyance of child escalates to arrest -*** A police member tried to convey a child home due to concerns he may breach his suspended sentence. The child became argumentative, the situation escalated and the child began spitting. A spit hood was used briefly when removing the child from the police vehicle at the watch house. This incident raised issues of poor communication (including inappropriate comments made by members), failure to utilise available PPE and failure to conduct sentinel review.

- ***Incident 2: Young child wants to remove clothing himself and spits during search –*** A child was arrested for property offences. He was initially cooperative at the watch house, however poor communication and force used during processing preceded escalated behaviour, including spitting at a member. A spit hood was applied briefly. This incident involved failures to use PPE and to identify opportunities for improvement on review.

- ***Incident 3: Child with FASD claims difficulty breathing in spit hood –*** A spit hood was applied to a child known to have FASD during processing at the watch house as he had been spitting on the ground and threatening to spit at police during arrest. The child repeatedly complained of difficulty breathing. Internal reviews considered the spit hood use to be justifiable due to the child's behaviour and the terms of his custody management plan. This incident highlighted themes of PPE use, the use of spit hoods on intoxicated people, the associated use of force, and the potential to develop more therapeutic custody management plans. The discussion also covers the traumatic experience of "air hunger" and the risk of assessing a person's ability to breathe by reference to their ability to speak.

- ***Incident 4: The crying child who claimed "but anybody spits" –*** A 13 year old child was arrested for breach of bail. The child began crying at the watch house and spat on the floor to deal with excess mucous. His behaviour escalated when members told him to stop spitting. A spit hood was applied during processing and left on for the child to remove himself once secured in his cell. Issues raised in this incident include failure to use PPE, poor communication, the threshold for use of a spit hood (where a person is spitting on the floor or in a vehicle), in-cell use, failure to conduct or record wellbeing checks, and internal reviews conducted without review of footage.

- ***Incident 5: "You can vomit through it, that's what it's designed for" –*** Police responded to an incident where a child was vomiting profusely and asking for help. Police decided to take the child into protective custody. Police tried to convince the child to wait outside for an ambulance, but considerable force was ultimately used to move him. After the use of force, the child escalated significantly and spat at a member. A spit hood was applied, but was not positioned correctly. The child repeatedly asked for the spit hood to be removed so he could vomit, but his requests were refused with a member expressing a belief that the spit hood was designed to be vomited through. The discussion of this incident raises concerns regarding a significant failure of internal review processes, the use of a spit hood contrary to policy, and incorrect placement of the spit hood creating health risks.

- ***Incident 6: Spit hood used in cell, limited real threat to members –*** A child was arrested for property offences in circumstances where there was a significant delay in transportation and processing of the child. During this time, the child repeatedly complained of pain from handcuffs. At the watch house, the child's behaviour escalated and he spat at a member. A spit hood was applied in the holding cell. The child was left in the spit hood and handcuffs for a significant period of time, without appropriate welfare checks being made. This incident raised themes of inadequate internal reviews, missed opportunities to de-escalate behaviour and the use of a spit hood contrary to policy.

- ***Incident 7: "I need to settle down" turns to ERC use –*** A child known by police to be in foster care was located by members in a local park, intoxicated and swearing. The child was yelling that she was not in a good mood, she needed to settle down and let her stress out. The child refused an offer by police to take her home, saying she would damage the care home. Members arrested the child for an infringement notice offence. Once in police custody, the child began to threaten self-harm. She was placed in an ERC at the watch house for a period of around 3 hours before being taken to hospital for a mental health assessment. The discussion of this incident highlights how members failed to take time to connect with the child and attempt genuine de-escalation before arrest, and raises failures to conduct wellbeing checks and sentinel review as required by policy.

- ***Incident 8: Medically fit for custody but self-harm continued –*** A child who had been sniffing spray was arrested. At the time of arrest, she was fixated on having lost her phone. The child was taken to hospital for assessment due to volatile substance abuse. She began self-harming in the rear of the police vehicle. The child spat on the floor at the hospital and a surgical mask was applied. The hospital assessed the child as medically fit for custody, expressing a desire to see how she settled in police custody. The child's self-harm behaviour continued to escalate and she was placed straight into an ERC on arrival at the watch house. She was released after about 30 minutes and went to sleep. The discussion of this incident highlights the use of alternative strategies to a spit hood, and touches upon a gap in therapeutic mental health crisis support for people in custody who are self-harming but not accepted for medical care due to intoxication or for other reasons.

- ***Incident 9: Watch House Keeper de-escalates child in ERC quickly*** – A child was arrested and suffered an injury to his ankle during arrest. At the watch house, the child complained of pain from his handcuffs and in his ankle, and expressed a desire to remove his clothing for processing by himself. When police failed to respond in the way he wished, the child's behaviour escalated and he forcefully hit his head twice on the counter. He was immediately placed into an ERC. This incident raised issues of missed opportunities to avoid escalation, the need to clarify the purpose of policy requirements, and a heavy focus on reactive behaviours without considering triggers during internal review. The discussion also highlights positive strategies used by the watch house keeper to de-escalate the child's behaviour quickly after placement in the ERC.

103. These examples have not necessarily undergone the detailed investigation and consideration that might be undertaken in the course of a formal complaint investigation. While the cases have been examined closely, the primary purpose for their inclusion is to provide context to use of restraints and the potential for alternative action.

104. These incidents have not been investigated with a view to making any findings against individual officers, although some suggestions are made to bring issues to the attention of officers. It is also important to recognise that they represent a very small proportion of the interactions that officers have with children on a daily basis. Readers are urged to view them not from a perspective of whether individual conduct was understandable or justifiable in difficult circumstances or whether they might have taken a similar approach. Rather, they are intended to provide a basis for the NTPF and its officers to consider a move towards different strategies in dealing with their use of restraints and with children generally.

Examples of spit hood use

Incident 1: Conveyance of child escalates to arrest

105. A member responding to an incident came across a group of children who dispersed. On further patrolling, the member came across the child and his girlfriend walking through a school ground. The child had recently been released from detention on a suspended sentence.

106. The member questioned the child about his identity, and the identity of other children who were visible. The child provided a number of names, some of whom were listed in the child's conditions as people not to associate with. During this conversation, the child twice mentioned that the police lights had scared him. The child stated that he was not hanging out with these other boys, he was just walking his girlfriend home and was going to stay at her house that night.

107. After about 6 minutes, the member politely directed the child and his girlfriend to come to the road so that police could take them home, stating that he did not want the child hanging around with those other boys. The child challenged the direction, stating that he was on bail, he did not have a curfew, and was allowed to be walking around. The member said to the child that he did not get to choose, as he was a child and was on a suspended sentence. The child denied that he was on a suspended sentence, reiterated his position, and said he wanted to walk to his girlfriend's house.

108. After about 40 seconds of further discussion on the matter, the member appeared to get frustrated with the child's lack of compliance, stating to him "*you're a youth in need of care, you're a known thief and a criminal*". The member used a gentle push to the child's shoulder to cause him to start walking towards the street, and continued this contact while the child walked in that direction.

109. The child continued protesting. The member explained he had a suspicion that the child was going to commit offences. The member asked whether the child would continue walking by himself, or whether he needed to continue escorting him. After sitting down at a bus stop, the child continued arguing with, and began disparaging, the member. The member began to fluctuate in the tenor of his responses, at one stage responding with "*Let me tell you… you're going nowhere in life. Do you understand that? You are going to go nowhere in life. You are going to be a loser for the rest of your life with that attitude.*"

110. The child continued protesting why he was being forced to go home. He commented that the member was "*lucky that [he was] in uniform*", to which the member replied: "*Why, what would you do? Mate, you're the size of a toothpick. What do you think you're going to do?*" The child then said he would have "*sprayed*" him and called the member a "*racist dog*". The child said: "*Yeah brother, you're a little racist dog. I'm f***ing walking home brother. You racist m*** f***. We're walking home brother, we only live round the corner and you talk sh** and pulled us up for f*** all brother. …. I'll stab you m*** f***.*"

111. The member replied, "*What did you say? You said you're going to stab me? That's an assault!*" There was then a physical interaction that could not be seen clearly on the body worn footage. The member stated that the child had thrown his bag at the member, but the child alleged that the member had tried to choke him. The member then put the child in handcuffs and told him he was under arrest for disorderly behaviour.

112. The child then began saying: "*Lucky I don't spit on your little face you m***f*** … I'll spit on your f***en face, give you corona you dog. I'll give you corona brother. Trying to pick me up for no reason, I don't f***en do nothing brother. I was walking home m***f***.*" As a caged police vehicle approached, the member took hold of the child and directed him to stand up. A struggle occurred, the member was heard to say loudly "*stop resisting*" before calling into his radio to the police vehicle that had driven past them. The member then ground stabilised the child. The child yelled out that he was being scratched on the pavement and he needed the member to get off his ribs. The member was holding the child's head to the side so he could not spit. As the child was moved into the vehicle, the member applied head directional control by holding the neck from behind. The child yelled out that he was being choked.

113. The arresting member advised the conveying members that the child had spat on him right before they arrived, however this was not clearly visible or audible on the footage. A spitting noise was audible as the police cage was closed.

114. The child continued threatening to stab police from inside the cage, and was complaining that his handcuffs were too tight. He also began to ask after his girlfriend. A conveying member responded: "*She's gone, she left you*" and then laughed. The conveying member also stated to the child at a later stage: "*Oh, shut up… you know you're not tough, don't you?*"

115. The conveying members asked the watch house keeper to use a spit hood on the child due to concerns he had been repeatedly spitting. A spit hood was applied with minimal force as the child was removed from the vehicle. The child removed the spit hood within a minute and it was not replaced. Watch house staff used plastic face shields until the child was secured in a cell.

116. The Territory Duty Superintendent was notified, and a Custody Incident and Illness Report (**CIIR**) form was submitted. The senior member review did not identify any issues with the incident or use of the spit hood. No sentinel review was conducted. The matter was reported to the CSC in the RMIA monthly report as follows:

> ***Youth -*** *arrested for an offence and conveyed to the … Watch House. During arrest the detainee was spitting at members and upon arrival at the Watch House a spit hood was applied to the detainee to protect members from the risk of biological contamination. The detainee was displaying signs of anger and aggression towards members and managed to remove the spit hood from his head by swinging his hands over his head prior to being placed in the holding cell. The spit hood was no longer utilised from this moment onwards including during the reception process. Members protected themselves by using plastic masks. The spit hood was only applied from 2329hrs to 2330hrs.*

117. A complaint was made to the Ombudsman's Office about use of force during this incident. No grievance was raised regarding the spit hood. Notwithstanding that, I expressed concern that there were opportunities to de-escalate the situation, but inappropriate comments made by the members appeared to escalate the interaction.

118. On its review, the Office of the Children's Commissioner considered that the member engaged with the child in an adversarial tone from the beginning of the interaction, and missed or ignored opportunities that the child provided for collaboration to defuse the situation.

119. The Children's Commissioner was of the view that, psychologically speaking, the child's threats to spit and stab were actually an attempt to regulate their impulses to react physically, rather than considered threats of actual violence. The Children's Commissioner considered that the member may have been better to ignore these statements rather than escalating the situation with their actions and responses, which finally resulted in the child following through with the action of spitting at the member.

120. The Children's Commissioner held the view that the spitting incident could have been completely avoided had the member approached the incident understanding the likelihood that the child had neurological impairments, and adopted a communication style which actively collaborated with the opportunities the child provided.

121. In addition to the comments raised by the Children's Commissioner, it is questionable whether Watch House staff needed to use a spit hood once they assumed custody of the child. It may have been possible to engage with and de-escalate the child upon arrival, in combination with the use of PPE, rather than using a spit hood.

122. This incident is also an example of a missed opportunity to improve performance through sentinel review, which would have included a root cause analysis of contributing factors.

Incident 2: Young child wants to remove clothing himself and spits during search

123. A 13 year old child was arrested on a warrant as well as for fresh offending. He was arrested in scrubland at night. After he was handcuffed and stood up, the child walked compliantly with members towards the police vehicle.

124. The child made some disparaging remarks, to which the members replied, "*Oi chill out bro, don't make this worse than it is, yeah?*" The child made other threatening comments, such as "*I'll kill you m***f***"*. These were not accompanied by any threatening behaviour and the arresting members did not appear bothered by them, simply responding with, "*Alright, no need for that.*"

125. At the vehicle, members conducted a search of the child, but without any explanation or commentary of what they were doing or why. The child said: "*Ay, you don't do that m***f***"*, to which the member replied "*We've got to search you mate, for your safety*" and then "*Just relax, bro, okay?*" The child stood still for the remainder of the search.

126. The child climbed into the vehicle when directed. As the cage was closing, one member said: "*Oh, assault police now, well done bro!*", and then laughed at the child and said "*that was weak as piss mate.*" The arresting members reported that the child had kicked out, connecting with the bicep of one member.

127. The child continued making comments from within the cage, the details of which could not be identified on the footage. The child also kicked the cage door, and a member was heard to respond to some comments with, "*you're the one in the cage, mate*." One of the arresting members then advised the child again of what he had been arrested for, including assault police for kicking the member as he was placed in the cage. The child began kicking the cage door again.

128. Upon arrival to the watch house, one member spoke to the child before opening the cage, saying: "*Alright braz, no need to act up, just come out, settle down, and we'll get you in and processed, alright?*" The child nodded, and got out of the vehicle on his own. An escort hold was adopted and the child was taken to the reception counter where a further pat down search was conducted. The child was compliant and did not object or react during this search.

129. The handcuffs were then removed with the intention of removing some of the child's clothing. Members discussed the logistics of this with each other, but there was no explanation or direction given to the child. The child was physically held in place by his shoulder, wrist, and one side of his head. One member said, "*I've got to take your shirt off*", to which the child responded, "*I'll take it off*". The child said this twice, before tensing up, shaking his head, raising his voice and saying, "*You're making me angry*". The member patted him on the shoulder and said: "*Are you going to be a good fella for us?*" The searching member started talking to the other members about letting the child take his own shirt off, but after a short sudden movement by the child, this idea was abandoned and the child was stabilised against the counter again.

130. The searching member then tried to calm the child saying: "*Chill out, bro. Hey, [name], settle*" and, "*Settle down, bro. Chill out, alright? Settle. Settle down. Alright? Chill. Chill out. Relax.*" The child was visibly agitated, taking shallow breaths and said to the member, "*you keep making me angry*". When the member again told him to settle down the child repeated: "*Nah, you keep making me angry",* before turning and spitting at the member to his right. At this point, the searching member suggested the use of a spit hood.

131. While the spit hood was being prepared, the child said: "*I gotta take my singlet off but you keep f***ing holding me.*" The spit hood was applied without incident or resistance. The searching members then stated to the child that he could remove his own shirt if he "*stops being silly*" and they released their hold on him. The child started to take off his singlet, and removed the spit hood himself. The searching member said to him: "*No more spitting, hey?*" The child looked at the member and said "*you want me to do it again?*" and his mouth moved in a manner that suggested he was about to spit again. The member said "*No, you're right*" and put up his hand towards the child's mouth to block any projectile, at which point the child looked back to the front and continued removing his singlet.

132. After his singlet was removed, the child was again grabbed by the wrist and neck and held against the counter. He was directed to kick his socks off to which the child replied: "*I can't if you're f***ing holding me*." The search was completed and the child was secured in a cell.

133. A Use of Force report and CIIR were completed. The CIIR reported that the child began spitting in the rear of the police vehicle at the Watch House. It also stated that the child became aggressive when members attempted to remove his singlet, and he was restrained against the reception desk. It also noted that a spit hood was applied after the child spat in the face of a member.

134. The senior member reviews were conducted and no issues were identified, noting that the child spat without warning. A sentinel review was also conducted. It was determined that all actions were in accordance with the Custody and Transport General Order. RMIA found that:

> *Upon arrival at the WH the youth was observed spitting in the rear of the caged vehicle. Once inside the WH the youth actively resisted police throughout the search process and told members they were making him angry before actively spitting at members. Members were observed to be attempting to calm the youth and remained courteous and professional throughout the event and explained why the spit hood was necessary. Youth took spit hood off during the search process while threatening to spit at members again. Members remained calm through the process and explained their concerns regarding spitting. Youth was escorted to* [cell] *whilst abusing members and continuing to spit.*

135. On review in this investigation, it is considered that good tactical communication was initially used to elicit the child's cooperation with climbing out of the police vehicle. It is unfortunate that this communication did not continue – instead members returned to using force to escort and stabilise the child at the reception counter. The child was clearly disturbed by the force used during the search and was volunteering to cooperate. Engaging with the child's offer to cooperate may have de-escalated the situation and avoided the spitting incident entirely.

136. The Office of the Children's Commissioner held a similar view. It noted that during the search the members should have improved their communication by:

- Using the child's name;
- Making instructions clear and simple;
- Narrating their actions in order to support trust and rapport, particularly before engaging in invasive and vulnerable search actions.

137. The Children's Commissioner also noted that the child had requested to see the searching member's face and that this may have been an aspect of the child establishing his safety. It was understandable in the context of a threat of further spitting that the member did not want to permit this, and the Children's Commissioner suggested that a small reflective panel could be set on the Perspex shield instead to enable children or shorter people to be directed in a manner such as "*look here [name], you can see us here, we're holding you like this to keep us all safe*."

138. The Children's Commissioner considered that the members approach to the child was not consistent with the likelihood that he would have had neurological impairments. In particular, the Children's Commissioner highlighted that attempting to calm or soothe children with directions to "*calm down*" or "*settle down*" is not an effective strategy to assist children who are trying to find a way to feel safe and in control of their emotions.

139. Internal reviews have an essential role to play in raising alternative courses of action to improve performance. It is unfortunate that none of the internal reviews identified more effective communication as an opportunity to avoid the use of a serious restraint on a child.

140. The investigation also considered that the use of PPE by members would have been an appropriate alternative strategy, particularly where members were aware that the child had been spitting. NTPF advised that only safety glasses and biohazard suits were available in the particular Watch House at the time, however full face shields are now also available.

Incident 3: Child with FASD claims difficulty breathing in spit hood

141. A child known to have Fetal Alcohol Spectrum Disorder (**FASD**) was arrested for damaging a police vehicle. The child had a Custody Management Plan (**CMP**) which required him to be held "at-risk", and encouraged consideration of PPE and a spit hood (if required) if the child engaged in violent behaviour.

142. At the time of arrest, members expressed the view that the child was likely intoxicated with drugs, alcohol, or both.

143. The child began spitting while restrained on the ground at the time of arrest, and continued to do so once placed in the police vehicle. He was threatening to spit in the face of members. Upon arrival at the watch house, one member advised watch house staff that the child had been spitting but "*probably doesn't have much left*".

144. Members reported that efforts were made to obtain compliance by the use of verbal requests and comments. These were observed to be stating the child's name a number of times, asking the child to "*settle down for us mate*" and "*stop spitting, please*" as well as saying "*you don't need to spit*". The child was heard to be yelling at members to "*hurry up*".

145. A member obtained a spit hood. When the child saw the spit hood, he immediately said he did not want the spit hood on and that he would not spit. The member climbed into the vehicle and applied the spit hood to the child while he was lying face down.

146. The spit hood was not applied correctly (the elastic was under the child's chin instead of sitting across the bridge of his nose). The child complained of difficulty breathing a number of times, escalating in volume and intensity. The member who filed the incident report stated that an assessment was made of his airway, noting that "*he continued to scream, confirming he had a clear airway*".

147. The child continued to complain of difficulty breathing and of pain in one of his knees. He was groaning and saying "*please, please*". Members moved him to the reception counter for searching, during which the child had difficulty standing. After the search, members dragged the child back to the bench seat where he slumped over. The child's speech sounded slurred and he said "*I can't* [see or speak] *straight*", he also sounded as though he may have been beginning to cry.

148. Members began asking the child health questions. The child continued to groan and say "*please, please*". Members stated that they were stopping his legs from moving because he was kicking out. One member said to the child: "*there's nothing wrong with you … it's all in your head.*" The child did not respond to the health questions, except for agreeing that he had been drinking and had smoked cannabis.

149. After processing, the child was taken to his cell and ground stabilised for the removal of handcuffs and the spit hood. The child continued to yell out and groan as this occurred, but there was no clear footage of what happened. The spit hood was in place for a total of 6 minutes and 25 seconds.

150. The child was released from custody as quickly as possible and taken home after about 90 minutes. Despite being identified as "at risk", the child's custody journal did not identify that appropriate checks or engagements were made with the child during the period of his custody.

151. There were no issues identified with respect to use of force or the use of the spit hood in the senior member review. The Watch Commander and Territory Duty Superintendent both concluded that the action taken was consistent with the requirements of the general order and the child's CMP.

152. There was no sentinel review conducted. The incident summary in the monthly Report relevantly stated:

> *The offender was agitated in the caged vehicle and was spitting out of the back of the cage. Upon arrival at the watch house a spit hood was applied in the back of the caged vehicle and was removed once reception was completed and the offender was placed into a cell. Of note, the offender is subject to a Custody Management Plan which includes the use of the spit hood if exhibiting violent or aggressive behaviour, which he was in this instance.*

153. The investigation considered that this was an incident that did involve a real risk of members being subjected to a biological assault. That said, there were still some aspects identified which may have assisted to achieve a better outcome for both the child and members involved:

- **Use of PPE:** The Bio-Hazard Procedures in the Instruction required members to utilise appropriate PPE when confronted with a person who spits. The CMP also identified the use of PPE as a strategy, stating a spit hood should be used "if required". None of the members involved considered or donned PPE before deciding to use a spit hood.

- **Intoxication:** As the child was intoxicated, there may have been a risk of vomiting. This was not considered by members in their decision to use a spit hood.

- **Avoiding the use of force:** It is questionable whether ground stabilisation was strictly necessary for removal of the handcuffs and spit hood. No instructions or explanation were given, nor any opportunity for compliance provided, before adopting this technique.

154. None of these issues were considered in the senior members' review, with the action taken being justified by reference to the child's CMP.

155. The development of a CMP is an ideal opportunity to consider therapeutic strategies for dealing with people in custody who may have complex medical conditions or who routinely display behaviours of concern. These plans provide an opportunity to research and develop strategies for eliciting cooperation or for de-escalation, such as contacting particular support people or services, or particular methods of communicating which may be more effective than standard strategies. It was disappointing that the details in the child's CMP relevantly went no further than:

- Identifying his medical condition;

- Noting that he may be violent or display self-harm behaviours;

- Identifying that he should be considered "at risk" for the duration of his custody episode; and

- Stating that the usual strategies for managing self-harm, violence and spitting (PPE, ERCs and spit hoods) should be considered if required.

156. It would be beneficial for NTPF to conduct a further review of its CMP process, in particular, with a view to considering how it could implement a more consultative process involving the particular person, known care providers and medical practitioners, in order to develop more targeted and effective practical strategies for managing a person in custody who requires a CMP.

157. On its review, the Office of the Children's Commissioner identified that the members involved were under a dangerous misunderstanding of the presentation and impacts of asphyxiation. In making their assessment that the child was able to breathe ("*he continued to scream, confirming he had a clear airway*"), it was apparent that members did not understand the physiological differences between the processes of breathing and talking.

158. The OCC referred to a medical article which explained that "air hunger" occurs when a person cannot get sufficient air into their lungs to enable oxygen exchange into their body, and can lead to fatal consequences. In the first part of a breath, air enters the upper airway, trachea and bronchi. These parts of the body enable speech to occur, but do not facilitate necessary gas exchange for ongoing bodily functioning. For effective respiration, sufficient air must enter the body to enable the alveoli (deeper into the lungs) to fill and conduct the gas exchange, thus feeding essential internal organs. The article explained that:

> *Waiting until a person loses the ability to speak may be too late to prevent catastrophic cardiopulmonary collapse.*
>
> *Air hunger is the most uncomfortable and emotionally distressing quality of dyspnea. It directly activates the insular cortex, a primal sensory area of the brain that responds to such basic survival threats as pain, hunger, and thirst. Data from studies of war and torture victims show that the sensation of suffocation is the single strongest predictor of posttraumatic stress disorder and can cause more persistent psychological damage than mock execution with a pistol …*[35]

159. The above extract also helps to highlight the traumatic impact of spit hood use on a person who subjectively believes they are unable to breathe, whether or not that is the case.

160. This incident involved a number of potential warning signs that the child may have been experiencing "air hunger": his repeated complaints about being unable to breathe, his difficulties with walking and standing up, his slumped posture, the development of slurred speech, and his complaint that he could not see or speak straight. While these may also be signs of intoxication, great caution must be exercised to ensure this assessment is correct and not based on incorrect assumptions.

161. It is imperative that, whether or not spit hood use continues, police training must include information with respect to the correct assessment of a person's ability to breathe, and a clear warning not to make such an assessment on the basis that a person is capable of speaking.

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[35] A Law, et al, *A Dangerous Myth: Does Speaking Imply Breathing?* (2020) 173(9) Annals of Internal Medicine 754.

Incident 4: The crying child who claimed "but anybody spits"

162. A young child was arrested for breach of bail at a skate park. No attempt was made to engage, discuss or explain the situation to him before arrest. Members took hold of the child and attempted to adopt an escort hold. The members almost immediately started saying "*don't, don't, don't*", "*stop, stop, stop*" and then "*stop resisting*", however little active resistance was observable on body worn video footage. One member present said "*Do you want me to put you in handcuffs or not? Do it good way.*" The child appeared to be quiet and compliant during the arrest and brief search, and hopped into the cage when directed by members.

163. The child sat quietly in the vehicle for a few minutes while members made notes in their notebook. One member then explained to the child why he had been arrested and what was going to happen next, however, some of the language used was complex (for instance, the word "*run away*" could have been used instead of "*abscond*").

164. At the watch house, the child was still sitting quietly in the vehicle. A member stood at the back of the cage and said to the child "*[Name], we're going to take you out, okay? Now, if you try to spit on me, you know what's going to happen? You see this spit hood? I'm gunna put it on your head. You understand where I'm coming from? And if you do spit on me, you'll be face down on the concrete so I don't get spat on again. You understand what I'm saying?*" The member then passed the spit hood to an officer, saying: "*Can you jam this on his head if he spits on me.*"

165. Neither of the members donned PPE before removing the child from the vehicle. The member who warned the child about spitting opened the cage door and adopted a position just behind the door (protective positioning) while the child stepped out. The member then took hold of the child and escorted him inside where he sat on the bench in the reception area.

166. The member told the child that they would need to start with his property, saying "*you know the drill*". The child stood up, without aggression, and was directed to sit back down, which he did. He was instructed to remove his shoes. The child put his head in his hands and began to cry. After a few seconds, the member said to the child "*what's the matter? You okay? Do you want us to talk to someone? Do you want to talk to someone?*" and after waiting a few seconds more, the member said "*I'll just give you a few minutes if you want, hey?*"

167. The child still had his face in his hands, then spat onto the floor. The member sternly directed the child to stop spitting: "*Oi, can you stop spitting? Stop spitting please.*" The child responded with a threat to kill the member, delivered somewhat unconvincingly. The member stated to the child: "*Stop. I'll put you in handcuffs if you keep threatening me.*" The child continued to make verbal threats, so two members took hold of his arms and moved him to the reception counter, where he was handcuffed and a spit hood was applied. The spit hood was not placed correctly, with the elastic sitting under the child's chin. A member then recapped with the child why these restraints had been used, to which the child responded "*but anybody spits*".

168. A Custody Health Assessment (**CHA**) was conducted by police, which noted the child had sniffed deodorant the night before or morning of his arrest. The child was marked as being "at risk".

169. Members completed the reception process with the spit hood on and took the child to a cell. Members decided to allow the child to remove his own spit hood once secured in the cell due to his clear and ongoing threats to spit on them if they removed it. Members instructed the child to remove the spit hood, however the child refused to do so, saying he wanted to spit on them when they came in to take it off. The child left the spit hood on for around 10 minutes, periodically lifting it up to spit within his cell and on the cell glass.

170. The child's custody journal recorded that after he had been in custody for a while, he asked members if he could clean the spit off his cell. He eventually settled down and laid down on his mattress.

171. A CIIR form was lodged outlining the incident. No reference was made in the report to the emotional state of the child immediately prior to the use of the spit hood. No issues were identified by the senior members on review.

172. A sentinel review was conducted, however body worn video footage was not accessed by the RMIA during the review. The RMIA concluded that members acted in accordance with the General Order. No issues were identified or addressed regarding the failure to utilise PPE, nor were any comments made with respect to the child's emotional state or opportunities for de-escalation. The outcome of the review reported to the Custody and Steering Committee relevantly stated:

> *The youth has several alerts for spitting at police when in custody. Upon arrival at the … Watch House, the youth was observed spitting inside the police vehicle cage. The youth was cautioned by police that if spitting did not cease a spit hood would be applied. The youth … spat on the floor. The youth was again cautioned about spitting and the use of a spit hood. The youth was moved to the processing counter where he spat on the counter and it was decided that a spit hood would be applied during reception. Upon reception being completed he was moved to a cell and was left to remove his own spit hood.*

173. This situation appeared to be one in which the child was reasonably calm and compliant initially, and the interactions with members escalated his behaviour. Considered as a whole, there was significant scope within this interaction for better communication to avoid the escalation points and force used. For instance:

- Providing a brief explanation prior to arrest and issuing appropriate directions to the child rather than defaulting to a use of force (escort hold) which appeared to trigger a physical reaction to being touched.
- Using calm directions at the watch house rather than threats to use force (the harsh caution about potential spit hood use) and actual force (escort hold), particularly given the child's reasonable level of compliance at the time.
- Continuing the simple and empathetic response to the child's emotional state by offering a tissue and gently explaining to the child that spitting in the watch house is not allowed, rather than reverting to harsh directions. The shift in members' approach at this point appeared to de-rail the fragile rapport that had been established and the child immediately escalated to threats of harm, resulting in force being used to control his body and prevent him from spitting.

174. This matter also highlighted two issues of policy observed in multiple incidents considered during the investigation. The first was whether the threshold for use of a spit hood is met by a person spitting on the floor of the watch house or another place, including the rear of a police vehicle. The Instruction states that a spit hood can be used when *"a person in custody has or is threatening to spit <u>at or on members</u> or other person/s in custody"*. There are two elements required to meet this threshold:

- **The occurrence of an incident or threat:** The Instruction is not drafted as a question of **risk**, that is, a spit hood can be used if there is a risk of a person spitting on members. It requires an actual incident or a threat, which is a higher threshold involving unambiguous words or actions by the person in custody.

- **Directed towards members or other persons in custody:** The Instruction requires the incident or threat to have been directed at or on members (or other persons). The general behaviour of spitting on the floor, or in the rear of a police vehicle, without additional surrounding circumstances to suggest the behaviour is targeted towards members or others, fails to meet this threshold.

175. It is, of course, appropriate for members to be mindful of biological hazards within the watch house environment, and to have regard to alerts that a person may be prone to spitting. However, on this particular occasion, the justification cited for applying the spit hood in the CIIR was that the child had spat on the floor, and spat on the reception counter. It was apparent that at least the act of spitting on the floor was not done with any ill-intent towards members, but rather as a way of dealing with the accumulated mucous created by crying.

176. The second issue of policy is the use of spit hoods within a cell. The Instruction is clear at paragraph 371 that a spit hood must be immediately removed upon lodgment of the person into a cell. While the members' rationale for wanting the child to remove his own spit hood was understandable, their approach was not consistent with the expectation of the Instruction.

177. Given no issues were identified during any of the internal reviews, none of the members involved received feedback regarding the failure to utilise available PPE, proper positioning of the spit hood, the failure to remove the spit hood upon lodgment into the cell, or the missed opportunities to de-escalate the child.

178. The final issue of concern noted by the investigation was a failure to conduct or record "at risk" checks for a young person who was distressed at the time of reception and who had recently been affected by a volatile substance. The CHA indicated that the child was to be considered at risk, however when questioned during the investigation about the absence of "at risk" records, NTPF advised that the child was not considered to be "at risk". This is not consistent with what was recorded and observed at the time.

179. On its review, the OCC were also of the view that the member's communication escalated the child, stating an opinion that the interaction created hostility and resistance, rather than building connection, rapport and cooperation. The OCC observed that the member did not approach the interaction in a manner which recognised the likelihood that the child had neurological impairments. The member displayed a preference for gaining compliance by powering over, and as a result, was focused on threat presentation to justify the use of power, without also being mindful of opportunities to build connection as a means of cooperation.

180. The OCC also noted that after the child had returned to a state of calm, he expressed a desire to clean up the mess he had made in his cell. In the OCC's view, this is an indication the child had a modicum of respect for members that could have been built upon during the initial interaction.

Incident 5: "You can vomit through it, that's what its designed for"

181. A cleaner at a child care centre contacted police when a child entered the centre after hours and sat down in the staff kitchen. When police arrived, the child was spitting on the floor of the kitchen. The first statement made to the child by the member upon arrival was: "*Oi, what's going on? Stop spitting on the floor you grub*." The child responded with: "*Well, help me out then you dumb c***, give me the green whistle.*"

182. Further questioning and assessment showed that the child had vomited and was clearly unwell. He was sweating profusely, having difficulty giving a coherent story of what had occurred, and was continually asking members to help him. One member sat down and began trying to talk to the child which appeared to build a degree of rapport. The child continued to vomit profusely on the floor while being questioned.

183. Members assessed that the child was severely intoxicated by an unknown substance. They contacted an ambulance and decided to take the child into protective custody.

184. Members began encouraging the child to come outside, however the conversation became frustrated when the child felt members were rushing him rather than helping him:

Member A: *[Name], come outside and wait for the ambulance mate.*

Child: *How long?*

Member A: *I don't know, to tell you the truth.*

Child: *Well f***en tell the truth.*

Member A: *I beg your pardon?*

Child: *Tell me the truth.*

Member A: *I don't know. Not long. Come outside mate. Quickly. You can't –*

Child: *I f***en can't –*

Member B: *Can you stand up?*

Child: *I feel like fainting.*

Member A: *Alright, well get outside in some fresh air mate. There's no air con on or anything in here.*

Child: *[Groans.] Help me up man.*

Member A: *We're doing that mate. I want you to come outside so we can do it. Get you in some fresh air. Where the ambulance is going to be.*

Child: *Any bucket?*

Member A: *Hey?*

Child: *Any bucket?*

Member A: *Any what, sorry?*

Child: *Bucket!*

Member B: *Nah, that's why come outside –*

Member A: *Bucket? That's why come on outside so you can keep spewing outside. Fresh air.*

Member B: *- get some fresh air. Better than sitting in here. Come on.*

Child: *Wait. F***en wait. [Groans]*

Member B: *Fresh air would be better for you.*

Child: *Any cloth or something, Miss?*

Member A: *Yep, we'll get it. There's a cleaner here. She'll clean up for you.*

Member B: *Yeah, come outside. They'll clean it up.*

Child: *I want a cloth. Help me out.*

Member A: *We're doing that mate.*

Child: *I can't breathe. I can feel snot getting in my f***ing lungs. Breathing.*

Member A: *Alright, well come outside we'll get some fresh air.*

Child: *Yeah, well get me a cloth –*

Member A: *Nah –*

Child: *– and I'll f***en get up.*

Member A: *– there's a cleaner here mate to clean up.*

Child: *Well I'll get up and a cloth.*

Member B: *What do you want a cloth for?*

Child: *To clean my nose!*

Member B: *Ah, for your nose, you want a tissue?*

Child: *Yes! That's what I f***en said!*

Member A: *No you didn't. You didn't say anything like that.*

Child: *Yes I did. You're not listening. You're just [undecipherable] me to get up. That's all you're waiting for.*

...

Member B: *Here, I've got some paper towels.*

Child: *Yeah, thank you.*

Member B: *There you go.*

Member A: *That's all you had to ask for mate.*

Child: *Yes, that's what I was f***en asking for from the start you dumb f***.*

Member B: *Hey, don't talk like that.*

Child: *Yeah, well listen, use your ears.*

Member B: *Now come on, blow your nose and come outside.*

Child: *Tell a f***en teenager to listen … here, look, I don't have any bin.* [Trying to hand rubbish to member.]

Member A: *Do it yourself, mate.*

Child: [Threw paper towel at member]. *Good catch.*

185. The situation then escalated quickly with the member deciding to use force to remove the child from the centre. The force used included a push, a headlock / choke hold, and then two members carrying the child outside. The Use of Force report justified this use of force as:

> *His behaviour became worse - he threw a piece of screwed up paper that he had been vomitting in and threw it at [Member A] - he got up in an aggressive manner and approached [Member A] in an assaultative manner.*
>
> *[Member A] attempted to grab him but the subject was sweaty, with no shirt on and slipped from his grip.*
>
> *He used re-direction and pushed the subject away from him.*
>
> *The room was small and cluttered and there was a significant amount of vomit on the floor - it was not suitable to take him down in the room.*
>
> *The re-direction moved the subject back towards [Member C] – [Member C] placed him into a headlock to extract him safely from the room and manouvered him out of the premises to an area where members could safely ground stabilise him and place him in handcuffs.*

186. During the use of force, the child was heard making noises that sounded as if he was choking or gasping, and it appeared that when he was placed on the ground outside there may have been a short loss of consciousness with the child lying momentarily still. One member controlled the child's head with pressure from his foot while he donned medical gloves. The child was then ground stabilised for an extended period while awaiting the arrival of an ambulance.

187. The child continued spitting while being ground stabilised. At one stage, a member said to the child: "*Stop spitting in my direction mate, it's unacceptable*". The child responded by saying "*Don't f***en stand in my direction you f***ing pig. I'm on the floor, you're not.*"

188. The child was complaining of pain from the handcuffs, and was clearly frustrated by the delay waiting for the ambulance. The interaction with members escalated and de-escalated a number of times during this period. About 13½ minutes after being taken outside and handcuffed, the child spat towards one of the members present. After this occurred, a spit hood was located and applied to the child without warning or explanation. It was not applied correctly, with the elastic sitting under the child's chin. The Watch Commander was notified of the spit hood use very shortly afterwards. While looking for the spit hood, one member was heard to question another member about the current rules around spit hood use, noting that at one stage police had been told not to use them.

189. A short time later, the child asked for the spit hood to be removed for a second as he needed to vomit. A member responded to him, stating: "*You can vomit through it, that's what they're designed for*." The child responded explaining that the spit hood was too tight with the elastic around his throat.

190. The ambulance arrived about 20 minutes after the child had been taken outside. A paramedic came to speak to the child after receiving a briefing from members. The child initially responded with verbal aggression. The child then referred to running to the child care centre for help, and then being put in handcuffs by police.

191. The paramedics and police then took some time to decide on a course of action. Members tried to calm the child by telling him that the paramedics were going to help him out. The child responded with frustration, stating: "*No one is helping me, you been standing around for 45 minutes.*" The child asked again for the spit hood to be removed, explaining that there was spit and snot all through it and he could not breathe. One member tried to adjust the hood, however the child's response suggested this had the unintended effect of rubbing the fluids over the child's face.

192. The child was then sedated for transport to hospital for further assessment. The spit hood was replaced with an oxygen mask, and it was noted that there was blood or bile inside the spit hood.

193. A CIIR was completed and the senior member review noted that the matter would be referred to a divisional officer to consider due to the use of a choke hold and a failure to advise the child of the reason he was taken into custody. When questioned on the outcome of the divisional officer review during this investigation, NTPF advised that the matter was never tasked to the divisional officer.

194. No sentinel review was conducted. The report to the Custody Steering Committee stated:

> *Person apprehended after being intoxicated where he forced his way into* [a] *Childcare Centre which was closed … the person was highly aggressive demanding pain medication. He was also suspected to be affected by unknown substances and he agreed that he had been drinking. Shortly after this he began to vomit over himself, the furniture and floor whilst remaining verbally aggressive to all persons present. The male was highly agitated and continued his verbal demands for pain killers, he began spitting on the floor and furniture. Due to the males increased aggressive manner he was escorted by police outside where he was ground stabilised and placed into handcuffs. The male then began a series of attempts to spit on members while verbally abusing them. A spit hood was located and was placed on the male to prevent the attempts to spit at members. Due to the high level of intoxication SJA were called to attend and upon arrival the male was left in the care of* [hospital] *staff.*

195. Notwithstanding the express reference to the child vomiting, it does not appear that any performance issues were raised or feedback provided to the members involved about the appropriateness of using a spit hood in such circumstances, the overall level of force used in this interaction, or missed opportunities for de-escalation.

196. This case study showed use of a spit hood that was plainly wrong. Having already vomited extensively, and communicated to members that he needed to vomit again, the Instruction is very clear that a spit hood should not have been used:

> *366. A spit hood must not be used on a person who has recently vomited or who is at risk of future vomiting.*

197. Contraindications are written into policies and procedures for good reasons. When devices such as these are used in breach of the contraindications, there can be a significant risk of an adverse event occurring.

198. The risk would have been higher on this occasion given that the spit hood was also applied incorrectly. The spit hoods were designed to have the elastic placed on the bridge of the nose or just over the nose, so that the fabric around the mouth is loose, allowing any fluids to drain away. When the elastic is placed under the chin, this reduces the effectiveness of this design – there is less ability for the solids or fluids to drain, and therefore a higher risk of asphyxiation or respirating bodily fluids. This issue was recognised by the RMIA in its 2016 Risk Assessment, where it was identified that:

> *Training required for all staff in appropriate use of hoods (noted that the current version is not always applied correctly – black material should cover mouth and nose, often pulled down so that white mesh is covering mouth with (sic) reduces the effectiveness of the hood.*

199. It is very fortunate that no immediate serious adverse outcome eventuated in this case.

200. This case also represents a serious failure of internal review processes at both the senior member, sentinel and executive review levels, such that the members involved have never had the benefit of corrective action to ensure such a situation would not occur again. In addition to improper use of the spit hood, the members involved ought to have received feedback with respect to their missed opportunities to de-escalate the situation and communicate more effectively for a positive resolution, the use of force to the point where the child may have briefly lost consciousness, and their failure to explain to the child why he was taken into custody.

201. That a member walked away from this incident holding a belief that spit hoods are designed to be vomited through is extremely concerning, and unacceptable. If this member is still a serving member, NTPF should take immediate steps to provide corrective advice. Despite the effluxion of time, NTPF should also seriously consider reviewing the failures in this incident with all of the members involved as a way of highlighting opportunities for better performance.

202. On its review of this incident, the Office of the Children's Commissioner also pointed out the incorrect decision to use a spit hood shortly after the child had vomited. The Children's Commissioner also considered that the members involved at the initial stage unnecessarily escalated the situation through their use of force. It was noted that this use of force could have been avoided by police problem solving, such as by finding a rubbish bin or other manner of disposing of the rubbish. Unfortunately, the significant force used at that stage fractured the beginnings of rapport that had been established with the child.

203. The Children's Commissioner also commented that while the child was restrained, he was experiencing members not listening or responding to his requests. It was considered that the verbal insults and spitting by the child were an attempt to regain some control or power over the situation while being restrained. It was noted that the members could have avoided engagement altogether, by remaining at a distance until the paramedics arrived.

Incident 6: Spit hood used in cell, limited real threat to members

204. Members responded to an incident involving a large group of children. One child identified by members as being involved was arrested, handcuffed, and placed in a police vehicle. The child was compliant and did not resist arrest, though he was heard to politely question the basis of his arrest a number of times, as well as to complain about pain from the handcuffs, requesting that they be loosened or removed.

205. Due to the complexity of the situation and the number of children involved, it took some time until police were able to return to the watch house for processing the children. During this time, the child continued his questions and complaints with respect to the handcuffs, becoming more agitated and less polite as time passed. The child was handcuffed in the vehicle for at least 18 minutes before it departed.

206. Upon arrival at the watch house, priority was given to processing the youngest and female children first. By the time the child was removed from the police vehicle and lodged in a holding cell, he appeared to be visibly in pain from the handcuffs and frustrated with his repeated, ineffective attempts to address his situation. The child spat at one of the members, striking him on the trouser leg. The Custody Sergeant made a phone call to the Watch Commander who approved the use of a spit hood. The spit hood was applied to the child in the holding cell while members continued processing the other children. It did not appear to have been applied correctly, with the CCTV footage showing the black fabric very close to the child's neck/chest area.

207. The child remained in the holding cell, handcuffed and with the spit hood on for over 23 minutes before he was removed for processing. During this period, the child was sitting and lying down in the cell. Physical checks were not made every 10 minutes as required by the Custody Instruction - it was almost 19 minutes before the first check was conducted.

208. The child was taken for processing and had the handcuffs removed about 90 minutes after they were first applied in the field. The child complained of pain in his arms and wrists from the extended handcuffing. He requested that photographs be taken of his wrists and that members provide him with the name of the arresting officer. The child's demeanour during processing was still heightened but generally compliant. He removed the spit hood and passed it to the members immediately upon being lodged in the male cell. The spit hood was in place for a total period of 29 minutes.

209. The senior member review did not identify any issues with respect to the spit hood use. A Use of Force report was also created for the use of the handcuffs, noting that the child had complained of pain. This was closed by the supervising member, who concluded that the force used was "*minimal and justified in the circumstances*." No comment was made on the extended duration of handcuff use, or the potential impact of this on the child's behaviour.

210. The sentinel review conducted by the RMIA identified that there had been a lack of physical check and engagement for 19 minutes after the spit hood was applied, that the child had asthma, and that the spit hood had been left in place in the cell, contrary to the requirements of the Custody Instruction. Combined with the likely incorrect placement of the spit hood, the failure to conduct wellbeing checks involved a significant degree of risk to the child's health. The sentinel review failed to consider this, simply concluding: "*CCTV review demonstrated there was Nil punitive decision to purposefully leave the youth in the spit hood in the cell. Was an inadvertent issue.*" (Emphasis as in original). There was no indication that the issues identified were raised with the members involved.

211. In August 2022, a post-script was added to the sentinel review report noting that a complaint against police had been made to the NT Ombudsman and the NTPF Professional Standards Command (**PSC**) had determined that managerial guidance was required for the members involved. It was also noted that the RMIA had been provided with feedback and would refer any future issues of this kind to PSC for determination.

212. This incident highlighted for the investigation the critical nature of a strong internal review process to ensure best practice at all times. A relatively small number of incidents come to the Ombudsman's Office for consideration as a complaint against police. It is fortunate a complaint was made in this case, otherwise the members involved would not have received the feedback they required. While there can be benefits to the sentinel review process operating with a systemic focus, where non-compliance is identified but not communicated to members, there is a lost opportunity to improve performance, and consequently, a high degree of risk that the non-compliance will be repeated. A recommendation is made in Chapter 8 as to how this might be improved.

213. It was also considered surprising that the root cause analysis conducted by the RMIA in the sentinel review failed to identify the child's pain and frustration from being in handcuffs for such an extended period as a causal factor to the incident. It was clear that the ongoing failure to address this continued to escalate the child's behaviour, and that responding to the child's complaints may have been a simple de-escalation opportunity.

214. Lastly, it is important to emphasise the purpose of spit hood use – to protect members from the risk of biological assault. When a person is held inside a cell, no such risk remains. This is one of the key rationales for the inclusion of paragraph 371 in the Instruction (the requirement to remove the spit hood on lodgment in a cell). Unfortunately, this was one of a number of incidents considered by the investigation that involved non-compliance of this nature.

215. It is acknowledged that the watch house was busy, with a number of children being processed. However, even if the need for a spit hood during processing was accepted, officers could have waited until they were ready to process the child before placing a spit hood and handcuffs on him. In that regard, it is noted that officers entered the cell separately to place the spit hood on him and could have delayed doing so until they were ready to process him.

216. The findings and recommendations in the complaint against police for this incident involved a number of suggested clarifications to the wording of the Instruction. If there is to be any continuation of use of spit hoods on adults, it is imperative that these ambiguities in the Instruction be addressed as soon as possible.

217. In considering this incident, the Office of the Children's Commissioner was of the view that the child presented as reasonably compliant and calm throughout a significantly prolonged arrest. The senior police officer who was involved in the decision to apply the spit hood displayed an authoritarian and dismissive attitude that was not conducive to cooperative communication with the young person. That member's actions and decision appeared to be consistent with seeking an opportunity to apply a punitive measure or retributive response rather than a protective measure, particularly given the environmental safety already in place to protect from ongoing biological hazards.

218. The Children's Commissioner also considered this was another occasion on which the members' manner of response to the child appeared to be inconsistent with the likelihood that they had neurological impairments.

Examples of emergency restraint chair use

Incident 7: "I need to settle down" turns to ERC use

219. Police attended an incident where a child was located intoxicated and swearing in a local park. The child was known to be in the care of Territory Families. Members offered the child a lift home and she declined, saying that she would "*smash the place up*". The child continued yelling loudly, saying things such as "*I'm not in a good mood*" and "*I need to settle down*" and "*stop humbugging me when I'm not in a good mood.*"

220. The members told the child to stop yelling, and she responded by shouting "*I'm not yelling*". One member laughed at this, which seemed to anger the child and she then began to re-direct her anger towards the members. At one stage, the child said: "*I just want to let me stress out. If I be in that house, I won't let my stress out.*"

221. When the child continued to yell at members, one member said quietly "*f*** this, I don't have to put up with this sh***". The members then took the child into custody under s 133AB of the *Police Administration Act 1978* (NT) – custody for an infringement notice offence. No information was provided to the child regarding the reason for her arrest.

222. The members believed the child may have smoked synthetic cannabis and described her as hysterical and emotionally unstable. The child began to threaten self-harm while in the police vehicle. The Custody Nurse assessed the child as fit for custody but requested that the ERC be used.

223. The child's carer attended the Watch House but was unable to calm her and assessed that it was not safe to return the child to the group care home.

224. The CIIR stated that the child calmed while under observation in the ERC. The custody journal for the child did not contain sufficient entries to demonstrate that health checks were conducted as required by the Instruction. In particular, one journal entry was made 40 minutes after the previous check, and this entry noted that the child had gone to sleep. There was no watch house footage available to this investigation to consider whether appropriate checks were conducted.

225. The child escalated again when an attempt was made to release her from the ERC. The Territory Duty Superintendent authorised an additional 1 hour period for use of the ERC. The Custody Nurse sought a medical opinion and a recommendation was made to convey the child to hospital for a mental health assessment. Paramedics attended, the child was sedated and taken to hospital.

226. The senior member review of the Use of Force report identified a failure to advise the child of the basis for her arrest and feedback was provided to the arresting members. No issues were identified regarding the use of the ERC. No sentinel review was conducted, however a detailed summary was provided in the CSC Monthly Report as follows:

> *Youth was located by members for acting disorderly in public. The youth was apprehended as she was extremely intoxicated and was conveyed to the* [Watch House]*… The youth was yelling loudly that she would commit self-harm whilst in the cage of the vehicle in the sally port…..*
>
> *The youths property had been removed from her, amongst which was a smoking cone piece that smelled of a chemical substance, indicating the use of synthetic cannabis …. the youth was uncooperative and struggled against members and threatening to hit her head on the wall*

… the youth began hitting her head against the reception room wall, and had to be physically prevented from injuring herself, by members putting their hands behind her head. The youth continued these behaviours and also advised that Custody Nurse and members that she would kill herself and also that she would [harm her sibling] ….

Approval was granted to the use of the ERC and the youth was placed in the ERC at 2205hrs.
…
The youth continued to hit her head on the back of the ERC once restrained and blankets were used to pad between her head and the ERC to prevent injury. A short time later the youth fell asleep whilst in the ERC where she was medically assessed to see if she was now calm and could be released from the ERC. Once awake the youth began yelling and trying to hit her head on the ERC and threatening self-harm. Approval was sought to continue to hold the youth in the ERC for an additional hour past the initial 2 hours. At 0022hrs the incoming Custody Nurse determined that the youth be conveyed to hospital by SJA for the purpose of a mental health assessment. Due to the youth being aggressive upon SJA arrival, SJA were required to sedate the youth while in the ERC prior to transport…

227. This incident was one where members could have slowed down and made a more significant effort to connect with the child before arrest. It was clear that the child was in a heightened state – this may have been from something occurring in the care home, or the child's previous trauma being triggered. Members knew that the child was in care, and as such, could have been expected to assume that there may have been trauma-based behaviours occurring, including challenges with emotional regulation. The child seemed to know that she needed to calm down, but was struggling to do this on her own.

228. In the middle of this, police officers attended, started asking her questions and telling her to calm down. As noted by the Children's Commissioner in Incident 2 above, this is not an effective instruction for a heightened child. The members did not take a moment to even ask the child what had happened, why she was not in a good mood, or if there was some way they could help her settle down. Unsurprisingly, the police response appeared to escalate the child's behaviour.

229. It is disappointing that a sentinel review was not conducted on this matter, and that the senior members on review did not identify the aspects of the interaction that escalated the situation. In addition, it appears that there was a failure to identify the non-compliance with the regime of health checks required under the Instruction, and consequently, this was not addressed with the members involved.

230. In its review of the matter, the Office of the Children's Commissioner also considered that the members' communications and attitudes escalated the situation. It was noted that the child was experiencing distress and seemed to be hearing voices. The first member on the scene managed to establish a fragile but workable rapport with the young person. However, a second member approached the child from behind which startled her and escalated her behaviour. In addition, the member's dismissive communication with the child broke the fragile rapport which had been built, and continued to escalate the situation.

231. Specifically with respect to this incident, the Children's Commissioner considered that it would be helpful for members to better understand the impacts of their movement and approach in contributing towards a child's experience of threat and safety. In addition, it may assist if members were trained in a manner that produced a better tolerance of child expressions of distress, and taught how to respond and support children through these situations with empathy and collaboration. Such skills would be likely to produce a safer outcome for all involved.

Incident 8: Medically fit for custody but self-harm continued

232. A child was arrested by police for stealing with violence. The initial interaction with police and movement into the police vehicle appeared to be reasonably calm. Once in the police vehicle, the child began to get upset about losing her phone. She also spoke of having a sore hand and being punched by a man. The child also stated she had been sniffing spray.

233. Members initially tried to engage and build rapport with the child, with one member asking her questions about being punched, and offering to help her find her phone if she told the members where the stolen bag was. Unfortunately, these efforts were hampered by other, unhelpful comments within the discussion, such as one member who had tired of hearing about the lost phone saying, "*we don't have your phone, stop whinging about it*" and telling the child that her carer did not want to look after her when she was drunk.

234. The Custody Nurse at the watch house advised they were not willing to have the child in custody there due to the volatile substance abuse. As a result, members transported the child to the hospital to undergo a fit for custody assessment.

235. Upon arrival at the hospital, the child began to hit her head on the police cage. She intermittently laid down, gasped and failed to respond to verbal prompts, as well as yelling about losing her phone and wanting her boyfriend. The child requested to have her handcuffs removed, but members declined.

236. While in the hospital, the child had to wait for some time to be seen. During this time, she spat on the floor. A member said to the child: "*stop spitting, it's disgusting*" and immediately placed a surgical mask over the child's mouth. This appeared to be effective at preventing any further spitting behaviour.

237. A discussion occurred between a doctor at the hospital and the attending members. The doctor advised that he was intending to give a physical clearance for custody only, rather than a full mental health assessment. The doctor stated that this was due to a history of the child wanting to sleep at the hospital, knowing that she would be released the following morning. The doctor stated a preference to proceed in this manner and see how the child settled in police custody.

238. The child's behaviour appeared to escalate during transport to the watch house and while waiting to be removed from the police vehicle. The Watch Commander was contacted during the transport to advise of the intention to use an ERC. On arrival at the watch house, the child was lying still, face down in the cage, groaning and gasping. The child remained in the cage for 8-9 minutes while members stood out the front of it. Given the sallyport footage provided had no audio, it could not be determined whether the members were speaking amongst themselves, or with the child. Footage provided from within the watch house intermittently included audio of the child screaming and banging in the cage.

239. An ERC was wheeled out to the police vehicle, the members present donned PPE (face shields) and removed the child from the vehicle, placing her straight into the ERC. The footage showed that a spit hood was also prepared for use, but was not ultimately used. The watch house keeper was heard explaining to the other members present that he had gone straight for the ERC, because the manner in which the child was banging her head, she would likely have ended up in there anyway if they had tried a padded cell first.

240. The Custody Nurse was on duty and was involved in processing the child into custody. The child's head had to be stabilised during the reception process to manage spitting behaviour. The watch house keeper stayed in the cell with the child for almost 6 minutes, and immediately upon leaving the cell instructed watch house staff to set a 5 minute timer to check on the child. During this initial period in the cell, the watch house keeper was standing behind the child. It is unlikely that she would have been able to see him. A body search was conducted by a female member and health checks were conducted by the Custody Nurse during this time. Head control was used intermittently by the watch house keeper during these checks.

241. Although it was not accurately captured in the offender journal, footage reviewed during the investigation showed that welfare checks of the child were conducted as required by the policy. During the fourth welfare check, the decision was made to remove the child from the ERC. She was removed shortly afterwards, provided with a mattress and went to sleep.

242. A CIIR form was completed, and no issues were raised by the senior members on review. A sentinel review was also conducted, concluding that:

> *Nil issues with use identified – all checks completed, noting youth refused to answer health questions so pregnancy could not be determined, deemed fit for custody.*
>
> *The length of time spent in the ERC was as short as possible. Custody Nurse was present throughout the ERC use and two female members observed to be actively engaging throughout the process.* [Supt] *briefed during the process.*
>
> *Unable to determine ERC training status of members. ERC training status will be added to monthly WH audit procedure.*

243. This incident was of interest for a number of reasons. The first was the demonstration of utilising alternative strategies to a spit hood in order to prevent harm to members from spitting – a surgical mask, PPE, and head control were observed to be used effectively.

244. Secondly, the case illustrates the difficulties sometimes encountered when health professionals are not prepared to accept care of an intoxicated person who may be demonstrating self-harm behaviours. This issue was observed on multiple occasions during the investigation – with NTPF members sometimes reporting that a child would not be accepted for a mental health assessment due to intoxication.

245. This position results in police officers, who are not therapeutically trained, needing to provide crisis support for people in custody who are self-harming. The end result, on occasion, appears to be ineffective de-escalation and resort to the use of padded cells or an ERC. This appears to be a significant gap in the provision of mental health crisis support services to people in police custody, and one which potentially results in the use of extreme restraints which can create an additional form of trauma.

246. Self-harming behaviours can often emerge during a state of intoxication due to the altered pain threshold and a lowered state of inhibition. While intoxication may be a barrier to obtaining a proper medical diagnosis of any underlying mental health condition, it should not prevent the provision of therapeutic crisis support. It is understood that services such as Men's Helpline, Lifeline, and Beyond Blue assist people who are intoxicated.

247. Options available to address this gap may include:

- An expansion of the Health/NTPF MOU (for the Custody Nurse service) to also provide a mental health crisis support service;

- Investment in additional training for police officers in mental health crisis support, particularly for members who work within the watch house environment. For instance, the MAPA course (now known as CPI Verbal and Intervention & CPI Safety Intervention)[36] was referred to by one Government body during the investigation.

248. On its review of this incident, the Office of the Children's Commissioner considered that the police officer's communication unnecessarily exacerbated the situation, with one member in particular constantly talking down to the child and asserting a will to control the child's behaviour. The Children's Commissioner explained that an interaction that would have been most helpful would have involved the members helping the child make sense of the distress they were experiencing. The child provided a suggestion as to the basis of her distress (the loss of her phone), and this was an opportunity for the member to express comfort and empathy, rather than cognitive reasoning.

249. It was noted that the child visibly settled when the member asked about her family, and the failure to further pursue this line was a missed opportunity to build connection and rapport, to support the child to de-escalate to a calm state. It was also noted that movement (such as towards the paddy wagon) was calming for the child as it seemed to discharge nervous energy, but that the child appeared to escalate by non-movement and a lack of knowledge of what was going on. The Children's Commissioner suggested that members could have been preemptive and explained what was going on, rather than dismissing her actions as seeking attention.

250. The Children's Commissioner again stressed that repeated requests for a distressed child to "calm down" is often experienced as general noise which can worsen their distress. It was also noted that there were multiple attempts made by the child to be left alone and go quiet, at which point the members and medical staff denied her that by giving her commands to be quiet or sit still despite her already being in that state. The Children's Commissioner stated that such situations can trigger incongruence, distrust and hostility.

Incident 9: Watch House Keeper de-escalates child in ERC quickly

251. A child was arrested for breaching a Domestic Violence Order and aggravated assault. His ankle got stuck in the police vehicle door when it was being closed. The child was not intoxicated, however cannabis was located on him when he was searched.

252. Upon arrival at the watch house, the child was swearing at the watch house keeper and kicking the cage. There were 6-7 members standing outside the cage. The watch house keeper opened the cage and spoke to the child: "*Come on mate. You remember me from talking the other side of the hill that time ... I've always been good way to you. You jump out, come out by yourself, I'm not going to touch you and no one else will touch you. We'll get you inside and take those handcuffs off. Sound good?*"

[36] More information available at: https://www.crisisprevention.com/en-AU/Our-Programs/Verbal-Intervention-1.

253. After waiting about 10 seconds, the child was removed by the watch house keeper and members, and taken into the watch house using an escort hold.

254. The child was searched at the reception desk and was heard objecting to being searched and having his clothes removed. The child said that he was not a child and wanted to remove his clothes himself. He was also complaining about pain from the handcuffs and in his ankle. The handcuffs were removed in the reception area, but the process of doing so appeared to be painful.

255. After the handcuffs were removed, members stood the child back up and with some difficulty moved him back to the reception counter. The child banged his head twice hard on the counter. The watch house keeper immediately called for the ERC (there was no padded cell).

256. The watch house keeper then had the following interaction with the child:

WHK:	*[Name], I'm going to put you in a restraint chair, just to stop you trying to hurt yourself, okay? I don't want you hurting yourself mate.*
Child:	*Yu mob been already hurt me. It's why I want to hurt myself. I want to hurt myself!*
WHK:	*Well you're not going to mate. We're not going to let that happen to you [Name], okay?*

257. The child was then seated into the ERC by members. He said twice "*I don't want to sit here*" and then said "*I want to get up by myself, please*". The watch house keeper repeated: "*I don't want you trying to hurt yourself.*" The child continued to protest that he did not want to sit in the restraint chair. He yelled out that this was making him more angry and he was losing his wind.

258. Once the child was secured, the watch house keeper immediately said to him: "*I'm going to loosen your ankle off just a little bit so it stops hurting okay?*" After loosening the strap, the watch house keeper cleared the area of members, and went to make the appropriate senior member notifications.

259. A Custody Nurse was present and assessed the child. The child was complaining that he couldn't breathe and asked for his shoulders to be loosened so he could breathe. The Custody Nurse assessed the straps and asked for one arm cuff to be loosened.

260. Members then completed the Custody Health Assessment. The child sat quietly throughout, refusing to answer the questions. After this was completed, the child again began screaming out that he wanted to get out of the chair. The custody observer remained present with the child in the reception area during this time, but did not engage with him.

261. One member came and stood in front of the child and said: "*[Name], listen for a minute mate. So, last time you played up too. If you play good, good way with us, you'll get out of there, alright? But because you're trying to bash people and you're trying to hurt yourself, you've been put in here for your own safety, okay? So if you chill… you gotta relax and calm down first.*" The child sat quietly for a short while after this, but then became agitated again, stating he wanted a drink of water.

262. At this point, the watch house keeper returned and immediately took up the request for water, asking another member to get a drink of water. The watch house keeper then sat down on the bench next to the child. He spoke to the child calmly as follows:

WHK: *You're only in this chair mate because you were trying to hurt yourself, okay? And I don't want that.*

Child: *I want you to take it off. Just take this off.*

WHK: *[Indecipherable]*

Child: *Yu mob want to sit here? Yu mob sit here.*

WHK: *Oh mate, I've sat in that chair myself, I know how uncomfortable they are.*

Child: *Argh - I don't want to f***en sit here.*

WHK: *Now, your ankle is sore. Are you sore anywhere else?*

Child: *Yes, in my two arms. Argh – I want to f***en get out!*

WHK: *I know you want to get out mate, and soon as you calm down, we'll get you out, okay? Here's the drink of water for you [indecipherable]. Look, open your eyes.*

Child: *Argh… I want you to take my hand off so I can drink it myself.*

WHK: *Nah, just calm down for a second. I'll do that, just calm down.*

…

Child: *Take this off, I want to drink the water.*

WHK: *Okay, we can do that mate.*

Child: *I don't want to stay here. This thing making me no wind. I don't want to stay here. I don't want to sit in this chair. This chair making me no wind.*

WHK: *[Name], listen to me.*

Child: *This chair.*

WHK: *Sssh, sssh, sssh. You need to listen to me mate. Okay?*

Child: *Please.*

WHK: *[Indecipherable]. I'm here to look after you.*

Child: *[Indecipherable]. You don't care. No one don't care. They're just good at hurting people.*

WHK: *Well, I'm just looking after you mate, okay?*

Child: *Nah you're just good at hurting people. F***ed up cops honest. Argh! M*** f***ers all of you.*

WHK: [Asks an arresting member in the area to do his paperwork in another room.] *Alright, [Name], if I take this strap off for you, will you calm down and then you can have a drink, yeah? Alright? No being silly or it will have to go straight back on again, you understand?* [Begins removing one wrist strap].

Child: *Nah, I want it all off.*

WHK: *Well, we'll start with one strap. We'll work towards more then after, okay?*

Child: *My ankle is hurting, please, can you help. My ankle! My ankle, honest! Argh! Argh, my ankle, please. Argh!*

WHK: [Wrist strap released]. *Pull your hand out mate. Pull your hand out, okay? Now, I've been good, I told you. But if you try to start hurting yourself again,*

your hand goes straight back in here, okay? We'll give you 5 minutes of calming down like this, and then I'll take you out of the chair completely, [indecipherable]? [Points to water] *Have a drink.*

Child: [Drinks water]. *Oh, my ankle. Take this off, please. Argh. Sh** my ankle. [Indecipherable] Nah, my ankle.*

WHK: *Calm down a minute mate, okay.*

Child: *I can't calm down, it hurts too much. It hurts too bad, I want to f***en thing.*

WHK: *Once you calm down hey we'll get your ankle looked at too, okay? Alright?*

Child: *I'm already calm. Hurry up. Just do it.*

WHK: *Can you get that nurse, you going to let the nurse look at your ankle?*

Child: *Argh, yes.*

WHK: [Asks for nurse to be located.] *We don't want you here any longer than you have to be.*

Child: *I want to just get out. I want to just get out.*

WHK: *I understand you're frustrated, [Name].*

Child: *I want to go back. I want to go.*

WHK: *We want you to be gone as soon as we can as well. We don't want you to have to stay here.*

Child: *Urgh.*

WHK: *But there's little things we have to do, alright? Now, I'm going to undo your ankles, and the nurse is going to have a look at your ankle quick okay?*

Child: *Hurry up, it hurts really bad. Please!*

WHK: [Releases ankle and nurse takes a look.]

Child: [Groaning, swearing]

WHK: *Ssssh, ssssh, ssssh. Calm down.*

…

WHK: *I'm going to stay here with you, okay? I need you to remain calm, okay?*

…

WHK: *We're going to put a band aid on, okay?*

Child: *I don't want to f***en sleep here.*

[Nurse applied bandaid.]

WHK: *Now, if I take you out of this chair, are you going to sit down [indecipherable] and I'll get on the phone to your lawyer [indecipherable]. You want to talk to your lawyer?*

Child: *Yes.*

…

[Discussion about when child last smoked cannabis and if he was currently under the influence of drugs. Child was responsive.]

WHK: *Have you had some guyu, some beef?*

Child: *No feed.*

WHK: *No feed. Do you want a feed? I can get you a sandwich, yeah? Alright. You've calmed down a bit now, so I'm going to take this off for you now, okay?*

263. The child was then released from the chair, and members offered to wheel him to the cell to hop out due to the pain in his ankle. The child had spent a period of about 18 minutes in the ERC.

264. A CIIR form was completed and no issues were identified on the senior member review. A sentinel review was conducted with the following comments from RMIA:

> *Youth was aggressive upon arrival at WH … youth needed to be restrained as he had commenced forcibly head butting the charge counter. ERC was brought out immediately ... Members unsuccessfully attempted to verbally de-escalate self-harming behaviours prior to ERC utilisation. Members observed to be courteous and respectful throughout the process and were continually engaging with youth and advising him of their actions and why.*
>
> *…*
>
> *… use was appropriate as per current procedures. PIC was exhibiting self-harm behaviours. Members with PIC at all times. Custody Nurse present and engaging with PIC throughout incident. Use time approximately 17 minutes. Nil issues identified.*

265. The description of this incident in the sentinel review appeared to focus on the reactive behaviours of the child – describing him as aggressive without also recognising the child's apparent pain and distress. This focus was also observed in the actions of the members themselves. Once the child had been brought into reception, there appeared to be an emphasis on getting the processing done through the use of force rather than further attempts to listen and engage with the child. The child was complaining of pain, and expressing a wish to remove his own clothing. These issues might have been used by members as an opportunity to build trust and de-escalate the behaviour, avoiding the subsequent resort to self-harm.

266. For occasions where a child has been placed into an ERC, the Instruction requires a member to remain with the child for the first 5 minutes. While the purpose of this requirement is not articulated in the Instruction, it is presumed to be to assist with calming and re-assuring the child, and monitoring their physical response to the significant restraint. This is supported with reference to the ERC Training Facilitator's Guide which states:

> *Where a person in custody who is placed in an ERC is not an adult, a member will remain in the cell with the individual for the first five (5) minutes after initially being placed in the ERC,* ***and engage the person in conversation in an attempt to de-escalate their behaviour****.*

267. On this occasion, the child remained in reception and there were various members and a Custody Nurse in the vicinity. Although the child was physically observed, there was little engagement directed towards de-escalation during this initial period. A recommendation addressing this point is included in Chapter 8.

268. It was clear in the footage, with the dialogue extracted above, that when the watch house keeper sat and talked with the child, he de-escalated quickly. The watch house keeper used a quiet, calm and reassuring manner and tone, frequently adopted an at-level and non-confrontational body position, narrated his actions, demonstrated active listening and was responsive to the child's reasonable requests. These appeared to be effective strategies for building trust and confidence with the child.

269. On its review of this incident, the Office of the Children's Commissioner commented that:

- The watch house keeper could have been more patient in waiting for the child to disembark from the paddy wagon, noting that less than 10 seconds were provided for the child to consider the offer made of walking in independently and having the cuffs removed. The Children's Commissioner held the view that additional time waiting, negotiating and building rapport with the child at that stage may have saved time and resistance during what ended up being a rather invasive strip and search process. It was noted that waiting for a young person's physiology to be calm can assist with minimizing escalations; and

- Notwithstanding that, the watch house keeper in this incident demonstrated a good example of developing a connection and building upon an existing relationship with the young person, which helped him to de-escalate and return to a calm state where they could cooperate together.

270. This incident demonstrated that there is a base level of skill among some members in empathy, understanding, and engaging effectively with heightened children that can be further developed and expanded to the broader police force in order to achieve better outcomes for all involved.

Children's Commissioner's general comments and observations

271. The Office of the Children's Commissioner contributed a number of additional general comments, observations and recommendations with respect to its broader review of the available material in this investigation, as follows:

> *The OCC reviewed the video footage evidence for 20 events, which was either body worn camera or watch house camera videos.*
>
> *Following the review of the evidence, it is the view of the OCC that many of the incidents observed could have likely been avoided. Broadly, the OCC observed incidents in which highly vulnerable, distraught, confused and distressed children were handled by NT Police Officers in a manner that exacerbated the children's behaviours of concern, which then lead to the implementation of a spit hood or restraint chair in order to further restrain and control the child.*
>
> *It is noted that the OCC did not observe videos of NT Police Officers engaging with children in which the use of spit hoods or restraint chairs were not used. For this reason the OCC surmises that the manner in which NT Police Officers engaged with children in these videos may not be common practice in all incidents between children and NT Police.*
>
> *The OCC hypothesises that there are three contributing factors that influenced situations in which spit hoods and restraint chairs were used on children. One factor is related to the complex behavioural needs of the child, the second is the overwhelmingly significant representation of children being Aboriginal, and lastly the failure of the NT Police Officer to appropriately respond to the vulnerable child in that challenging situation.*
>
> *<u>Factor One:</u> The evidence explored revealed that these are complex vulnerable children, with difficulty in auto-regulating their stress responses in the presence of NT Police Officers or situations of distress. The behaviour of the children was potentially further complicated by an increased likelihood of intoxication (drugs, alcohol, volatile substances), a history of adverse childhood experiences, neuro-cognitive disabilities (FASD, ADHD, Autism), sensory overload and complex intergenerational trauma possibly further triggered by the presence of NT Police Officers.*

<u>Factor Two:</u> With the predominant proportion of children represented being Aboriginal, the OCC cannot ignore the potentially underlying influences of unintentional bias or systemic racism that may be impacting on these interactions.

<u>Factor Three:</u> The failure of NT Police Office to appropriately engage with vulnerable, highly distraught, confused and distressed children in a manner that created safety, but instead exacerbated the children's behaviours of concern leading to the use of a spit hood or restraint chair to further restrain and control the child.

Albeit two contributing factors that the OCC has posed that led to the use of spit hoods and restraint chairs on children in the observed incidents, the OCC highlights the significant hegemony and power dynamics in the interaction between an NT Police Officer and a vulnerable traumatised child. The power dynamic accentuates the importance of appropriate and intelligent conduct when engaging with vulnerable children in a manner that supports safety for all parties involved.

It would be remiss of the OCC not to mention the extreme over-representation of Aboriginal children in the evidence collected and the additional level of power dynamic, control and hegemony of the interaction between NT Police and Aboriginal children that was experienced in these traumatic events.

Observations

The OCC made the following general observations in its review of the evidence:

- *The failure of NT Police Officers to listen and engage with children resulted in escalated behaviours of concern for children and increased risk for the NT Police Officer, their partner and the child. The OCC observed that the increased risk was addressed with the use of force, mechanical restraints and spit hoods.*
- *NT Police Officers behaved in a manner in which multiple competing operational demands created a sense of urgency for the officers. This resulted in NT Police Officers appearing to 'rush through' work processes, which resulted in minimal regard exhibited for the child's physiological response to the acute stressor of arrest and detaining.*
- *Children displayed behaviours related to a difficulty in auto-regulating their stress responses in the presence of NT Police Officers. This was potentially further complicated by an increased likelihood of intoxication (drugs, alcohol, volatile substances), a history of adverse childhood experiences, neuro-cognitive disabilities (FASD, ADHD, Autism), and sensory overload which appeared to have no bearing upon influencing the NT Police Officer's practice and interaction with the vulnerable child.*
- *When there is a "spitter" alert, NT Police Officers appeared to be primed to escalate the behaviours of children through interactions that necessitated and justified the application of a spit hood.*
- *There were multiple opportunities observed in the videos when the children invited connection with the NT Police Officer, these opportunities were missed with NT Police Officers who were more focused on operational matters, instead of listening to the concerns of a vulnerable child.*
- *NT Police Officers failed to create safety for children by securing an empathic connection and seeking to understand the concern of the child.*

- *NT Police Officers used ineffective commands when addressing distressed children telling the child to "settle down", "just relax" which did not support a highly distressed child to feel safe.*
- *NT Police Officers failed to introduce themselves to children that could assist with rapport building from the onset.*
- *NT Police Officers did not show children their attention. Situations were observed by the OCC in which NT Police Officers were requesting particulars and information from children whilst interacting with tablets/phones for information and not making eye contact, listening, or responding to the child.*
- *In the Watch House, NT Police Officers were seen rushing through COVID and Health Screening checks before supporting the child to regain calm/regulation in a stressful situation (resulting in the screening questionnaire being useless and more of a box ticking exercise, rather than gathering information).*
- *NT Police Officers were observed holding, restraining, body searching and stripping children to minimum clothing (shorts, t-shirt, barefoot) without explaining their actions, which can further trigger fear and trauma responses in children.*
- *Building initial rapport with the child can be challenged by the presence of multiple Police Officers. On some occasions the OCC observed rapport built between one NT Police Officer and the child. Unfortunately, the child was often fragile, and could be easily violated by other members present who have failed or ignored the emerging indicators and complex needs of the child. Many of the NT Police Officer commands were accompanied by interactions that broke the very fragile rapport that may exist between police and child, for example comments such as "don't be silly" or "that's disgusting".*
- *There were some instances of police making remarks that were explicitly inflammatory, such as telling a child "that's piss weak" or "you're a nobody"*.

Recommendations[37]

The OCC recommends that the use of spit hoods and restraint chairs on children be ceased, and NT Police Officers undergo training to assist in understanding the complex needs of children. NT Police Officers should be educated in ways to engage with children that is cognisant of the complex vulnerability of the child and the powerful responsibility that NT Police Officers hold in managing the situation, so as not to create greater risk for all parties involved.

The OCC observed that there were many situations where opportunities for NT Police Officers to engage with children in a manner that would reduce the risk for all parties should they be trained, but they failed to do so. Specifically, the OCC recommends training that facilitates:

- *Understanding complex behaviours in children with diagnosis;*
- *Acknowledging the distress and the emotion;*
- *Rapport building;*

[37] These recommendations were made in a response to the NT Ombudsman specifically with respect to review of the case studies involved in this investigation. For the broader OCC position and recommendations, refer to the OCC Position Paper.

- *Strategies and opportunities for de-escalation;*
- *Developing greater levels of patience and distress tolerance;*
- *Communication with those with limited cognitive processing capacities; and*
- *The impact of unintentional bias on operational practices and decision making.*

By NT Police Officers generating compassion/care and tolerant calm containment around the young person, there will be better opportunities to support state change from escalation to calm, reducing incidents from occurring. This will ensure that there is less risk, distress and trauma to the child, the NT Police Officers involved and the auxiliary service staff involved in supporting the child.

CHAPTER 7: OTHER APPROACHES

Other jurisdictions

272. The investigation requested information from NT Police with respect to the use of spit hoods and ERCs by police in other Australian jurisdictions.

Spit hood use

273. At the outset of the investigation, NT Police advised that spit hoods were used by police in the following jurisdictions:

- Western Australia (in the Perth Watch House only, which does not accommodate children);
- Queensland;
- Australian Federal Police.

274. During the course of the investigation, Queensland Police announced in September 2022 that it would be discontinuing the use of spit hoods in police watch houses.[38]

275. In October 2022, the Australian Federal Police (including ACT Police) commenced an internal review into the use of spit hoods, following reports that they had recently been used on minors in custody.[39] The review concluded that "*the risk of using spithoods outweighed the benefits of their use, given they are ineffective in protecting against transmissible diseases*", and in April 2023 it was announced that spit hoods would no longer be used in those jurisdictions, with police instead being provided with equipment and procedures to better protect members from spitting and biting.[40]

276. It was advised that police services in the remaining jurisdictions do not utilise spit hoods for the management of people in custody engaging in spitting and biting behaviours. The following information was provided with respect to the alternatives adopted in those other jurisdictions:

Jurisdiction	Alternatives used
Tasmania	• Training focused on situational awareness, tactical positioning and body language. • Additional PPE in watch houses including face shields and protective over-garments.

[38] Media Release, Queensland Police Service, 19 September 2022, available online <https://mypolice.qld.gov.au/news/2022/09/19/qps-discontinues-use-of-safety-hoods-in-watchhouses/>.
[39] Jasper Lindell, 'Australian Federal Police reviewing officers' use of spit hoods' *The Canberra Times*, 15 October 2022, available online <https://www.canberratimes.com.au/story/7942732/federal-police-reviewing-officers-use-of-spit-hoods/>.
[40] Australian Federal Police, Media Statement, 14 April 2023 (https://www.afp.gov.au/news-media/media-releases/media-statement-0).

Jurisdiction	Alternatives used
Victoria	• Use of PPE including safety glasses, gloves and a face mask. • Recording instances of spitting as a custody management risk to ensure information visible in future interactions.
South Australia	• Surgical mask on spitting person. • PPE for members including goggles, surgical masks and face shields.
New South Wales	No information available.

277. As at the date of publication, only South Australia has enacted legislation to prevent the use of spit hoods by police.

Restraint chair use

278. A 2017 position paper developed by the RMIA considered the use of ERCs in other jurisdictions within Australia and New Zealand. It was noted that New Zealand did permit the use of a restraint chair in some circumstances, while no other jurisdiction in Australia did. Most jurisdictions instead adopted the use of a padded cell or alternative physical restraint methods, as outlined below.

Jurisdiction	Alternatives used
South Australia	• Padded cells. • Physical restraints: handcuffs and flexicuffs.
Western Australia	• Padded cells. • Physical restraints: handcuffs, flexicuffs, leg restraints, velcro straps.
Queensland	• Padded cells. • Physical restraints: handcuffs, flexicuffs, body belt/leg shackles, GRIP restraint (trial). • Chemical restraint through Queensland Ambulance Service.
Tasmania	• Padded cells. • Physical restraints: handcuffs.
Australian Federal Police	• Padded cells. • Physical restraints: handcuffs.
Victoria	No information available.
New South Wales	No information available.

279. The investigation has not been advised of any changes to the above information for Australian jurisdictions since the date the position paper was prepared.

280. It is noted that the New Zealand Human Rights Commissioner and the New Zealand Children's Commissioner have since criticised the use of restraint chairs and recommended their use be discontinued.[41]

St John Ambulance NT

281. The investigation also sought information from St John Ambulance NT (**SJA**) in relation to how its paramedics deal with patients who may be spitting or engaging in serious self-harm.

282. It was advised that in addition to their medical training, SJA paramedics undertake a 2-day training course on operational and personal safety before commencement of their duties. During this course, paramedics are taught additional de-escalation techniques, how to recognise trigger signs for people who are becoming anxious and aggressive, and self-defence.

283. SJA emphasised at the outset that spitting may not always be a behavioural issue, and paramedics are trained to consider other causes of that behaviour, such as respiratory issues or sepsis. It advised that the primary protection for SJA staff against patients who may be spitting is the use of PPE.

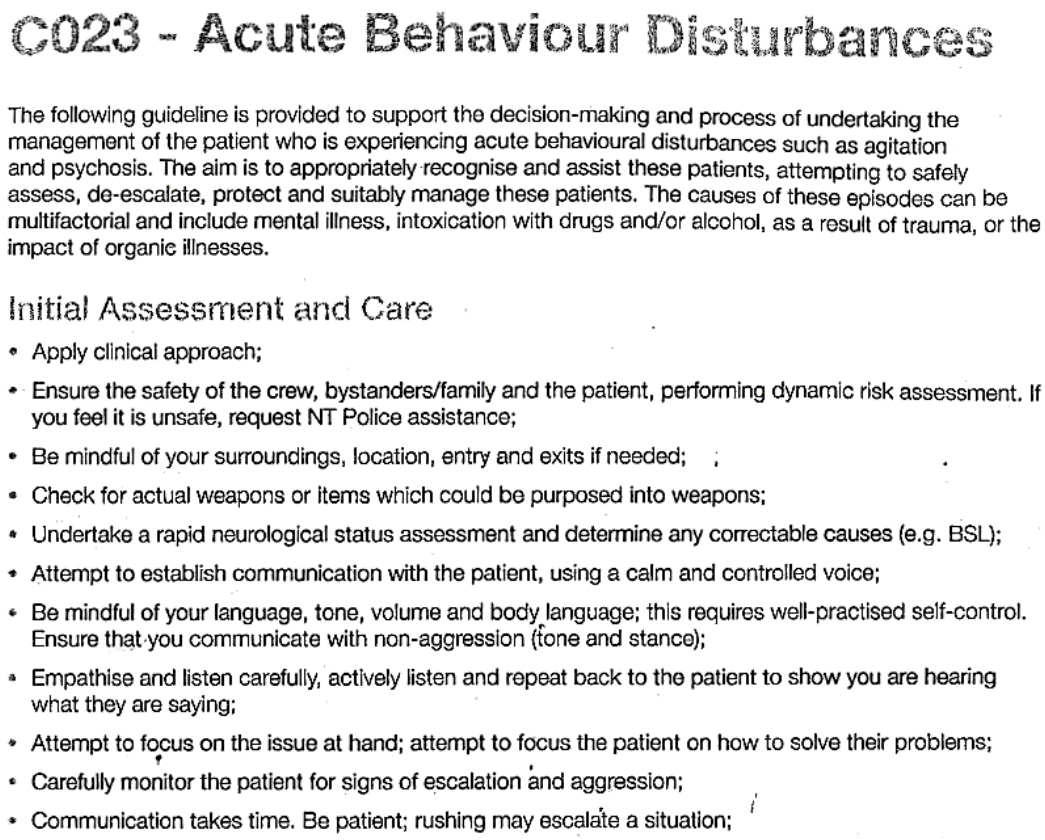
284. To protect themselves, paramedics will wear a mask, and will often ask a patient to put a mask on, or assist them to do so. Paramedics will not force a patient to wear a mask. If a patient refuses, paramedics will increase their own PPE levels to include masks, goggles, gowns and/or face shields. Paramedics also use strategic body positioning (that is, sitting behind the patient) as required to avoid contact with bodily fluids from a patient who may be spitting.

285. SJA advised that its paramedics would not ask police to apply a spit hood to a patient. However, it was noted that paramedics do work collaboratively with police, and this may involve waiting for a patient to comply with police directions or restraint before stepping in to provide medical care, particularly if the patient is violent or aggressive. It was also noted that an oxygen mask can be a useful tool to prevent spitting as well as providing the patient with a means to breathe and calm themselves down. The oxygen mask is especially useful when the patient requires sedation.

286. In relation to patients who are displaying self-harm behaviours, SJA advised that its paramedics are taught de-escalation techniques to help them engage with patients who are distressed, aggressive or self-harming for any reason. These tactics include, for example, talking with the patient, making a connection, and adjusting the communication style to suit the patient (such as more child-friendly language for children).

287. The SJA Clinical Practice Manual includes guidelines on how to approach a patient who is having an acute behavioural disturbance, which includes significant emphasis on appropriate methods of communication and stresses the importance of being patient during the interaction.

[41] See above footnotes [5] and [6].



C023 - Acute Behaviour Disturbances

The following guideline is provided to support the decision-making and process of undertaking the management of the patient who is experiencing acute behavioural disturbances such as agitation and psychosis. The aim is to appropriately recognise and assist these patients, attempting to safely assess, de-escalate, protect and suitably manage these patients. The causes of these episodes can be multifactorial and include mental illness, intoxication with drugs and/or alcohol, as a result of trauma, or the impact of organic illnesses.

Initial Assessment and Care

- Apply clinical approach;
- Ensure the safety of the crew, bystanders/family and the patient, performing dynamic risk assessment. If you feel it is unsafe, request NT Police assistance;
- Be mindful of your surroundings, location, entry and exits if needed;
- Check for actual weapons or items which could be purposed into weapons;
- Undertake a rapid neurological status assessment and determine any correctable causes (e.g. BSL);
- Attempt to establish communication with the patient, using a calm and controlled voice;
- Be mindful of your language, tone, volume and body language; this requires well-practised self-control. Ensure that you communicate with non-aggression (tone and stance);
- Empathise and listen carefully, actively listen and repeat back to the patient to show you are hearing what they are saying;
- Attempt to focus on the issue at hand; attempt to focus the patient on how to solve their problems;
- Carefully monitor the patient for signs of escalation and aggression;
- Communication takes time. Be patient; rushing may escalate a situation;

Figure 4: Extract from SJA Clinical Practice Manual

288. In addition to verbal de-escalation, it was advised that paramedics may use padding (such as a pillow) to soften self-harm blows, or physical restraint, such as holding a person back from a wall where they are hitting their head. It was stressed that paramedics do not restrain patients on the ground, unless they have been requested to render assistance to NT Police members.

289. If paramedics have not been able to verbally de-escalate the patient, they would consider chemical restraint (sedation). According to the SJA objectives of taking the least restrictive intervention, paramedics will try to have the patient voluntarily take an oral sedative before proceeding to involuntary treatments such as administering a sedative by injection.

Spit hood alternatives

290. Many of the alternatives to spit hood use have been touched upon elsewhere in this report. Chiefly, alternative measures used in other jurisdictions appear to include (but may not be limited to):

- Increased use of PPE by members;
- Focus on tactical/protective body positioning;
- Additional training on general de-escalation of aggressive or distressed persons in custody (including training with respect to child development and engagement);
- Use of surgical masks (if required) on person in custody; and
- Use of warnings and alerts of past incidents to enable adequate preparation.

291. It is noted that NT Police have announced that spit hoods will no longer be used on children, however, there has been no change with respect to their use on adults in custody. NT Police have announced that they have adopted the use of a "safer design" of spit hood (now called "spit guards") for adults, pictured below.

Figure 5: New spit guard design adopted for use on adults (Spit Guard Pro).

292. The investigation requested a sample of both the previous design and the proposed new design of spit hood. Both were tried on by members of the investigative team in order to get a sense of the personal feel, design aspects, and degree of sensory deprivation.

293. It was observed that the new design did include a finer, more breathable style of mesh, improved visibility for the wearer, and potentially an increased ability for members to monitor the skin tone and general wellbeing of the wearer (although reservations were noted about the ability to assess skin pallor for darker skin tones). The design was also less likely to be incorrectly placed when compared with the previous design.

294. However, the manner in which the sealed plastic portion of the spit hood tucks in under the chin towards the neck gave cause for concern with respect to the ability for high viscosity fluids and/or solids (such as vomit) to effectively drain away from the mouth and nose. NT Police referred to the manufacturer information in this regard, which states that:

> *Spit Guard Pro eliminates risk of blocked airway, avoiding asphyxiation via fluids or solids. Expelled materials held away from face, ready for hygienic disposal of mask.*
> *…*
> *… No known health or safety risks.*

295. In theory, should vomiting occur, observing members would remove the spit hood to dispose of the expelled materials (as outlined in the manufacturer's information) and allow free movement of further fluids. However, as observed in this investigation, failings in monitoring and care do sometimes occur, and the concern identified in this investigation is that the effects of such oversight could create a serious threat to health or life.

296. It is clear from the emerging trend across Australia and internationally, that there is a general public desire to move away from the use of spit hoods. A number of other jurisdictions already operate without their use on either adults or children.

Restraint chair alternatives

297. The most obvious alternative to the use of an ERC is the use of a padded cell, with at least five Australian jurisdictions in 2017 indicating it was one of the methods used for people in custody displaying serious self-harm behaviours.

298. The use of padded cells by NT Police has waxed and waned over time. This may have been connected to the broader context and pressures at various times, as well as practical challenges experienced with padded cell use. A chief concern appears to be the recommendation made by the *Royal Commission into Aboriginal Deaths in Custody* (**RCIADIC**) in 1991 that padded cells no longer be used due to concerns about sensory deprivation:[42]

> *24.3.102 The use of padded cells as a way of managing persons who pose an immediate threat to their own lives and/or to others is not an issue which has arisen directly from any of the cases investigated. However, it is an issue which, I believe, calls for comment. I have noted the inclusion of such cells in draft plans of new police complexes which I have had the opportunity to peruse during the hearings and have personally viewed such cells in some police lockups that I have visited. They are generally cells which are devoid of all furniture and fixtures and the walls and floor are padded.*
>
> *24.3.103 The use of padded cells in police facilities is an issue raised by Dr Joseph Reser in his paper The Design of Safe and Humane Police Cells, prepared at the request of the Commission. In that paper, Dr Reser commented that such cells 'can act as a sensory deprivation chamber, and can markedly increase distress, reactance and experienced isolation' (p.33). He noted that the use of 'seclusion' rooms in psychiatric facilities are only used on the authorisation of, and with the continued supervision of a mental health professional and under strict written guidelines, but that no formal policy guidelines appear to be in existence in relation to the use of padded cells in police facilities. He concluded that the use of padded cells in the police lockups, without the presence and involvement of an appropriately qualified person, was ill-advised.*
>
> *24.3.104 I am aware that the Northern Territory Police Service has considered the removal of padded cells from its police lockups. Indeed, following the receipt of a report which the Commission obtained from Dr Reser on the Katherine cells, it was decided by the Service to remove the padded cell from the then newly constructed Katherine Police Station. I am not aware of the practices relating to the use of padded cells in other States. It is my view that the installation and use of padded cells in police lockups should be discontinued immediately.*
>
> *24.3.105 I would add, however, that I think that there is a need for police lockups to contain one cell which could be utilised to accommodate those prisoners requiring special monitoring. It has been suggested that such a cell could be situated close to the general administration area to facilitate continual surveillance by those officers stationed in the area and prompt intervention. The design of such a cell would require careful consideration.*
>
> (Footnotes omitted).

[42] *Royal Commission into Aboriginal Deaths in Custody (*Report, 1991) Vol 3.

299. In 2018, NTPF advised in a review of RCIADIC recommendations that it currently operated only one padded cell and would not be constructing any further padded cells. Subsequent to this, the new Palmerston Watch House was built, including a new padded cell.

300. In April 2021, a recommendation was made by the RMIA to the Custody Steering Committee (**CSC**) to decommission padded cells. In addition to visual and aural sensory deprivation, a number of other practical challenges were outlined that had been experienced over many years, including:

- Difficulty maintaining dignity where clothing has to be removed due to self-harm with clothing (modesty smocks offered only when calm enough not to self-harm with it);
- Ineffectiveness of padding to completely prevent injury (person in custody can still suffer injury if hitting head on the door or door window);
- Difficulties with conducting immediate medical assessments;
- Biological contamination from bleeding, spitting and faecal matter;
- Staff injuries during cell insertions and extractions, and when undertaking welfare checks; and
- Damage to cell padding being expensive and technical to repair, resulting in lengthy time out of use.

301. In the paper, the RMIA also discussed the use of ERCs, acknowledging that the totality of physical restraint can worsen mental distress and pose additional medical risks, particularly if not used correctly. However, the RMIA advised that a review of restraint times demonstrated that the ERC was more effective for de-escalation than the padded cell.

302. The CSC requested further risk assessments to be undertaken. The investigation was advised that no determination has been made to date and the two current padded cells (in Darwin and Palmerston) remain operational as a de-escalation tool alongside the use of ERCs as appropriate.

303. A further potential alternative, already touched upon above, involves additional training to improve the holistic treatment and de-escalation of children during the entire police interaction. The aim of this approach would be to help keep children out of police custody in the first place (for protective custody or minor offending), or at least to have them in a calmer state by the time they reach the watch house such that significant restraint is not required.

304. In recent times, NT Police have been piloting an initiative with similar objectives in the mental health area. Termed the "Co-Response Operational Protocol for Collaborative Care", it creates a Co-Response team staffed by an NT Police member, an SJA paramedic and a Mental Health and Alcohol and Other Drugs (MHAOD) worker. Similar models also operate in Tasmania and the Australian Capital Territory.[43] At this stage, there is only one team working an eight hour shift, five days a week in the Darwin region. The intent is to dispatch this team to jobs involving a mental health crisis or emergency with the aim of de-escalating the situation, connecting the person with appropriate services to be managed within the community, or, where required, to safely and humanely have that person brought into a treatment facility for appropriate medical treatment.

[43] See, eg, M Whitfield, 'New Tasmanian PACER program aims to ease ED pressure with mental health aid', ABC News (online), 14 September 2022.

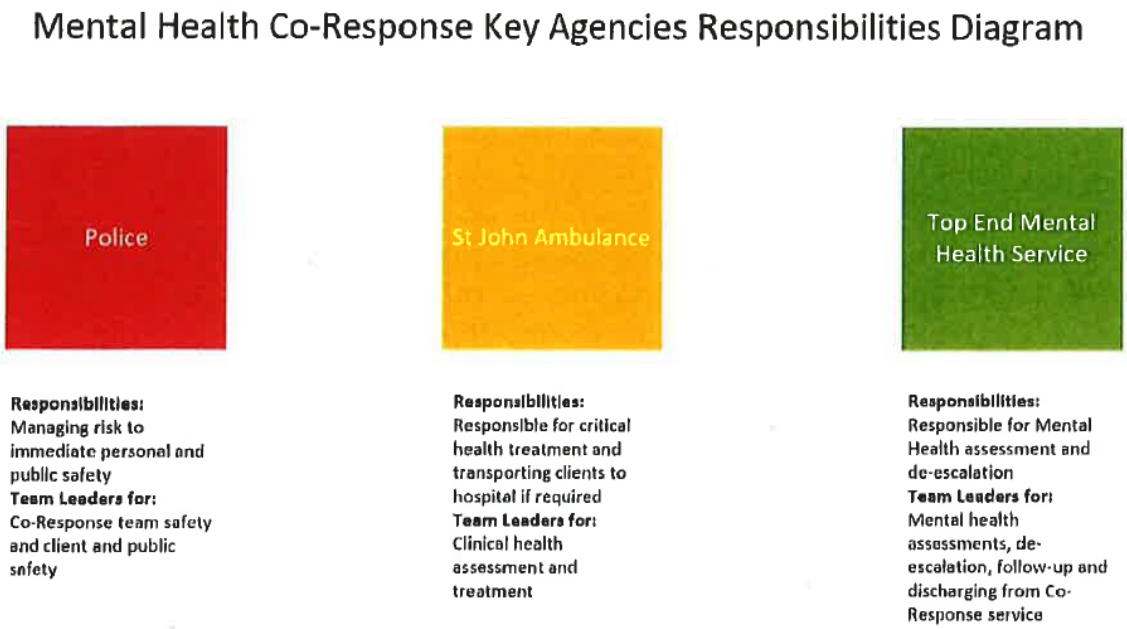


Figure 6: Diagram showing the core responsibilities of each member of the Co-Response team.

305. At its core, this objective of this model is to utilise the specialist skills of a multi-disciplinary team to achieve safer and more therapeutic outcomes. As can be seen from the diagram above, the mental health professional assumes the lead role with respect to de-escalating the person experiencing distress. Such an approach is commendable, and this Office looks forward to being apprised of any evaluations of the program.

306. This Office has, over the years, observed a tendency in police custody (including with the Custody Nurse service) to focus on the presence of a potential mental illness as a basis for transferring a person in custody to a medical facility for assessment and care. It has been observed that this focus can, at times, leave a therapeutic gap for people who may have a mental illness or disability but are intoxicated (and as a result cannot be immediately assessed), or for people experiencing significant distress falling short of mental illness.

307. An impressive feature of the Co-Response model is its broader focus, to bring a therapeutic approach to any person experiencing a "mental health crisis" – defined as:

> *… a situation in which an individual is exhibiting extreme emotional distress or behavioural disturbance, considering harm to self or others, is displaying disturbance of rational thought, or is otherwise distressed or distraught.*

308. Any extension of this kind of highly skilled or multi-disciplinary "crisis support" for people who are in police custody, or who are at risk of being taken into police custody, would represent a significant step towards achieving better outcomes for all parties involved.

CHAPTER 8: OMBUDSMAN CONCLUSIONS AND RECOMMENDATIONS

309. The comments, observations and recommendations in this chapter are drawn from the consideration of all incidents reviewed during the investigation, the input of the Children's Commissioner, research by my Office, and the training, policy and quality assurance information detailed in this report.

310. NTPF has already responded positively to a number of the recommendations. More detail on steps it is taking appear in Chapter 9.

311. I note at the end of this chapter that it is important for recommended changes to be implemented in consultation with officers, with provision of information to establish that alternative approaches which adequately safeguard the interests of officers and the people who they come into contact with, are available and will be implemented.

Communication and patience

312. Perhaps the fundamental point to be drawn from the investigation relates to how police interact with children, and more broadly, with the general population.

313. It has been acknowledged by both the Children's Commissioner and this Office that police often experience enormous pressures to carry out the many functions they are expected to undertake in any given shift. There is also a reality that the situations they face can be incredibly confronting and highly unpleasant. They are often subjected to lack of reasonable co-operation, abuse and threats, and sometimes physical attack. Theirs is a complex and onerous job which many of us would shy away from. It is a job that they do day after day, and often night after night, in the service of the community.

314. In such circumstances, it is not surprising that officers may wish to speed things up or express frustration with non-compliance. A temptation may develop to use force as a timely way to get a situation under control, or as a punitive measure against an uncooperative person. Such behaviours were observed in some cases under review where, for example:

- Force was used from a very early stage in an interaction, such as an escort hold or handcuffs on a generally cooperative child, triggering resistance and aggression;

- Ill-considered or antagonising comments were made to children, invariably escalating their behaviour further.

315. This investigation has highlighted the risks and poor outcomes that can eventuate where police lapse into these ways of thinking or behaving, ranging from generally worsened relationships between children and police, to very significant physical and psychological health risks.

316. The situations that are most likely to give rise to use of these extraordinary restraints are those where children are emotionally charged or experiencing mental health issues, or the nature of their interaction with police has moved them into one of those states. As the comments of the OCC show, in order to achieve positive outcomes for children in such situations, it is essential that those interacting with them take the time to establish rapport and assist the child to work through the situation they are facing.

317. Rapport and compliance will not be achieved instantly. It will not be achieved in the same way for every child. In most cases, this process will involve police starting with consideration of the best form of communication with a child, rather than contemplating the minimum force necessary. It will involve considering alternative communication strategies if initial efforts do not work, and re-considering strategies as the situation evolves. It will involve genuine listening to the child and talking through the issues they raise.

318. Such an approach requires significant patience, an empathetic attitude, and well-rehearsed skills in engagement and de-escalation. To facilitate this approach, there is significant scope for improvement in the general training for members on strategies for effective engagement with children, and by extension, other people impacted by trauma, significant distress, or other challenges with cognition, communication or self-regulation. These skills must be learned, and practiced regularly, in order to become the default approach in high pressure situations.

319. This approach will not only improve outcomes for the children involved, but also limit the potential need for any use of force, including restraints, and consequently offset the psychological impact and time that officers would have to spend recording and explaining use of force.

320. In saying this, I do not wish to paint a rosy picture where every attempt at communication is ultimately met with a successful interaction. It is acknowledged that best efforts at communication may prove fruitless on occasion. Police have a job to do and that may well conflict with the wishes of the child. Even the best communication efforts of an officer may not prove successful. There will also be situations where there is a need for officers to bring a situation quickly under control that do not permit extended attempts at communication.

321. However, our observations and those of the OCC make it clear that greater emphasis should be put on developing a culture and default practice of patience, empathy and connection as a routine first step in all police interactions, particularly those involving children, people with disabilities or people experiencing significant distress due to trauma or other circumstances.

Recommendation 1

NT Police should, in all relevant documentation, guidance and training, place major emphasis on encouraging patience, empathy and connection as a routine first step in interaction with children and other members of the public.

Use of spit hoods

322. With regard to points put forward in favour of spit hood use, it may assist to differentiate the issues of disgust at being spat on, physical harm (actual transmission of a disease), and psychological harm (stress and trauma caused by the incident and the need for extended testing and precautionary treatment).

323. I acknowledge that spitting at an officer who is carrying out their duties is an odious act and officers have every right to protect themselves in order to prevent such action from impacting on them. The NT Police Association (**NTPA**) queried whether 'odious' is a strong enough term. I consider it is on an equal footing with disgust and revulsion. I accept the experience of being spat on is as described by the NTPA:

Frontline police officers will tell you that being spat on is one of the most disgusting and disrespectful acts that can be perpetrated against them. It is often deliberate and designed to humiliate. The feeling of someone's saliva on your skin or worse, in your mouth and eyes, is a violation of your personal space and dignity.

324. Such an experience is not deserved by anyone, least of all frontline workers who are dedicating their lives to the protection of the community, sometimes at great personal cost. The Legislative Assembly has recognised the seriousness of spitting at an officer. If a member is spat on appropriate charges can be laid and consequences imposed through the justice system. As highlighted in the NTPA submission, recent legislative changes to the *Criminal Code Act 1983* (NT) and the *Sentencing Act 1995* (NT) in September 2022 have increased the potential penalty faced by offenders who engage in this kind of action.

325. In terms of protection of members from physical harm, the NTPA also stated:

It is especially heinous when an offender does so knowing that they have a communicable disease. In fact, our members have told us they would rather be punched in the face than spat on.

326. The fear of contracting a communicable disease through being spat on is clearly present in the minds of many officers. However, despite this fear, the investigation was not able to identify any information or evidence to suggest that there is a substantive risk of transmission through spitting. The information available to the investigation variously described the transmission risk as 'negligible' and 'very low to non-existent' (see discussion in Chapter 5). That research did not differentiate between the transmission risk for children and adults.

327. It is acknowledged that the psychological harm arising from prolonged testing, as well as the stress, worry and anxiety around the potential consequences of contracting a serious communicable disease can be significant. However, I agree with the position expressed by the Northern Ireland Policing Board (adopted by the Australian Human Rights Commission), that educating members on the scientific evidence regarding the very low risk of transmission may assist to alleviate these psychological consequences. It is for this reason that Recommendation 6 of this report (additional training for members with respect to spit hoods) includes a component to "*address the real prospects of contracting infectious diseases through spit, mucous or other bodily fluids*."

328. The NTPA made submissions with respect to stress experienced by officers:

In contrast to the general population, who may experience only one or two traumatic events during their lifetime, law enforcement officers encounter traumatic situations on a regular basis throughout their professional careers. It is this repeated exposure to such events that contributes to their cumulative trauma and subsequent mental distress, including but not limited to the development of Post-Traumatic Stress Disorder (PTSD).

Our members face many challenges, which are well documented in the performance of their duties, but as the statistics show, they are not only exposed to danger, traumatic events, prisoner threats, conflicting task demands, short-staffed stations, court appearances, departmental enquiries and work in very isolated and remote areas, but are constantly face a high risk of assault and harm through exposure to communicable diseases (that may be transferred through attacks with syringes, bottles, saliva or blood).

Without spit guards, the policing environment will become far more dangerous for our members. There are very real risks and consequences of not having proper protective equipment in place. It puts police at a higher risk of assault, which can result in physical injuries, mental trauma, and post-traumatic stress disorder (PTSD).

> "Acute stress reactions can arise up to a month after a person experiences a distressing incident – such as a fatality, a serious accident, physical or sexual assault or a natural disaster such as a bushfire or a flood. Even a "near miss" can cause an acute stress reaction.
>
> These reactions can include fear, horror, anger, sadness and hopelessness - and they are perfectly normal and natural after trauma. These reactions can give rise to emotional, psychological and physical distress. Symptoms can include "flashback" episodes, decreased emotional responsiveness, amnesia and feelings of guilt about enjoying normal things.
>
> *[In most instances, these symptoms will abate with time and after confiding in friends or family.*
>
> *If, however, these reactions last for more than three or four weeks, it's important to seek help from a doctor or health professional as an acute stress reaction can also lead to Post-Traumatic Stress Disorder (PTSD).]*
>
> About 25% of people who are exposed to a distressing or traumatic event will develop Post-Traumatic Stress Disorder (PTSD). Clearly, this accounts for the high level of PTSD in policing."[44]

329. There is no doubt that police face extremely complex and challenging events on a regular basis. However, I do not accept that the policing environment "*will become far more dangerous*" in the absence of spit hood use. The current limited level of spit hood use does not support such a conclusion. The alternative measures discussed in this report will mitigate the potential for any increase in harm. General comments seeking to draw on the potential for officers to develop PTSD as an argument for continuation of spit hood use must be viewed with caution.

330. Turning to factors weighing against spit hood use, the investigation pointed to numerous problematic uses of spit hoods on children. Even for those who consider use can be justified in appropriate circumstances, the practical application of spit hoods and review mechanisms in 2020 and 2021 must give cause for concern that risks and impacts have not been minimised.

331. The investigation also highlighted numerous serious risks to the mental and physical health of children on whom spit hoods are used (see Chapter 5).

332. Further, it identified a range of alternative measures that can be taken and protections that are available, to minimise the prevalence of spitting incidents and protect police when they arise. Police can be provided greater education and support to deal with the challenging situations they face, as well as better protective equipment options.

333. With regard to alternatives, the NTPA submitted:

> *There are several alternatives outlined in the consultation draft include Proposed Personal Protective Equipment for police to utilise, such as a full-face shield. We submit these measures are impractical at best and would greatly restrict the ability of our members to perform their duties effectively when a person in custody is violent or otherwise resisting police. PPE can impair a police officer's situational awareness and ability to access and use Use of Force options in a confrontational violent situation. Spitting can't be stopped with handcuffs.*
>
> *Feedback from interstate jurisdictions that have trialled so-called alternatives is that: face shields are cumbersome, especially when police are going 'hands on' with an offender. They get in the way and can fog up, obstructing the view of the offender. The last thing an officer*

[44] Quoting excerpts from *A Cop in the Family: A social and emotional wellbeing / mental health initiative for Australia's police officers*, page 41. Additional paragraphs in italics have been added to provide the full context.

needs while trying to restrain an offender is a hinderance, such as a face shield. Donning PPE can also be seen as a 'challenge' to offenders. However, none of the PPE alternatives, such as goggles, safety glasses, or face shields protect against offenders who bite.

334. I also note a comment attributed to the NTPA at the time spit hood use on children was ceased, which included a suggestion that members may need to use additional force on children in order to resolve such situations:[45]

> *Without the option to use spit hoods on young people … police will have to use "alternate use of force options" to protect themselves.*
>
> *"Use of force includes striking, take-downs [and] removing that individual to an alternate area until proper safety equipment can be used" …*

335. One minor use of force observed to be effective in numerous cases where a spit hood was not used has been for the officer/s to adopt a position standing to the side or rear of the individual and prevent them from turning their head towards the officer by using their hand.

336. Other uses of force may be necessary to control a violent or aggressive person but spit hoods have routinely been applied after those uses of force, once the person is under a measure of control. This is the same for other PPE and avoidance measures, which I do not consider to be impractical in those circumstances.

337. With regard to biting, no instances of biting or use of a spit hood in an attempt to stop biting were identified in the course of the investigation. I also note that literature on minimal risk of transmission of communicable disease extended to biting (see Chapter 5).

338. The initial emphasis should always be on meaningful communication. The potential need for alternative use of force on occasion is acknowledged, but should not be overstated.

339. The objective risks to police (including the potential for disgust at being spat on and the need to take precautionary steps) must be balanced against the potential serious harm to children, and considered in light of the identified available alternatives. Bearing in mind those factors, and noting the same conclusion has been drawn in other jurisdictions, I do not consider that use of spit hoods can be sustained with respect to use on children.

340. In light of my findings, I welcome the decision to cease use of spit hoods by NTPF in relation to children in the Northern Territory. It is important that use does not resume. In this regard, one aspect to consider is the mechanism of change. An administrative policy change sends a strong message to members about the direction the organisation currently wishes to take. However, the disadvantage with this approach is that subsequent social pressures or changes in key leadership roles have the potential to result in rapid reversal. Supporting this new policy direction with legislative reform, as has occurred elsewhere and in the NT with respect to youth detention centres, would be a method of creating more stable, publicly scrutinised and long-lasting change.

[45] S Dick, 'NT government ends use of spit hoods on children in police custody, years after youth detention royal commission ban', ABC News (online), 7 October 2022.

Spit hoods and adults

341. Given the commentary in Chapter 5 on the developmental stages of individuals up to age 25, the arguments against spit hood use are of equal strength for people up to that age. While there is great force in the argument for not using spit hoods up to that age, the risks and negative impacts of use are also present for older people. The alternatives identified are likewise equally available to officers dealing with persons of any age.

342. NTPF submitted:

> *The NT Police does not support the cessation of the use of spit guards (replacement for spit hoods) as a protective measure for its members. There is an obligation to provide a safe working environment for members and the act of being spat on or bitten presents an unacceptable risk that is reasonably mitigated by the correct use of spit/bite guards in strict and controlled environments.*
>
> *Ongoing controls around the use of spit guards have been strengthened and each application is subject to an independent review by Risk Management and Internal Audit Division (RMIA).*

343. The NTPA submitted that a draft recommendation to cease the use of spit hoods for adults was predominantly based on the review of information and evidence regarding children, stating:

> *While there may be some correlation, the risks that are presented by each cohort are substantially different. None more so, than the risk of contracting a communicable disease from an adult, as opposed to a child.*

344. I acknowledge that the extension of the cessation of spit hood use to adults is a step beyond the core of this investigation. However, it is a small step. Accepting for the sake of argument, that adults present a greater likelihood of having communicable diseases, the actual risk of transmission remains, as discussed in Chapter 5 and above, 'negligible' or 'very low to non-existent'. This does not decrease the abhorrence at being spat on but there is little to differentiate between adults and children in that regard.

345. I accept that some of the potential adverse psychological effects on children discussed in the report may not present as prominently for adults (at least those over age 25). However, the potential physical risks remain, as does the potential for psychological harm. The investigation has provided ample evidence for me to form a conclusion in respect of the use of spit hoods on adults.

346. The same factors are present for use of spit hoods on adults, although psychological risk factors may differ in degree for adults over 25. Considering the objective merits of factors for and against complete cessation, they substantially favour cessation. Those factors have supported cessation of use in all but one other police facility in Australia. I therefore consider NT Police should entirely cease use of spit hoods / spit guards.

347. On a practical note, NTPF has officers operating throughout the Territory. It is important that adequate supplies of personal protective equipment are provided and maintained to ensure availability of PPE as needed.

Recommendation 2

NT Police continue the cessation of use of spit hoods on children.

Recommendation 3

NT Police extend the cessation of use of spit hoods to all people in custody.

Recommendation 4

The NT Government consider legislating to preclude future use.

Recommendation 5

NT Police ensure that adequate personal protective equipment is available to all officers to provide for their reasonable protection against spitting or other transfer of bodily fluids.

348. During the investigation, numerous examples were encountered of non-compliance with a variety of aspects of the Instruction which were not identified by supervisors during the senior members review, or on review by the RMIA. In some cases, there may have been ambiguous or unclear aspects of the Instruction involved, and in other cases requirements were simply overlooked.

349. Many of these non-compliance issues were outlined in the case examples in Chapter 6 and Annexure A. One that particularly deserves further comment is the prohibition in the Instruction against using a spit hood on a person who "*is at risk of future vomiting*". There were a number of instances of spit hoods being used on children who were significantly intoxicated, and therefore, as a prudent measure, should have been considered at risk of vomiting. If spit hood use is to continue in any respect, then use of the devices on intoxicated persons is an issue worthy of urgent clarification in the Instruction.

350. If contrary to my above recommendations, spit hood use is retained as an option for use of force by officers on adults, I make the following recommendations:

Recommendation 6

NT Police introduce into its recruit training and ongoing professional development program for members practical, scenario-based training on the correct use of a spit hood. This training should, at a minimum, address the real prospects of contracting infectious diseases through spit, mucous or other bodily fluids, and test members ability to:

a. **utilise alternative strategies to avoid the use of a spit hood;**
b. **appropriately apply the threshold for use of a spit hood: that is, the existence of a threat to members or others beyond the general behaviour of spitting;**
c. **recognise the circumstances in which spit hoods must not be used; and**
d. **monitor the health and wellbeing of a person in a spit hood to a high standard.**

Recommendation 7

NT Police review and consider amendments to the Instruction to address the following matters:

a. **Require members to first utilise PPE and other de-escalation and avoidance techniques before turning to the use of a spit hood;**
b. **Specify whether spit hood use is permitted in-field or within the watch house only;**
c. **Prohibit the use of a spit hood on any person who is intoxicated due to the associated high risk of vomiting;**
d. **Clarify the requirement to remove a spit hood once a person is "secured in a cell" so it is clear to members that it is not appropriate for a spit hood to remain in place while a person is secured in the rear of a police vehicle or in a cell;**
e. **Remove the statement with respect to monitoring a person in a spit hood by CCTV, as this creates ambiguity with respect to the requirement to remove a spit hood once a person is secured in a cell;**
f. **Require any person in a spit hood to be processed into custody as a matter of priority;**
g. **Implement a maximum time limit on the duration a person can remain in a spit hood.**

Use of ERCs

351. As can be seen from the examples in this report, there will be times when a child attempts self-harm in police custody, for example by striking a part of their body (often their head) against a hard surface. It is important for police to act to minimise the potential for injury to the child.

352. The potential for intervention by communication (as discussed above) is a crucial first step in trying to address self-harming behaviour. Additional training and meaningful attempts at communication are equally important here.

353. The benefits of seeking advice and assistance from medical and counselling professionals has also been discussed above (Chapter 7). Support may also be sought from family and community members in smaller communities. Even an assurance that help is on its way may provide a sufficient level of comfort to diffuse the situation.

354. While such options should always be pursued with vigour, it is accepted that there may be situations where immediate restraint of some type is required. In those most serious cases, current options for restraint where an individual is actively trying to self-harm include a padded cell, an emergency restraint chair, seeking medical assistance (which may include sedation) and other physical restraint, for instance applying cuffs to the hands and possibly legs.

355. All of those options can be regarded as confronting. However, there will be cases where the circumstances dictate that no option is welcome but one must be chosen as necessary. The reality of operating in a small police facility, far from outside assistance, may further limit available options.

356. In such circumstances, attempts at engagement through communication should normally come first and be ongoing, with advice and assistance from professionals and other supports next. If immediate action is needed to protect the person, physical intervention may be required, followed up with further attempts at communication and monitoring.

357. The situation can, however, be complicated when the child is not only trying to self-harm but also trying to harm officers, or when intoxication may prevent assessment or treatment of other underlying mental health concerns.

358. If further action is required, placement in a padded cell (if available) may at least provide a safe space for an individual to recover. Use of an emergency restraint chair or hand and leg cuffs are perhaps equally likely to further distress and traumatize. Sedation by a health professional may appear a less confronting option but brings its own concerns, including the need for continuing management of the person at a health facility.

359. With regard to ERCs, the NTPA submitted:

- *We question why the responsibility of managing violent offenders' therapeutic needs are being placed solely on police. It is not uncommon for these individuals to be deemed unfit for admission to medical facilities due to their violent tendencies. The health department could potentially play a larger role in ensuring appropriate measures are taken to accommodate such individuals in medical facilities.*

- *The ERC is recognised by medical professionals as a safer restraint option than, for example, extended ground stabilisation, or restraint to a bed. That is because there is a greater risk for asphyxiation while restrained on a bed or on the ground.*

360. There is no single, easy answer to this situation. In the circumstances, I consider that it would be beneficial for experts from NT Police, the Department of Health and Territory Families to prepare, in consultation with a range of relevant stakeholders, a more comprehensive therapeutic plan for the effective management of children who attempt self-harm while in police custody. The plan may well involve a limited period trialing alternatives, with an embargo on ERC use other than in exceptional circumstances, and only as approved by a senior officer.

361. In doing so, it would be logical to approach the topic from the point of view of all people who attempt self-harm, while nevertheless considering and providing for the special circumstances of children.

362. The development of such a plan should be approached with a view to strictly minimising, and ultimately phasing out, use of ERCs within a stipulated timeframe.

Recommendation 8

NT Police promptly engage with a range of relevant experts and stakeholders to develop a more comprehensive therapeutic plan to provide and promote alternative approaches and support mechanisms that do not involve use of ERCs by police, with a view to immediately minimising ERC use and preferably phasing it out as soon as practicable.

Recommendation 9

NT Police explore options to fill the therapeutic gap for crisis support for persons in custody, or at risk of being taken into custody, who are exhibiting extreme emotional distress or behavioural disturbance.

363. For as long as ERC use is retained as an option for use of force by officers, I make the following recommendations:

Recommendation 10

NT Police expand on its ERC training module to incorporate scenario-based training on effective communication to avoid the use of an ERC, and practical strategies for effective health monitoring and rapid de-escalation to minimise the duration of use.

Recommendation 11

NT Police review and consider amendments to the Instruction to address the following matters:

a. **to make clear the purpose of remaining with a child for the first five minutes they are placed in an ERC includes engaging with them in order to connect with and de-escalate their behaviour, and expand this requirement to any adult placed in an ERC;**
b. **require that the basis for an assessment of the need to continue restraint in a padded cell or ERC be recorded in the custody journal; and**
c. **ensure that the entire duration of ERC use, including wellbeing checks and assessments of the need to continue use, is recorded in a manner that captures both video and audio.**

364. Stakeholders have expressed concern about the potential for the mere presence of an ERC to create or heighten anxiety, particularly if a person has been previously restrained in one. It would seem a relatively simple step for NT Police to address the issue by storage away from entry and cell areas.

Recommendation 12

NT Police ensure that ERCs are stored out of sight, so as not to unnecessarily raise concerns.

365. NTPF confirms it has taken this step.

366. If there is continued use of both spit hoods and ERCs on adults, their combined use is extraordinarily confronting and unnecessary. Once a person is restrained in an ERC, officers have sufficient alternatives to practically avoid the potential for a person to spit on them. There should be no combined use.

Recommendation 13

NT Police ensure that spit hoods and ERCs are not used in combination under any circumstances for any people in custody.

367. The NTPA recognised that the ongoing simultaneous use of spit guards and an ERC should not be necessary, however submitted it should be recognised that at times, particularly in the initial restraint, that both measures may be required.

368. NTPF has stated that it supports the intent of the recommendation and that spit hoods should only be utilised during the transition of a person into an ERC and should be removed as soon as staff are out of range of biohazardous material.

Training

369. Recommendations for improving the training available to members with respect to the use of spit hoods and ERCs are outlined above.

370. With respect to broader training for members in child development, trauma, communication and de-escalation, it is beyond the scope of this investigation to consider all available options for training, or to recommend any particular course. However, it is apparent that there are numerous options available to develop a tailored training program in this area, as well as a variety of options as to how such training could be included within the existing recruitment and professional development frameworks available to NT Police.

371. For instance, options may include (but are not limited to):

- Full implementation of all recommendations made by the Royal Commission with respect to police training in these areas (discussed in Chapter 4);
- Supplementing existing recruit training;
- Including practical de-escalation focused scenarios within annual defensive tactics / operational safety requalification training;
- Developing a specific training module for regular member training days;
- Implementing specialised training for members of the Youth Division, in combination with a strategy for expanding that knowledge into other Divisions, such as partnering Youth Division members with General Duties members to assist with on the job mentoring and development;
- Consideration of a pilot broader Mental Health Division focused on the impact of development and trauma on behaviour generally, with specialised response strategies.

Recommendation 14

NT Police develop a strategy for training and ongoing development for all NT Police members with respect to child development, the impact of trauma and disability on behavioural responses, and specific communication and de-escalation strategies for children.

Quality assurance

372. Structurally, the internal review process appears to be sound. However, it is concerning that this investigation identified a number of incidents of apparent non-compliance and opportunities for improved performance that were either not identified, or identified but not communicated to the members whose capability would be enhanced by that information.

373. The investigation observed the following specific weaknesses in quality assurance measures:

- **Inability to access required information (such as BWV, CCTV footage or member training information)**

  This hampers the ability of the reviewing officer to consider the matter and its root cause holistically, and can prevent an assessment of whether the incident is described accurately in the CIIR. In particular, the review of footage is important in order to consider any missed opportunities for better communication and/or de-escalation which may have avoided the use of force entirely.

- **The sentinel review focus on '*systems and processes (not individual performance)*'**

  While it is acknowledged that there can be benefits of high level process-based review, it is also important to recognise that some incidents can involve blatant or mistaken non-compliance with clear policies, and in such circumstances, individual performance feedback is critical to ensuring improved performance. Particularly in instances where the senior member review has failed to identify and address the non-compliance, there must be a pathway for this to occur at the independent review stage. It is also important for the supervisor who failed to address the non-compliance to have this performance issue addressed.

  It may be appropriate to consider amendment of the Framework to require the RMIA to complete a report to the Professional Standards Command of any identified potential non-compliance (similar to a Blue Team Report for police complaints taken by members). This may, by extension, involve an agreed referral process to the Ombudsman's Office, such that there is a degree of external oversight on the use of significant restraints.

- **Deviation from Framework and externally reported safeguards**

  As noted above, the NTPF obtained support to retain the use of these devices in 2016 on the basis of strengthened internal controls, including sentinel review. However, the documentation obtained in the investigation showed that sentinel reviews did not commence until about two years later – in September 2018.

  Furthermore, in April 2020, changes were made in the CIIR reporting process. Instead of quarterly trending reports, the RMIA began providing more detailed monthly reports to the CSC, which included short summaries of individual CIIR details. At the same time, there was a shift away from sentinel review of all incidents (as required under the Framework), replaced instead by a sampling plan, where CIIRs were selected at random to undergo full sentinel review.

  It is disappointing to see that the basis on which the 2016 support was provided, and which continues to be used to justify the ongoing use of these devices in external communications with stakeholders, was not being conducted as described, nor in compliance with the expectations under the Instruction.

374. Lastly, the investigation also considered whether it was appropriate for the CIIR review and sign off to be conducted by the same senior members who were responsible for providing contemporaneous approvals. On one view, this structure could produce cursory sign off due to time pressures, or self-serving reviews. However, it must be recognised that the contemporaneous approvals given by these senior members are done on the basis of very short briefings from members who require an immediate decision. Requiring these same senior members to sign off on the CIIR could also be considered to give them the opportunity to consider the matter in more detail, determine whether a different approach should have been taken, and address any shortcomings or opportunities for improvement with the members involved.

375. Provided there is an effective secondary level of review beyond this, it is not considered that any change to the initial senior member review process is necessarily required.

376. A strong quality assurance framework is a critical protection for both persons in custody and members when it comes to significant uses of force such as the devices considered in this report. It provides an important opportunity to identify and correct procedural non-compliance, and to provide feedback on the efficacy of the member's interactions, including alternative practical strategies for resolving similar situations in the future.

Recommendation 15

NT Police review its quality assurance framework and consider appropriate amendments to address the following matters:

a. Senior member reviews and RMIA reviews must not be finalised without the review of relevant CCTV, BWV footage and training records. In the event that footage is not available due to a failure to record, this should be addressed as a non-compliance issue; and

b. Reviewers should be specifically required to consider the broader police interaction with a view to identifying and reporting on escalation points or missed opportunities to de-escalate.

Recommendation 16

NT Police involve the RMIA and the Professional Standards Command in development of an appropriate referral mechanism for any identified potential non-compliance or other performance issues identified by RMIA during sentinel reviews to be further considered and addressed with members.

Recommendation 17

Until such time as the use of spit hoods and/or restraint chairs has been ceased for all people in custody, NT Police ensure that full sentinel review is conducted on all incidents involving use, as required by the Framework.

Adequacy of record keeping

377. There were multiple occasions observed in the investigation where a member's summary of events in a Use of Force report or CIIR form described a child as "aggressive" without fairly describing the situation or addressing the child's distress or other significant contributing factors. There were also references to attempts to verbally de-escalate which were not genuine or significant, on some occasions little more than a direction to "calm down".

378. In addition, it was frequently observed in the footage that wellbeing checks and other notification requirements were conducted without being recorded at all, or recorded with insufficient detail, in the custody journal. Although detailed record keeping can be demanding, such records are a critical aspect of demonstrating the care provided to people in custody, and an important source of information to assist with resolving complaints which may arise.

379. Best practice record keeping of such checks should also include a summary of the basis on which an assessment was made that the restraint or force being used needed to continue. No notes of this nature were observed during this investigation. This would be a significant improvement to the standard of record keeping, particularly considering that the alternative source of evidence is CCTV footage that often lacks any audio component.

Recommendation 18

NT Police take steps to reinforce the importance of good record keeping, particularly in relation to decisions and actions around use of force/restraints and ongoing checks. Good record keeping would include, at a minimum:

a. A fulsome and accurate account of events which occurred prior to the use of force;

b. What less significant use of force options were considered or attempted;

c. Time of notifications made to superior officers;

d. Time and duration of wellbeing checks; and

e. Reasoning for any decision to continue the use of restraints, including the supporting facts and circumstances upon which the decision was based.

Involvement of members in change

380. Removal of restraint options is a matter of legitimate concern for members. It is important that they fully understand the rationale for change and are provided with sufficient information about alternative options to give reassurance that they will have adequate strategies and resources to protect themselves and the people in their care.

381. I have attempted to comprehensively address those points in this report. It will be essential for NT Police to do likewise and provide adequate communication, training, resources and support for the implementation of changes in the availability and use of these restraints.

382. From that perspective, it is important that changes be accompanied by a clear strategy for building understanding and appropriate skills and capabilities, so that members continue to feel confident and supported in the performance of their duties.

383. Any strategy should make it clear that use of force remains an absolute option of last resort and that considerations of communication and care, together with adequate protective strategies and equipment for the officers themselves, will underpin appropriate responses to behaviours of concern. It will also be important for NT Police at all levels of review to be vigilant in their scrutiny of use of force reports and footage to ensure there remains a strong focus on de-escalation and communication throughout the entirety of police interactions.

CHAPTER 9: NTPF AND NTPA RESPONSES

384. During the investigation, NT Police provided information regarding some improvements that had been made to NTPF processes since the investigation commenced. These included:

1. *The use of spit hoods on all youth has ceased and all internal instructional and training documents have been amended.*

2. *Full PPE sets are now available in all Watch Houses (WH) for the use of staff when managing the risks of spitting exposures.*

3. *The internal review process as provided by the Watch Commander (WC) and the Territory Duty Superintendent (TDS) has undergone significant improvement in the last 12 months. This can be evidenced via the improved identification of issues as being reported back to operations.*

4. *Risk Management and Internal Audit (RMIA) have improved the completed Custody Incident or Illness Report (CIIR) and Sentinel review process, the CIIR monthly reports have been strengthened and are now being distributed to a larger operational audience.*

5. *RMIA have identified short and long term corrective actions to address the issues as identified in the Sentinel reviews and other investigations undertaken on behalf of the Ombudsman by PSC.*

6. *The Use of Force project is progressing and will deliver greater compliance oversight to force as used on persons in Custody.*

385. The NTPF also offered a corrective and preventative plan for addressing the Ombudsman issues of interest outlined in Annexure A (the Schedule of Incidents).

OO issue identified	***Proposed Corrective/Preventative Plan***
Adequacy of record keeping	***Long term –*** *SERPro system to manage the recording of the cell check function.* ***Short term –*** *Request to DCDD for improvements to WebEOC to ensure cell checks are being allocated to a prisoner's record and that reports can be generated when needed.*
Policy Compliance	***Training*** *– Improved training schedule for all staff operating in the watch house environment.* ***Awareness*** *– Proposal to set up a Custody portal on the intranet to provide staff access to information on current issues – Case studies, coronial reports etc. to be included to assist in staff awareness and training*
Adequacy of Internal Review	*Ongoing training and improvement in the standard of review conducted by Watch Commanders and Duty Superintendents.*

OO issue identified	*Proposed Corrective/Preventative Plan*
De-escalation and communication ***Preparation and communication***	*Ongoing training inclusive of case studies on the art of and importance of de-escalation and communication.*
Use of Force	*All UoF reports are now independently reviewed by a UoF subject matter expert following review by the Watch Commander. This provides a level of separation outside of the officer's nominal chain of command and more broadly allows for the trending of potential issues with either practices or individual officers.* ***Policy** – amendment to the UoF General Order to include a requirement for officers to submit a UoF report for ERC and spit guard use.*
Adequacy of Medical Care	*Increased training and awareness on duty of care requirements especially for youth and persons who are in custody intoxicated.*
Proper Placement of Spit hood	*Old style spit hood no longer in use – new spit guards are simpler to apply and reduce the risk of incorrect placement*
Adequacy of the Custody Management Plan	*Improvements to the process governing the creation of Custody Management Plans and their ongoing review can be made and has been tasked to the Custody Steering Committee to action.*
Basis of Arrest	*Ongoing supervision and training inclusive of case studies required through Training Days to ensure members are equip with the knowledge and tools to make correct decisions when taking people into Custody.*
Lack of a CIIR (spit hood in cage)	*Reporting via CIIR submission has significantly increase in the last 12 months with ongoing oversight by RMIA.*
Failure to use PPE	*Custody and Transport Instruction has already been updated to mitigate this issue and clear directions provided re use of PPE in controlled WH environment is in place.*

386. Improvements with respect to these issues are welcome. They do not, however, impact the core recommendations set out in Chapter 8.

NTPF response to draft report

387. A consultation draft of this investigation report was reviewed by NTPF and the NT Police Association (**NTPA**). Each provided submissions in response. A number of those submissions have been addressed earlier in this report (particularly in Chapter 8).

388. NTPF agreed in principle to the majority of recommendations, but advised it does not support:

- The cessation of use of spit hoods to all people in custody (Recommendation 3);
- The introduction of legislation to preclude future spit hood use (Recommendation 4), stating that this is a matter for consideration by the NT Government; and
- A complete prohibition against the use of both restraints at the same time (Recommendation 13), although it supports the intent of the recommendation and states that the spit hood should only be utilised during the transition of the person into the ERC and should be removed as soon as staff are out of range of biohazardous material.

389. NTPF advised that its Custody and Transport Instruction has already been amended to prohibit the use of spit hoods on children, now stating that PPE and Operational Safety Training and Tactics techniques should be utilised to reduce biohazard risks where spitting is a perceived risk.

390. NTPF submitted that there are sufficient procedures in place to ensure there are adequate stocks of PPE available at all times (Recommendation 5). It also advised that a further review of the Instruction is underway which will address the majority of the recommendations made regarding the need for policy improvements (Recommendations 7, 11 and 18). Specific comments were made with respect to the following aspects:

- The Instruction now contains clear directions regarding the use of PPE, and PPE options have been increased;
- The use of spit hoods in-field and during transport has been ceased, with the Instruction stating approval is for use within designated custody facilities only;
- The intoxication level and risk of vomiting presented by a person in custody forms part of the risk assessment for use, and the new design chosen has been designed by the manufacturer to reduce any risk of asphyxiation;
- No maximum use time has been set, however the policy changes made mean that use will be restricted to the custody reception process and the person will never be outside the direct care and control of a custody staff member; and
- Cells in the custodial facilities do not have audio coverage in order to preserve the privacy of persons in custody, however NTPF will further investigate suitable methods to meet the audio component of recommendation 11(c).

391. NTPF also advised that all relevant Watch Houses now store their ERCs out of sight of persons in custody.

392. With respect to the greater need for therapeutic intervention for persons in custody displaying self-harm behaviours, NTPF were strongly supportive of any opportunity to further available supports, stating:

> *In conjunction with the Department of Health, NT Police undertakes to review the current operating procedures and memorandum of understanding regarding the deployment of custody nurses. NT Police strongly supports any proposal to expand the operating hours and locations of custody nurses across the NT, with a view to providing a greater therapeutic model of support for person in police custody who require medical intervention. NT Police strongly supports the expansion of Co-Response Operational Protocol for Collaborative Care, between Top End Mental Health and Other Drug Services (TEMHAODS), St John Ambulance Australia (NT) Inc and the NT Police Force.*
>
> *…*

The co-response function currently only operates in Darwin (Northern Suburbs) between Monday to Friday, 12:00pm to 8:00pm. NT Police strongly supports any proposal to further expand this model and provide greater coverage across the NT to persons requiring mental health intervention with a view to reducing the number of persons coming into police custody.

393. With respect to the recommendations regarding additional training for members (Recommendations 1, 6, 10 and 14), NTPF expressed its support, advising that the NTPFES College will be undertaking a review of all training material related to custodial practices, including ERC and spit guard use, and the recommendations made would form part of the scope of that review. Specifically with respect to recommendation 14 (training with respect to child development, trauma, disability, communication and de-escalation skills for children), NTPF stated that:

    … NT Police commits to ongoing reviews of all training material with a view to incorporating elements of child development, the impact of trauma and disability on behavioural responses. NT Police further agrees to consult with partner agencies to develop a strategy to best deliver this training with a view to maintaining ongoing development of frontline officers.

394. In terms of quality assurance, NTPF advised that the CIIR Sentinel Review Framework is currently undergoing review as part of the greater review of the Instruction, and that the recommendations made (Recommendations 15, 16 and 17) will form part of the scope of the review. NTPF noted that currently, all ERC, padded cell and spit guard use events are subject to full sentinel review and where issues are identified they are reported to both Professional Standards Command and the responsible operational Command.

NT Police Association response to draft report

395. In summary, the NTPA did not support the cessation of availability of spit guards (for use on adults) or ERCs. The NTPA advised that it was generally supportive of training packages and ongoing professional development for members, however it believed that more extensive consideration and evaluation of current usage of these restraints should be undertaken, in consultation with the NTPA, to appropriately inform amendments to policies and training.

396. The NTPA requested that the term 'spit guard' be used in the report rather than 'spit hood'. I acknowledge that the new item available to NTPF officers is described as a spit guard by the manufacturer, and that it is essentially transparent. Even so, I consider it is still accurate to describe it by the more commonly known description of a hood.

397. The NTPA raised two major concerns with respect to spit guards:

    - In its view, the report failed to fully grasp the harm caused to members occasioned by spitting and/or biting;
    - The recommendation made to cease the use of spit guards for adults was predominantly based on the review of information and evidence regarding children.

398. Those points are addressed in some detail in the *Use of spit hoods* section in Chapter 8.

399. The NTPA also made brief comments on ERC use, which are likewise addressed in Chapter 8.

Conclusion

400. I readily acknowledge that the protection of officers from the revulsion of being spat on and the need to adopt precautionary measures when that happens, are significant factors. However, this report has identified major risks in the continuing use of spit hoods/guards and viable alternatives that can serve to minimise the potential for such instances and provide protection when needed.

401. I also acknowledge the considerable work already done by the NTPF in addressing the issues raised in my draft report and recommendations. Many of those initiatives will go a long way to addressing particular points raised.

402. However, the information and submissions provided by the NTPF and NTPA do not convince me to take a different approach on the core recommendations I set out in the draft report. I consider there are sufficient alternative measures that can be taken to protect members without reliance on inherently risky and extraordinary restraints such as spit hoods/guards.

403. The position with ERC use is not as clear cut. Timely cessation of use should certainly be the goal but this must be matched by viable options for dealing with such highly problematic situations, developed with the benefit of expert and stakeholder advice. My recommendations reflect this.

404. Noting again my comments in Chapter 8 ('Involvement of members in change'), I consider that it is important wherever possible to involve members and their representatives in consultation with respect to issues and changes required to work practices. Such an approach enhances the prospects of successful organisational change. However, any such consultation should be done with firm boundaries regarding the outcome to be achieved and the timeframes for implementation.

ANNEXURE A – SCHEDULE OF INCIDENTS

Notes:

[1] *Figures used represent the best assessment possible on the basis of the information and documentation supplied.*

[2] *It was not feasible within the scope of this investigation to conduct an in-depth analysis all of the potential issues of non-compliance or improved performance that may have arisen in each incident. However, many incidents raised issues that our investigative team considered may have been worthy of closer scrutiny in another context. This schedule provides a summary of the circumstances of each incident reviewed. It also provides a short-form, non-exhaustive, indication of potential issues that the Ombudsman may have considered more closely had a complaint been submitted. In the interests of fairness, it is important to stress that no adverse findings are made on these issues. Further consideration may have resulted in any number of findings, including that the conduct was reasonable, not unreasonable in the circumstances or an adverse finding.*

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
1.	Female 17yrs Aboriginal	In field and Watch House	Spit hood	Unknown	No	Child arrested for outstanding warrants. She was intoxicated and argumentative, but initially reasonably compliant. After handcuffs were applied, the child dropped her weight to the ground and began to self-harm by banging her head on the ground. Members restrained the child on the ground to prevent further self-harm until the police vehicle arrived. Child began spitting during restraint. Spit hood applied in field. Further self-harm attempts at the watch house were managed by use of the padded cell for about 20 minutes. Watch Commander identified issues of non-compliance (extended use of spit hood without notification, and inadequate medical care) during review of custody incident report and these were addressed with members involved.	Nil identified on the material reviewed.
2.	Male 17yrs Aboriginal	Watch House	Spit hood	Unknown	No	Child arrested on outstanding warrants. He had a history of petrol sniffing and a heart condition. Initially apprehended by off-duty members and restrained on the ground after attempting to strike them. Records indicated a spit hood was used during processing until the child was secured in his cell due to the child spitting in the rear of the police vehicle.	• Custody Notification Service (CNS) requirements • Adequacy of record keeping • Use of force

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						There was no record of the time the spit hood was in place. A figure 4 hold was applied to the child in order to remove the spit hood and handcuffs. There was a 90 minute delay in notifying the Territory Duty Superintendent of the spit hood use due to a miscommunication between watch house staff and arresting members. Feedback was provided. An internal review of the use of force determined the force used was reasonable.	
3.	Female 15yrs Non-Aboriginal	In field	Spit hood	5 min	No	A child in the care of Territory Families had absconded. Territory Families had located the child. She was affected by drugs and in the company of a known drug supplier. Police were requested to assist with transport to hospital for a medical and mental health check. Carer was also present. The child's Custody Management Plan noted the child had an extensive history of mental illness and behavioural issues, was under treatment by a mental health service and was on medication to help manage behaviour. The Plan noted a history of violence to members, including spitting. It encouraged early consideration of need to remain in custody, use of padded cell (if required), and communication with health workers regarding release and/or transfers. It also encouraged consideration of personal protective equipment (such as spit masks) and appropriate techniques for cell extractions. Records stated the child was initially compliant but became unpredictable when informed she would be handcuffed behind her back. Child was secured to the side of the police cage with a second set of handcuffs in order to prevent attempts at self-harm. Notes indicate that child was making loud outbursts but no violent outbursts during transport. Child was complaining of pain from the handcuffs, but not adjusting her position as directed to ease the pain.	• Use of force (handcuffs) • Policy compliance (threshold for spit hood use) • Preparation and de-escalation • Adequacy of internal review

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						Spit hood recorded as being used as a precautionary measure during extraction from police vehicle as child was highly agitated and abusive towards members on arrival at hospital. There was no reference to specific threats or indicators of spitting. Spit hood and handcuffs were removed prior to entry to hospital, about 5 minutes after application.	
4.	Female 15yrs Aboriginal	Watch House	Spit hood	Unknown	No	Child was arrested for aggravated robbery. Child's police profile noted that she was a "spitter". During Covid-19 screening in sally port, child referred to being in contact with someone who had Covid-19. Child spat on police auxiliary from police cage when auxiliary was trying to clarify Covid-19 information. Full PPE was worn by members interacting with child after this. Spit hood was applied to child when removed from van. Child managed to remove her own spit hood a number of times. It was reapplied 3 times, and on 2 occasions the child was ground stabilised in order to apply the spit hood. Watch Commander reviewed incident, including watch house footage. The review noted that the spit hood was not used continuously - only from the van to the holding cell, and then from holding cell to female cell after reception. No feedback or non-compliance was identified.	• Use of force (ground stabilising) • Adequacy of internal review • Adequacy of record keeping
5.	Male 17yrs Aboriginal	In field	Spit hood	Unknown	Partial	Child was apprehended for protective custody. Child had spat from the cage and on the ground several times, but was not being aggressive towards members. Face shields were used to move child into the watch house. Custody nurse observed erratic behaviour. The Custody Health Assessment stated that the child's grandma had died and he was feeling very sad. Child admitted to smoking gunja and drinking spirits. Child had a history of psychosis when intoxicated. Decision made to take child to hospital for assessment and management.	• Adequacy of record keeping

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						St John Ambulance were arranged to convey child to hospital. Custody incident form stated that child began spitting in ambulance and decision was made to apply spit hood and sedate child. Internal review did not identify any issues with use, noting that no other PPE options were available at the time.	
6.	Male 17yrs Aboriginal	Watch House	Spit hood	Unknown	No	Child was taken into protective custody at the same time as his sister. The watch house notes referred to the child being transferred and placed into the holding cell without incident, but when child was directed to come to reception for processing he declined, stating he was cold. Records stated he started being abusive and hostile to Police at this point. Records stated that child was provided with a new t-shirt, and he stood up and frothed saliva in his mouth, ready to spit. The cell door was re-secured. A decision was made to use a spit hood during processing due to high probability of biological assault, also referencing that the child's sister had spat on members in the sally port only moments prior. Internal review noted that the spit hood was used as a successful harm minimisation tool. No issues were identified on review. No responsible adult could be located for the child. He was dropped home the following morning.	• Adequacy of record keeping
7.	Female 16yrs Aboriginal	Watch House	Spit hood	Unknown	No	Child was taken into protective custody at the same time as her brother. She spat on the face of a member when being transferred from the vehicle to the holding cell. Decision was made to apply a spit hood due to risk of further spitting. Internal review noted the spit hood use to be appropriate and for no longer than necessary.	• Adequacy of record keeping

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
8.	Male 17yrs Aboriginal	Watch House	Spit hood	12 min	No	Child was arrested for disorderly behaviour and assaulting police. Child had drunk a bottle of spirits. Records stated the child had been spitting in the rear of police vehicle, however, no spit hood was used to move child to the holding cell. Records stated that child began spitting on windows while in the holding cell. Members donned PPE and applied a spit hood when removing the child from the holding cell and during processing. Records stated that the spit hood was in place for 12 minutes. Child was ground stabilised to remove handcuffs and spit hood once inside male cell. Internal review noted either a failure to notify the Territory Duty Superintendent, or poor record keeping of the notification. It does not appear that any feedback was provided to members on this point.	• Use of force (ground stabilising) • Policy compliance (notifications) • Adequacy of internal review (feedback to members)
9.	Male 17yrs, Aboriginal	Watch House	Spit hood, ERC	Spit hood: unknown ERC: 2 hrs	No	Child brought into protective custody. Custody Health Assessment stated child was intoxicated and had anger management issues, especially to authority figures. No issues during initial transition into custody. Incident notes stated that the child stuffed clothing and a blanket into the toilet and caused water overflow. The child was also observed putting his fingers down his throat to induce vomiting. A mattress was removed from the cell when the child began damaging it. The child began banging his head on the cell door and a decision was made to use the ERC to prevent self-harm. Records do not indicate any consideration of a mental health or medical assessment. Child's history included past behaviour of a similar nature, including an assault on a member during a cell extraction. Members decided to show OC spray to the child and warn him he may be sprayed if he assaulted members. The child complied with instructions to exit his cell and was strapped into the ERC.	• Policy compliance (vomiting, use in cell) • Use of force (OC spray) • Adequacy of record keeping (ERC checks and re-assessments) • Adequacy of internal review

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						While being wheeled in the ERC to the observation cell, the child spat at members, making contact with the back of the head and face. A spit hood was applied. The spit hood remained in place after the member left the cell, but after re-assessment and discussion with the Watch Commander, it was removed by a member in PPE. Notes indicated prior vomiting as a consideration for the spit hood use, but indicated a view that the vomiting was self-induced and was therefore unlikely to be repeated. Notes stated that ERC checks were conducted as required and the child was released after an initial two hour time period expired. Child was charged with offences arising from the incident. The custody incident form submitted by the member requested an alert to be added to the child's profile, and also noted the need for member awareness of PPE. NT Police were unable to establish if or what advice was provided to staff following this incident with respect to PPE use. Internal review considered that the actions taken were reasonable, necessary, proportionate and appropriate, and that proper offences were pursued as a result.	
10.	Male 16yrs Aboriginal	Watch House	Spit hood	8 min	No	Child was arrested for stealing. Child resisted arrest and was ground stabilised and handcuffed. Incident report stated that child began threatening to spit on members while in the cage at the watch house sally port. Members donned PPE and applied a spit hood. The child remained handcuffed and was taken to the holding cell. The spit hood remained on while in the holding cell, and during processing at reception. Notes indicated that the child removed his own spit hood once he was lodged in his cell and the handcuffs were removed.	• Policy compliance (use in cell)

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						The spit hood was in place for 8 minutes. The incident report stated the decision was made to use it in order to prevent biohazard exposure to members and it was effective. Internal review identified no formal notification made to watch commander or Territory Duty Superintendent of spit hood use but considered it was arguable whether this was required by the Custody Instruction. The Custody Sergeant was encouraged to notify these supervisors in future if spit hoods are used in the watch house, especially on children.	
11.	Female 16yrs Aboriginal	Watch House	Spit hood	8 min	Partial	Child apprehended for protective custody. At the time of apprehension, she was complaining of pain from a burn on her leg, as well as pain in her arm, and stating she had been thrown on the ground. The child told members not to touch her, and stated that she would go home to her mum. Members tried to tell the child that they would take her home. The child was not restrained in the cage. After the child was placed in the cage, she began complaining that she did not want police, she wanted an ambulance. The child was not able to provide a name or address for a responsible adult. Members considered taking the child to the hospital for a fit for custody assessment and a medical review which may help her calm down, but considered that the watch house nurse could do that. Alerts for the child included a history of spitting, biting, kicking and mild hearing loss. Records stated that the child spat on the apprehending members when she was being put into the holding cell at the watch house. A spit hood was applied while she was being processed. The child was ground stabilised for the nurse to check and re-bandage the injury to her leg.	• Planning and de-escalation • Use of force (ground stabilisation) • Adequacy of internal review

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						Police were not able to locate a responsible adult so released the child into the care of Territory Families due to behavioural and health concerns. No issues were identified on internal review.	
12.	Male 15yrs Non-Aboriginal	Watch House	Spit hood	Unknown	No	Child brought to watch house for protective custody. Members had tried to take child home, but parents said he was uncontrollable there. The child said he had taken drugs. The child had dried blood smears on his face, arms and chest at the time of his apprehension. The child spat twice on the reception counter while being processed, with members noting there was blood in the spittle. A decision was made to apply a spit hood as a preventative measure. The child's behaviour within the watch house was unusual and erratic. Members consulted with the custody nurse and a decision was made to transport the child to hospital for assessment. The child was monitored closely by members while waiting for the ambulance, and calmed down considerably. The ambulance conveyance was cancelled and the child was taken home. Internal review did not identify any issues. It was noted that the use of the spit hood was justified.	• Adequacy of record keeping
13.	Male 17yrs Aboriginal	Watch House	Spit hood	15 min	Partial	Child was arrested for protective custody. At the time of police attendance, the child had been held down by security guards for an unknown amount of time. The child appeared to cry out in pain when being loaded into and moved about within the police vehicle. It was stated that the child had been spitting while waiting for police. Members noted they observed the child spitting in the cage during transport. Members stated they observed the child's pupils to be dilated and they believed he may have been affected by drugs.	• Adequacy of medical care • Use of force (ground stabilisation) • Policy compliance (in cell use) • Adequacy of internal review

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						They had considered transport to hospital for assessment, but believed his behaviour would continue there. He urinated in the vehicle during transport. The watch house keeper obtained PPE for all members prior to arrival. In transit to holding cell, the child began to cry out again. The child spat on the watch house keeper, but no contact was made due to the PPE. The child was ground stabilised and a spit hood was applied. The child was searched on the ground and taken to reception where he would not answer any questions. The child was then taken to an observation cell. The child removed his own clothes, but not the spit hood. Notes stated that the custody nurse monitored the child's breathing and after 15 minutes members went in and removed the spit hood. Members tried to contact Territory Families regarding the child but could not make contact. The child was taken home at 8am. On internal review, it was noted that the child appeared to be sleeping at the time of re-entry to remove the spit hood. No issues were raised or addressed on internal review.	
14.	Male 17yrs Non-Aboriginal	Watch House	Spit hood, ERC	*Spit hood:* 5 min *ERC:* 1 hr 55 min	Partial	Police attended premises to speak to child regarding a social media issue. Child had a background of Aspergers, previous self-harm, parental separation, drug use and a recent personal relationship breakdown. Police attendance appeared to escalate the child's behaviour. Police tried to reassure child by telling him he was not in trouble, they just wanted to speak with him. The child continued to escalate and attempted to punch and threatened to stab his father. When the child went downstairs, his father spoke of a recently expired DVO and the family feeling frightened of the child. Members decided to apprehend the child for the purposes of a DV application.	• De-escalation, communication • Adequacy of record keeping (ERC checks and re-assessments) • Use of force and policy compliance (spit hood threshold)

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						At the time of arrest, the child said he did not want to go to the watch house, he wanted to go to the mental health unit. While waiting to be transported, members tried to calm the child by offering a cigarette, but when the child became angry again, a member told him to "*stop acting like a fucking child*" and said that they would not negotiate with him. The child's father spoke to members about previous mental health episodes. The child had previously self-harmed (cutting and overdosing). The father told members that on the last occasion the child was taken to the mental health unit, he was released and returned to the house with a knife within half an hour. Members decided to take the child to the watch house. Child began to self-harm on the way to the watch house by hitting his head with handcuffs, stating that he was going to kill himself in the cage. At the watch house, he was placed straight into the ERC due to the level of self-harm displayed. At the watch house, the child was angry, yelling at police that they told him he was not in any trouble but now he had been arrested. Notes stated that a spit hood was applied due to the child spitting while talking to the Custody Sergeant. The spit hood was removed during processing so the custody nurse could treat the injury on the child's forehead. The child stated he was having withdrawals from drugs, he had wanted to kill himself all week and that he had tried earlier that day. The child said he did not want to talk to anyone about it and told the members to hurry up and do what they had to do so he could go home and kill himself. After further medical consultation, the child was transferred to hospital for a mental health assessment. The incident report stated health staff were "dismissive" of police actions, saying that the child was not mentally ill, just had Aspergers.	

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
15.	Male 14yrs Aboriginal	Watch House	Spit hood	Less than 1 min	Yes	See detailed summary in **Incident 1** within the Report. Child initially stopped for questioning and a conveyance home, but due to argumentative and threatening behaviour was arrested for disorderly behaviour. A further charge of assault police was added when the child spat on the arresting member. A spit hood was used by the conveying members when removing the child from the police vehicle at the watch house. The child managed to remove the spit hood within one minute and it was not replaced. Face shields were used by watch house staff while processing the child.	Nil additional issues to those already considered on complaint.
16.	Male 13yrs Aboriginal	Watch House	Spit hood	Unknown	Partial	See detailed summary in **Incident 2** within the Report. Child arrested on a warrant in a town camp. Notes stated the child was aggressive and verbally abusive towards members at the time of arrest. Spit hood was applied to the child during search at the watch house after he spat in the face of one of the searching members. The child's behaviour calmed and he managed to remove the spit hood himself. The spit hood was not reapplied with further risk being managed by maintaining directional head control of the child. Full face shields were not available in the watch house at this time. No issues identified on internal reviews. All charges against the child were subsequently withdrawn with a determination made that the child was *doli incapax.*	• De-escalation, communication • Use of force (during search) • Adequacy of record keeping
17.	Female 15yrs Aboriginal	Watch House	ERC	Unknown (between 2.5 to 3hrs)	Partial	See detailed summary in **Incident 7** within the Report. Police attended an incident where a child was located intoxicated and swearing in a local park. The child was known to be in the care of Territory Families. The members offered the child a lift home and she declined, saying she would "*smash the place up*". Members took the child into custody under s 133AB of the *Police Administration Act 1978* (NT) – custody for infringement notice offence.	• De-escalation, communication • Policy compliance (observations)

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						Members believed the child may have smoked synthetic cannabis and described her as hysterical and emotionally unstable. The child began to threaten self-harm while in the police vehicle, including a threat to harm a sibling. The custody nurse assessed the child as fit for custody but requested that the ERC be used. The child's carer attended but was unable to calm her and assessed that it was not safe to return the child to the group care home. The child calmed while under observation in the ERC, but escalated again when an attempt was made to release her. The Territory Duty Superintendent authorised an additional 1 hour period of ERC use. The custody nurse sought a medical opinion and a recommendation was made to convey the child to hospital for a mental health assessment. Paramedics attended, the child was sedated and taken to the hospital. Internal reviews identified a failure to advise the child of the basis for her arrest. No issues were identified regarding the use of the ERC.	• Adequacy of record keeping • Adequacy of internal review
18.	Female 14yrs Aboriginal	Watch House	Spit hood	Unknown	Partial	Child was arrested for breach of bail and assault police. Notes stated that child had been granted bail earlier that day, and that the child's electronic monitoring device had been cut off. The child spoke marginal English and notes indicated that the child would require an interpreter or a particular responsible adult in order to assist with communication. Records stated that the child was violent during her arrest, which included spitting at the arresting members. There was an alert for spitting on the child's profile. Upon arrival to the watch house, the arresting members donned safety glasses and obtained a spit hood from the watch house keeper. The child was directed to exit the vehicle and complied. Members warned the child not to spit and used directional head control.	• Adequacy of care to child in custody • Preparation and communication • Adequacy of record keeping

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						As they approached the watch house entry door, member was heard to say "*Ai, none of that*" but there was no audible spitting noise so it is unclear on review what occurred. A spit hood was applied immediately after that, and removed when the child was lodged in the female cell. The notes stated that the child was dirty and dishevelled when she arrived at the watch house. The CNS advised the watch house after they spoke with the child that she was hungry and cold, but there were no records to suggest these issues were addressed. A use of force review determined the force used during arrest was reasonable, and that OC spray or a Taser may also have been an appropriate response to the child at the time of arrest. Internal review of the incident report for the spit hood use referred to the full face shields available in other watch houses and that these may be a safer alternative to safety glasses. Risk Management and Internal Audit division advised that full face spit shields had been available for members in this location since early 2021.	
19.	Male 17yrs Aboriginal	Watch House	Spit hood	6 min 25 sec	Partial	See detailed summary in **Incident 3** within the Report. A child was arrested for damage to property. The child was known to have FASD and had a custody management plan which required him to be held 'at-risk' for the duration of his custody. The child had been spitting in the rear of the police vehicle, and threatened to spit in the face of members. The child was in pain from the handcuffs and a pre-existing knee injury. A member obtained a spit hood and directed the child to turn around and face the back of the vehicle, at which point the child saw the spit hood in the member's hands. The child immediately said he did not want the spit hood on and said he would not spit.	• Adequacy of custody management plan • De-escalation, communication • Proper placement of spit hood • Use of force (ground stabilisation)

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						The spit hood did not appear to be applied correctly, with the elastic under the child's chin instead of sitting across the bridge of his nose.[46] The child complained of difficulty breathing a number of times, escalating in volume and intensity. The member assessed that his airway was clear. When brought into the watch house, members sat the child down on the bench and held his legs to stop him from kicking out. After processing, the child was taken to his cell and ground stabilised for the removal of his handcuffs and the spit hood. The child continued to yell out and groan as this occurred, but there was no clear footage of what happened. The child was taken home after about 90 minutes, but was arrested a second time about 20 minutes later near the police station for fighting in public. The watch house keeper effected that arrest, and no spit hood was used. The child then remained in custody while intoxicated and was taken home with an infringement notice that evening. There were no issues identified on internal review.	• Adequacy of at-risk observations and/or record keeping
20.	Male 17yrs Aboriginal	Watch House	Spit hood	Unknown	Partial	Police attended an incident involving a complaint of people throwing rocks. When police arrived, they spoke to the child who asked them to lock him up. Members said they could not lock him up because he was only 17, and asked about his family. The child said his family were all dead. The attending members discussed the challenges involved with arresting a child and then resolved to arrest him for disorderly behaviour on the basis of their own observations.	• Basis of arrest • Adequacy of record keeping • Adequacy of internal review

[46] When placed correctly with the elastic over the bridge of the nose or just under the nose, the loose fabric at the bottom of the spit hood allows fluid to drain. If the elastic is placed under the chin, this reduces the effectiveness of that design aspect of the spit hood, resulting in a higher risk of asphyxiation.

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						Once arrested, the child escalated and began swearing. The attending members were hopeful the child would calm down on the way to the watch house. Arresting members observed the child spitting in the rear of the police vehicle during transport. The notes stated the child gave members the finger and began spitting in the holding cell. Records stated a member tried tactical discussion which did not stop the spitting, so a spit hood was applied during processing. Consequential force (holding the child by the hair) was involved in applying the spit hood. Records stated the child was released about 2.5 hours later to be served with a Notice to appear pending the outcome of the police investigation. No issues were identified by supervisors on internal review.	
21.	Male 17yrs Aboriginal	In field and Watch House	Spit hood, ERC	Spit hood: Unknown ERC: 26 min	Partial	An intoxicated child was apprehended at a shopping centre for disorderly behaviour. Records stated that a spit hood was used during processing at the watch house as the child was spitting on officers, however the available BWV showed the spit hood being applied in field. The spit hood was left on in the police vehicle during transport. Documents stated that after 45 minutes in custody, the child began hitting his head on the cell door. The child was handcuffed in an initial attempt to prevent this. The child was then shown the ERC and was warned they would have to use it if he continued trying to self-harm. The child was then placed in the ERC when the behaviour continued. The child was released into the care of a responsible adult shortly afterwards and issued with an infringement notice.	• Policy compliance (spit hood in cage; no CIIR for spit hood) • Proper placement of spit hood • Use of force (handcuffing) • Accuracy and adequacy of record keeping • Adequacy of internal review

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						There was no use of force form or CIIR form lodged for the use of the spit hood. A CIIR was lodged for use of the ERC. The internal review did not identify any issues.	• Adequacy of custody management plan
22.	Male 13yrs Aboriginal	Watch House	Spit hood	Unknown	Partial	See detailed summary in **Incident 4** within the Report. A child was arrested for breach of bail. There was little effort made to engage, discuss or explain the situation to him before the act of arrest. Documents stated child resisted arrest but little resistance observable on BWV. The child appeared to be quiet and compliant during arrest. Upon arrival to the watch house, a member had a spit hood on hand and showed it to child. The member said he would "*jam it on his head*" if the child spat on them, and that the child would be "*face down on the concrete*" to stop him spitting. Child was removed from the police vehicle and taken inside without the use of the spit hood. Child appeared compliant. When sitting down inside the watch house, the child put his head in his hands and began to cry. A member asked if the child was okay and whether he would like to talk to someone. The member offered to give him a few minutes. The child still had his face in his hands, then spat onto the floor. The member sternly directed the child to stop spitting. The child retaliated with a threat to kill the member, but delivered unconvincingly. There was little effort to de-escalate from here and a spit hood and handcuffs were applied to the child. The spit hood was not placed correctly, with the elastic sitting under the child's chin. The child was processed into custody with the spit hood on and taken to his cell. Members did not remove the spit hood when he was placed in the cell due to threats he would spit on them if they did. Instead, members instructed him to remove his own spit hood.	• De-escalation, communication • Use of force and policy compliance (spit hood threshold) • Proper placement of spit hood • Policy compliance (in cell use) • Duty of care (not considered "at risk") • Accuracy and adequacy of record keeping • Adequacy of internal review

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						The child refused to remove the spit hood, saying he wanted to spit on the members when they came in to take it off. The child left the spit hood on for around 10 minutes, periodically lifting it up to spit within his cell and on the cell glass. The Custody Health Assessment stated that the child had sniffed deodorant the night before or morning of his arrest. The child was remanded in custody and taken to a rehabilitation facility. Documents stated that the child asked members if he could clean the spit off his cell after he had been in custody for a while. There were no issues identified on internal review of the incident.	
23.	Male 16yrs Aboriginal	In field	Spit hood	22 min 42 sec	Yes	See detailed summary in **Incident 5** within the Report. Police were called to a child care centre. A child had entered after hours while a cleaner was present. When police arrived, the child was sitting on the couch in the staff kitchen. The child had vomited, was clearly unwell and asking for help. The child was spitting on the ground. Police tried to speak with him and encourage him to go outside. He asked for tissues to blow his nose. He tried to pass the rubbish to the member who refused to take it, at which point the child threw it at him. The situation escalated quickly from there with the members using force, including a headlock/choke hold, to move the child out of the centre. The child was then ground stabilised for an extended period awaiting the arrival of an ambulance. A spit hood was applied to the child while he was being stabilised on the ground. At one stage, the child asked for the spit hood to be removed for a second as he was going to vomit. A member said to him: "*You can vomit through it, that's what they're designed for*." The child complained that the spit hood was too tight with the elastic around his throat.	• De-escalation, communication • Use of force (choke hold) • Policy compliance (contra-indications to spit hood use) • Proper placement of spit hood • Accuracy of reporting • Adequacy of internal review

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						A while later, the child asked for the spit hood to be removed as there was spit and snot all through it and he could not breathe. A member tried to adjust it for him, but it appeared the effect was to rub the spit and mucous around on the child's face. When the ambulance arrived, the child was sedated for transport to hospital. It was noted that there was blood or bile inside the spit hood. A comment was noted on the custody incident form that the incident would be referred to a divisional officer for review due to concerns about the use of a choke hold and failure to advise of the reason for arrest. The divisional officer stated that this was never tasked to him. Internal reviews did not identify any issues with the use of the spit hood, and it does not appear that any feedback was provided to members about the decision to use it or manner of use.	
24.	Male 17yrs Aboriginal	Watch House	Spit hood	1 min 24 sec	Partial	Police attended a home to arrest child for aggravated unlawful entry. The child was lying down when he was handcuffed and initially appeared to be compliant. The child requested to be permitted to get a T-shirt before he left, which members did not allow. The child then resisted forcefully. The child calmed somewhat once placed in the cage, but became significantly agitated when members would not permit him to say goodbye to his partner, who had run out onto the street. The child was screaming, running into and kicking the cage door during transport. Upon arrival to the watch house, he vomited in the rear of the police vehicle, and then spat on the floor. . TRG members were requested to assist with moving the child to the holding cell. All members donned PPE face shields, except for one. TRG members directed the child to sit down on the floor of the cage, and the child complied. The spit hood was applied by the member who did not don PPE, and the child removed the spit hood himself immediately upon being lodged in the holding cell.	• De-escalation, communication • Policy compliance (threshold for use, contra-indications for use, in cell use) • Failure to utilise appropriate PPE • Adequacy of internal review

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						The spit hood was not used again for any subsequent processing through reception. A CIIR form was lodged, and no issues were raised on review by either the Watch Commander or the Territory Duty Superintendent.	
25.	Female 17yrs Aboriginal	In field	Spit hood	Unknown	Partial	Police were called to a residential care home when a child returned to the home intoxicated and began threatening carers. Police attended and located the child lying in bed with a screwdriver. The child appeared to be asleep. The screwdriver was removed and members woke the child. Members spoke to the child about what had occurred. The manner of engagement involved the child being told to stop swearing, show some respect, that she couldn't wake people and threaten people in the middle of the night, that she needed to sleep off the grog and get off grog. During the conversation, one member told the child to "*grow up*" and said "*I'm not scared of you, and running your little dirty mouth off doesn't do anything.*" The members tried telling the child to go to sleep. The child periodically got back on the bed and covered herself, but continued her angry comments and the members continued engaging with her. The members eventually left the room and went outside. Shortly afterwards, the child came outside carrying a fork, and the members apprehended the child for protective custody. The documents stated that on arrival at the watch house, the child was uncooperative, yelling, not answering questions, spitting, not standing up, laying on the floor, shaking and imitating choking. The custody nurse determined that the child was not fit for custody due to her erratic behaviour, her attempts at self-harm and her self-harm history, meaning she would need to be restrained for the entire custodial episode.	• De-escalation, communication • Adequacy of record keeping

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						An ambulance was called and the child was held in a padded cell while waiting for its arrival. The child walked to the ambulance, but upon being strapped in she began spitting. A spit hood was applied and the child was sedated for transfer to hospital. A CIIR form was completed and notifications were made at the time as required by the Custody Instruction. No issues were identified upon internal review.	
26.	Female 17yrs Aboriginal	Watch House	ERC	30 min 46 sec	Yes	See detailed summary in **Incident 8** within the Report. A child was arrested for stealing with violence. The initial interaction with police and arrest appeared to be reasonably calm. Once in the police vehicle, the child began to get upset about losing her phone. She also spoke of having a sore hand and being punched by a man. The child stated she had been sniffing spray. Members tried to engage with her but appeared to tire of it, eventually telling her they did not have her phone and to "*stop whinging*" about it. The custody nurse at the watch house stated that they would not accept the child into custody due to volatile substance abuse. Members transported the child to hospital for a fit for custody assessment. On arrival at the hospital, the child began to hit her head on the police cage. She intermittently laid down, gasped and failed to respond to verbal prompts, also yelling about losing her phone and wanting her boyfriend. In the hospital, the child spat on the floor. A member directed her to stop and immediately put a surgical mask on the child, which appeared effective. A doctor spoke to members and initially explained that he would give a physical clearance for custody, as the child had a history of wanting to sleep at the hospital, knowing she would be released in the morning.	• De-escalation, communication • Adequacy of record keeping

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						When returned to the police vehicle, the child asked to be returned to her placement. She also said she needed to use the toilet. A member stated she could take her in to use the toilet if she calmed down. On the way back to the watch house, the child continued banging her head in the cage. On arrival, the child continued to groan and gasp in the cage. Members donned face shields, removed her from the cage and immediately placed her into the ERC. Members conducted four checks and re-assessments of the child before the child agreed to stop attempting self-harm. The child was released from the ERC, provided with a mattress, and went to sleep. A CIIR form was completed. No issues identified on internal review.	
27.	Male 16yrs Aboriginal	Watch House	ERC	18 min 30 sec	Yes	See detailed summary in **Incident 9** within the Report. A child was arrested for breaching a DVO and aggravated assault. Documents stated that the child assaulted police in the process of being arrested. The child was not intoxicated, however cannabis was located on him when he was searched on arrest. The child's ankle was temporarily stuck in the cage door when it was being closed by members following arrest. Upon arrival at the watch house, the child was swearing at the watch house keeper and kicking the cage. There were 6-7 members standing outside the cage. The watch house keeper opened the cage and spoke to the child, reminding him of an interaction they'd had outside the watch house before, and that the watch house keeper had always treated the child in a good way. The watch house keeper offered the child the chance to hop out on his own, stating if he did so, no one would touch him and they would be able to take the handcuffs off. The child did not get out of the vehicle, and was removed by the members and taken into the watch house using an escort hold.	• De-escalation, communication (search)

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						The child was searched at the reception desk and was heard objecting to being searched and having his clothes removed. He said that he was not a child and wanted to remove his clothes himself. He was also complaining about pain from the handcuffs. The watch house keeper removed the handcuffs but the process of doing so appeared painful. While being processed, the child suddenly twice banged his head hard on the reception counter. The watch house keeper immediately placed him into an ERC, as there was no padded cell available. The child yelled out that this was making him more angry and he was losing his wind. The child screamed to be released from the ERC. A custody nurse was present and assessed the child immediately, asking for one arm cuff to be loosened slightly. Once the child was properly secured in the ERC, the watch house keeper sat down next to the child. He spoke to the child calmly and assured the child that he wanted to look after him. The watch house keeper agreed to release one of the child's arms so he could have a drink of water, and then made a deal to release the other arm after 5 minutes of calm. The watch house keeper continued to speak with the child about his last drug use, and asked the child, using the child's own language, when the child had last had meat and offered the child a sandwich. The child de-escalated quickly throughout this interaction with the watch house keeper, and was released from the ERC after a total of about 18 minutes. A CIIR form was completed and no issues were identified on internal review.	
28.	Male 15yrs Aboriginal	Watch House	Spit hood	29 min	Yes	See detailed summary in **Incident 6** within the Report. A child was arrested as part of a larger group of children with respect to some property offending. The child was on bail at the time and was wearing an electronic monitoring device.	• De-escalation, communication

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						The child was handcuffed and placed in the rear of a police vehicle. The child was compliant and did not resist his arrest. After he was placed in the vehicle, the child was heard to politely question the basis of his arrest a number of times, as well as to complain about pain from the handcuffs, requesting that they be loosened or removed. Due to the complexity of the situation and the number of children involved, it took some time until police were able to leave the scene to return to the watch house for processing the children. During this time, the child continued his questions and complaints with respect to the handcuffs, becoming more agitated and less polite as time passed. By the time the child was removed from the police vehicle and lodged in the holding cell, he appeared to be visibly in pain from the handcuffs and frustrated with his repeated attempts to address his situation. The child spat at one of the members, striking him on the trouser leg. The Custody Sergeant made a phone call to the Watch Commander who approved the use of a spit hood. The spit hood was applied to the child in the holding cell. The child remained in the holding cell, handcuffed and with the spit hood on for a period of 23 minutes and 34 seconds before he was removed from the holding cell for processing. During this period, the child was sitting and lying down in the cell. Physical checks were not made every 10 minutes as required by the Custody Instruction. The child was eventually taken for processing and had the handcuffs removed about 90 minutes after they were first applied. The child complained of pain in his arms and wrists from the extended handcuffing. The child complied with processing and removed his spit hood and passed it to the members immediately upon being lodged in a cell. The spit hood was in place for a total period of 29 minutes.	• Use of force (excessive use of handcuffs) • Policy compliance (use in cell and observations) • Accuracy of record keeping and reporting • Adequacy of internal reviews

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						Internal review of the CIIR form by the Watch Commander and Territory Duty Superintendent did not identify any issues with respect to the spit hood use. The sentinel review conducted by the Risk Management and Internal Audit division noted some areas of non-compliance with the Custody Instruction, but it did not appear that any feedback was provided to members.	
29.	Female 15yrs Non-Aboriginal	In field	Spit hood	8 min	Yes	Police were called to a motor accident. A child in the care of Territory Families had attempted suicide earlier in the day and was taken to the hospital, which had refused to admit her. During the conveyance back to her secure residential facility, the child kicked the window out on the vehicle. The child was restrained by her carers, and police were contacted to assist with a conveyance back to the care facility. The child was restrained face up on the ground. When the police arrived, she was heard to say she hated the police. The child spat at one of the members, and a spit hood was applied in field. The spit hood was not applied correctly, as the elastic was placed under the chin. The child was moved to the rear of the police vehicle, and the spit hood was left on. The child was making threats from within the police vehicle that she would smash the care house up and that she would kill and murder her parents. The child managed to get her own spit hood off before the vehicle departed. There were no issues identified on internal review.	• Policy compliance (use in vehicle) • Proper placement of spit hood
30.	Male 15yrs Aboriginal	In field	Spit hood	Unknown	Yes	A child was taken into custody under s 133AB of the *Police Administration Act 1978* (NT) for fighting in public. It took some time for police to take the child to the police vehicle, as they were also trying to deal with another alleged offender. During this period, the child spat on the ground near members a number of times. It did not appear from the footage that the child was doing this in a manner such as to target members.	• Proper placement of spit hood • Policy compliance (use in vehicle)

No.	Demographic	Location	Device(s)	Duration of use[1]	Footage available	Circumstances of use	Ombudsman issues of interest[2]
						The members were concerned about the spitting, with one member making a comment about COVID-19. The child was warned a number of times to stop spitting or a spit hood may be used. The child continued to spit and a spit hood was applied. The spit hood was not applied correctly, as the elastic was placed under the child's chin. Members left the spit hood in place after they locked the child in the rear of the vehicle. The child managed to remove the spit hood himself once inside. Notifications were made as required. Internal reviews did not identify any issues with respect to the use of the spit hood.	• Adequacy of internal review